

INSTITUTO UNIVERSITÁRIO EGAS MONIZ
MESTRADO EM PSICOLOGIA CLÍNICA E DA SAÚDE

**SEXUAL, RELATIONAL AND BODILY SATISFACTION IN YOUNG
PARENTS: PERINATAL ISSUES AND NEEDS**

Trabalho submetido por
Katell Anne Bourdon

para a obtenção do grau de Mestre em Psicologia Clínica e da Saúde

julho de 2025



EGAS MONIZ SCHOOL
of HEALTH & SCIENCE

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Trabalho orientado por

Prof. Doutora Marta Sofia Pereira dos Reis

julho de 2025

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Abstract

The transition to parenthood is a period of profound psychological and relational transformation, often accompanied by changes in sexual and body-related satisfaction. This study investigates these dimensions among young French heterosexual parents, with particular attention to the perceived quality of perinatal support. Based on a cross-sectional, predominantly quantitative methodology, the research collected data from 52 participants through validated psychometric tools and open-ended questions. Results highlight a significant decrease in sexual satisfaction during pregnancy, persisting moderately postpartum, while relationship satisfaction remains high. Body satisfaction appears more variable, with mixed attitudes among mothers. Importantly, over 60% of participants reported receiving little or no information from healthcare providers about sexuality, couple dynamics, or bodily changes, and expressed a clear need for better guidance. These findings underline a critical gap in French perinatal care and point to the necessity of integrating relational, sexual, and body-related support into existing health systems.

Keywords: Perinatal Sexuality, Couple, Body, Support, Need

Note from the author: This thesis was originally written in French and translated into English using the assistance of digital tools to support the linguistic adaptation. The scientific content, methodology, analysis, and interpretations remain entirely the author's original work.

Resumo

A transição para a parentalidade é um período de profundas transformações psicológicas e relacionais, frequentemente acompanhado por alterações na satisfação sexual e corporal. Este estudo investiga estas dimensões em jovens pais heterossexuais franceses, com especial atenção à perceção da qualidade do apoio perinatal. Com base numa metodologia transversal, predominantemente quantitativa, a investigação recolheu dados de 52 participantes através de instrumentos psicométricos validados e perguntas abertas. Os resultados revelam uma diminuição significativa da satisfação sexual durante a gravidez, que persiste moderadamente no pós-parto, enquanto a satisfação relacional se mantém elevada. A satisfação corporal apresenta-se mais variável, com atitudes mistas por parte das mães. Importa salientar que mais de 60% dos participantes referiram ter recebido pouca ou nenhuma informação dos profissionais de saúde sobre sexualidade, dinâmica do casal ou alterações corporais, e expressaram uma necessidade clara de melhor orientação. Estes resultados evidenciam uma lacuna crítica nos cuidados perinatais em França e apontam para a necessidade de integrar o apoio relacional, sexual e corporal nos sistemas de saúde existentes.

Palavras-chave: Sexualidade Perinatal, Casal, Corpo, Apoio, Necessidade

Nota da autora: Esta dissertação foi originalmente redigida em francês e traduzida para inglês com o auxílio de ferramentas digitais, com o objetivo de apoiar a adaptação linguística. O conteúdo científico, a metodologia, as análises e as interpretações permanecem inteiramente como trabalho original da autora.

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1. Introduction

“One is not born a parent, one becomes one” (quotes attributed to Françoise Dolto, inspired by Simone de Beauvoir’s “One is not born a woman, one becomes one,” 1949). This quote suggests that parenthood is a process, a transition from one state to another. This journey brings deep personal and relational changes, often accompanied by new and specific needs that emerge during the process.

For young parents, the transition to parenthood represents a major developmental milestone with significant psychological, relational, and social implications.

According to INSEE (2024), 663,000 babies were born in France in 2024, meaning several hundred thousand people became parents. Even when anticipated, becoming a parent brings major shifts in couple dynamics, sexual intimacy, and body perception. Numerous studies have highlighted a frequent drop in sexual satisfaction after birth, a weakening of the marital bond and an alteration of body image, particularly among women (Grussu et al., 2021; Klapilová et al., 2020; Meltzer & McNulty, 2010).

Yet, these changes are rarely addressed in French perinatal care, which is still largely focused on biomedical aspects. The subjective experience of young parents, particularly in terms of sexuality, relationships and their relationship to the body, remains undervalued, even invisible in support practices (Raymond, 2021).

In this context, a central question arises: how do young parents experience their sexual, relational and bodily satisfaction in the perinatal period, and what support needs do they express in these areas today in France?

Today, it is particularly important to address this topic in France. On the one hand, research that simultaneously explores body, sexual, and relationship satisfaction in the postpartum period remains very rare, particularly when it comes to integrating the experiences of both partners in the couple. Men are still largely underrepresented in the scientific literature on these topics, even though they are just as subject to the changes associated with parenthood.

Furthermore, this study is part of a global health perspective, which goes beyond a purely biomedical approach. The few studies available are mostly conducted in the medical field, particularly by midwives, and often adopt a vision focused on

1. Introduction

physiological aspects. However, psychology has its place in the analysis of the transformations that a couple goes through upon the arrival of a child.

Finally, previous research has highlighted a significant lack of structured support for young parents. Given this lack, it is essential to document the challenges experienced by young parents and their support needs in order to inform thinking about current and future support practices.

This thesis aims to explore how young French parents experience sexual, relational, and body satisfaction and what kind of support or information they feel is lacking.

In order to address the complexity and interconnection of sexual, relational and bodily satisfaction, this study adopts a quantitative method design. This choice allows for the measurement of satisfaction levels using standardized psychometric tools. This approach is essential to inform and enrich perinatal support practices.

After presenting the state of current knowledge on parenting and its issues, we will outline the methodology of the study, before presenting and discussing the results obtained.

To better understand the challenges of modern parenthood and the needs of young parents, it is essential to draw on existing research on relational, sexual, and body satisfaction. This literature review will situate this research within its theoretical and clinical framework.

2. State of the Art

2.1. Definitions of the Primordial Concepts

To better understand the findings presented later, it is useful to first clarify how the key concepts used in this study are defined. Although the notions of sexual, relational, and body satisfaction are frequently used in the literature, their definitions vary depending on theoretical or clinical frameworks. Since these three notions are at the heart of this work, it is essential to define them as we understand them here.

2.1.1. Relationship Satisfaction

Relationship satisfaction is considered here as the level of contentment of an individual with his or her relationship, including emotional, communicational, and behavioral aspects. It reflects the perceived quality of the relationship, measured through dimensions such as mutual support, conflict resolution and emotional intimacy. This study is based on the relationship assessment scale (*Relationship Assessment Scale*, Hendrick, 1988) to assess this dimension unidimensionally, with scores reflecting levels of satisfaction.

2.1.2 Body Satisfaction

Body satisfaction is considered here as an individual's perception and acceptance of their own body, particularly after the physical changes associated with pregnancy and childbirth. It includes positive or negative attitudes toward physical appearance, body weight, and perceived desirability. In this study, it was measured in mothers using the *Pregnancy and Weight Gain Attitude Scale* (Palmer, Jennings & Massey, 1985), allowing the identification of bodily attitudes (positive or negative) and their impact on overall well-being.

2.1.3 Sexual Satisfaction

Sexual satisfaction is defined here as the level of contentment in the sexual dimension of a couple's relationship. It encompasses various elements like how often partners have sex, the quality of those experiences, their ability to feel pleasure, and how well their sexual expectations align. The study uses the *Index of Sexual Satisfaction* (ISS, Hudson et al., 1981) to measure this dimension through a score.

2.2. Parenting-Related Changes and Relationship Satisfaction

The transition to parenthood causes a major upheaval in the couple's relationship (Favez, 2013). During a survey conducted by IFOP (French organization responsible for conducting opinion polls and market studies) it was shown that 50% of parents surveyed felt like breaking up with their partner after the birth of their youngest child (Thomas, 2022).

This finding is supported by the research of Cowan and Cowan (2000), who showed, through a longitudinal study, that the arrival of a child often leads to a deterioration in the quality of the marital bond, even in couples without major conflicts beforehand. However, the sample of this study is mainly composed of middle-class married couples, which limits the transfer of these results to other populations, particularly those more precarious or without marital status.

Becoming parents often forces couples to reorganize their relationship, which can lead to emotional distance or even tension. Murray, Holmes, and Collins (2006) propose the risk regulation model, suggesting that how secure a partner feels shapes how much emotional effort they're willing to invest. When that security is undermined, for example, due to fatigue, identity shifts, or reduced intimacy, individuals may unconsciously withdraw or disengage in order to protect themselves. This model can help explain some of the distancing behaviors observed in couples after childbirth.

The transition from partner status to co-parent status requires a redefinition of roles and an ability to adapt to the new demands of daily family life. For their part, Shapiro et al. (2000) highlight that the quality of communication within the couple in the months following birth is a key factor in preserving emotional intimacy. Couples who manage to keep communicating openly and kindly, even when they're exhausted or overwhelmed, tend to navigate relationship stress with more resilience. This work highlights the need to include, in perinatal support, a specific component focused on supporting the couple's relationship, which is still poorly integrated into French practices.

2.3. Postpartum Sexual Satisfaction

Among all areas of intimate life, sexual satisfaction is often the one most impacted after childbirth. Numerous studies show that the transition to parenthood frequently leads to a decrease in sexual desire, frequency of intercourse, and orgasm, as

well as an increase in pain during intercourse (dyspareunia) (Grussu, Vicini, & Quatraro, 2021). These alterations are influenced by a combination of physiological (fatigue, discomfort, healing, breastfeeding), psychological (depression, stress, anxiety), and sociocultural factors, including gender norms and implicit expectations about the maternal role (De Pierrepont et al., 2022). The Interpersonal Exchange Model of Sexual Satisfaction (IEMSS) (Mark, 2015) also helps to understand how perceived imbalances between efforts (fatigue, pain, mental load) and benefits (pleasure, connection, support) can affect sexual desire within the postpartum couple. This theoretical framework highlights the importance of the feeling of balance and mutual recognition in the experience of sexual satisfaction, beyond purely physiological or hormonal factors.

While the sexuality of the young couple may be subject to change, it often remains a taboo in postnatal medical discourse, rarely addressed during consultations (often initiated by young mothers), which contributes to the isolation of parents and the entrenchment of false beliefs (Baudry, 2008; Raymond, 2021). In France, sexuality is rarely addressed in a structured way during postpartum care, unlike in Canada, where specialized professionals are sometimes part of perinatal teams (De Pierrepont & Polomeno, 2014).

Foucault (2011) found that when sexuality is openly addressed (both during pregnancy and after birth) couples are more likely to resume intimacy in a positive and connected way. This study, although qualitatively rich, was based on a limited number of interviews, which does not allow its results to be generalized to all French parents.

More than a decade later, the recommendations from this work remain poorly implemented in French maternity wards. Generally speaking, perinatal interventions targeting sexuality remain rare (Byers-Heinlein et al., 2019). However, studies show that postpartum sexual well-being goes far beyond simply resuming intercourse; it is deeply tied to emotional and relational health (Elia et al., 2019; Meltzer & McNulty, 2010). These authors show that sexual satisfaction directly influences the quality of the couple's relationship, particularly through its effect on emotional intimacy and the frequency of positive interactions.

Finally, postnatal sexuality can be compromised by feelings of undesirability or bodily inadequacy, particularly among women with a negative body image (Klapilová et al., 2020). When these challenges aren't acknowledged or addressed, they can lead to tension in the relationship, or even to long-term sexual avoidance. These elements

highlight the need to recognize sexual satisfaction as a perinatal health issue in its own right, and to integrate a sexological approach into the postnatal journey, in the same way as physical or mental health.

2.4. Body Image, Desirability and Sexuality

The postpartum period is a particularly sensitive time for body image, as women deal with fast, visible changes that aren't always easy to accept. While pregnancy and motherhood are generally valued in social discourse, the resulting bodies are often judged against rigid aesthetic standards. Tiggemann (2011) emphasizes that body image can remain unstable throughout adult life, and that periods such as pregnancy or the postpartum period exacerbate this instability. Cash and Smolak (2011), in their review on the prevention of body image disorders, show that body dissatisfaction is strongly associated with a drop in self-esteem, depressive symptoms, but also a deterioration in interpersonal relationships, particularly in the sexual sphere.

Several recent studies, including that of Klapilová et al. (2020), confirm that postpartum bodily changes profoundly affect female sexuality. They note not just lower desire and pleasure, or lingering pain, but also a strong social pressure to quickly 'bounce back' to a normalized sexual routine. Meltzer and McNulty (2010) explain this phenomenon through a mediation model: women who feel undesirable or dissatisfied with their bodies tend to avoid emotionally engaging or intimate behaviors, which limits the frequency and quality of sexual interactions within the couple. This can lead to a vicious circle: the more someone feels unhappy with their body, the more they may avoid intimacy, deepening emotional distance in the relationship.

The bodily experience during pregnancy is shaped not only by physical changes but also by psychosocial factors. DiPietro et al. (2003) demonstrated that attitudes toward weight gain are strongly influenced by psychological and social variables, such as stress levels, internalized cultural norms, and perceived support. Their study suggests that some women may experience weight gain as distressing, while others perceive it more serenely, particularly when it aligns with positive representations of motherhood. These differences help explain the highly varied experiences of body image observed during the perinatal period.

As early as 2000, Brown and Lumley denounced the structural weakness of postnatal care, pointing out the lack of real support for the subjective needs of mothers,

particularly with regard to their bodily and sexual experiences. Twenty years later, the issue remains relevant. Feminist approaches, such as that of Susan Bordo (2003), remind us that standards of thinness, youth, and body control have historically been imposed on women, and that motherhood, although idealized, is not immune to this surveillance. The postpartum body then becomes a terrain of tension between maternal identity and sexual identity, which weakens the reappropriation of sexuality.

These findings converge on a key recommendation: integrating postnatal support focused on the body dimension, not only medical, but also psychological, emotional, and sociocultural. A comprehensive approach would help give young mothers a sense of legitimacy in their transformed bodies and restore a positive relationship with sexuality within the couple.

2.5. Articulation between Body, Sexual and Relational Satisfaction

Body, sexual, and relationship satisfaction form a set of interconnected dimensions that mutually strengthen or weaken each other during the postpartum period. The study of these interactions is essential, both clinically and theoretically, because it allows us to understand how new parents, particularly mothers, navigate the upheavals of parenthood, in terms of desire, intimacy, and self-relationship.

Numerous studies have shown that body image, often undermined after pregnancy and childbirth, plays a fundamental role in postnatal sexuality. Body dissatisfaction frequently leads to a decrease in desire, avoidance of nudity or sexual behaviors, and a feeling of undesirability (Tiggemann, 2011; Cash & Smolak, 2011). Meltzer and McNulty (2010) highlighted a mediation model according to which body dissatisfaction negatively influences marital satisfaction via a decrease in sexual satisfaction. When the person feels less attractive or less desirable, they tend to reduce emotional openness behaviors, which weakens the couple's intimacy. Although this model is statistically robust, it remains essentially correlational, which does not allow us to conclude causal links between body image, sexuality and marital satisfaction.

Sexuality therefore constitutes a pivot between body esteem and the marital relationship. A sexuality experienced in a positive way, even in a context of bodily transformation, can act as a protective factor by maintaining a form of mutual recognition and intimacy within the couple (Shaw & Rogge, 2016). Conversely, painful,

absent, or unsatisfying sexuality reinforces the feeling of distance, incomprehension, or even relational failure (Klapilová et al., 2020).

The quality of the couple's relationship also plays a moderating role in these interactions. The work of Shapiro, Gottman, and Carrère (2000) has shown that couples who are able to maintain empathic and sustained communication after birth are better able to preserve their relationship satisfaction and intimacy. Cowan and Cowan (2000) emphasize that the transition to parenthood profoundly redefines roles within the couple, and that couples who withstand the stress of this reorganization are those who manage to maintain an open emotional and sexual space.

These dynamics suggest the existence of a circular model in which body image, sexuality and the marital relationship influence each other in a feedback loop. A decline in satisfaction in one of these spheres can thus have direct repercussions on the other two. Although the majority of French research only addresses these dimensions separately, some foreign studies highlight the value of an integrated approach. For example, a study conducted in the Netherlands by van den Brink et al. (2018) showed that a positive body image among young mothers is associated with a better perceived quality of the marital relationship, via an increase in sexual satisfaction. This dyadic model highlights the strength of the links between body experience, intimacy and relationship satisfaction in couples becoming parents. Although carried out in a different sociocultural context, this study highlights psychological mechanisms that can reasonably be considered in the French context.

This observation reinforces the need for comprehensive perinatal support, integrating not only physical and psychological health, but also issues of intimacy, desirability, and marital dynamics. However, in France, few systems take these three dimensions into account in a coordinated manner, which leaves many young parents without support in the face of these interdependent upheavals.

2.6. Support for Parenthood in France and Elsewhere

Parenting support modalities vary considerably depending on cultural and institutional contexts. Several countries, including Sweden and Canada, have developed innovative approaches aimed at supporting young parents beyond the purely biomedical aspects of pregnancy and childbirth. These systems integrate, to varying degrees,

emotional, educational, and sometimes sexual dimensions, contrasting with the still limited practices in France.

2.6.1 The Swedish model: a Universal and Preventive Approach

In Sweden, parenting support is based on a logic of prevention and universality. According to Lundqvist (2015), local policies offer parents free and voluntary access to educational programs aimed at strengthening parenting skills, fostering the parent-child bond, and preventing family difficulties. These programs are implemented regardless of any vulnerability, with a view to providing generalized support for family well-being. Although sexuality and marital relationships are not directly addressed in the interventions described, this holistic approach reflects a broad conception of parenting, in which emotional and relational support has its place. It is clearly distinguished from the French model, which is more focused on the medical aspect of motherhood and less inclined to offer psychoeducational support accessible to all.

2.6.2 The Canadian model: Integration of Intimate Issues in Perinatal Monitoring

In Canada, some provinces have developed an interdisciplinary approach to perinatal care, integrating professionals specifically trained in postpartum sexuality issues. However, these systems are not present in all regions, and their long-term effectiveness is still the subject of little evaluation. De Pierrepont and Polomeno (2014) describe the role of the perinatology-sexologist as a key player in perinatal teams: he supports couples on the themes of desire, body image, intimate communication and the reintegration of sexuality after childbirth. These interventions not only help to normalize postnatal sexual fluctuations, but also to reduce marital distress linked to the lack of information or the feeling of guilt often felt by parents. This specialization illustrates an institutional recognition of the sexual and relational needs of young parents, which remains largely absent from the French system.

However, it is important to understand that these systems are implemented in very different cultural and social policy contexts, which limits direct transposition to the French model.

2.6.3. An Institutional Delay in France

In France, postnatal follow-up remains predominantly focused on the physical health of the mother and child, with a biomedical approach focused on bodily recovery and short-term medical monitoring. However, this approach shows its limitations when

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considering the psychosexual, relational, or identity needs of young parents. A study conducted on professional discourse and patient forums highlights those issues related to postpartum sexuality, body image, or even the couple's relationship is very rarely addressed in postnatal consultations. These topics often remain taboo or perceived as secondary by caregivers, despite their recognized impact on overall well-being (Raymond, 2021). Raymond's study (2021), although relevant, is mainly based on female testimonies from online forums, which may introduce a selection bias.

This lack of integration of the intimate and subjective dimension in postpartum monitoring contrasts sharply with certain more holistic foreign models, and contributes to a form of invisibility of the emotional and relational experiences of mothers.

2.6.4. Challenges for France

Comparing these models reveals the interest of a double movement: on the one hand, offering universal and destigmatizing support for all parents (as in Sweden); on the other hand, integrating specialized skills in perinatal teams to meet the specific needs related to postpartum intimate and marital life (as in Canada). These combined approaches could inspire reforms in France in order to offer young parents truly comprehensive support adapted to their realities.

As summarized in Table 1, perinatal care models differ widely across countries in terms of the integration of intimate and relational dimensions.

Table 1

Comparison of International Perinatal Care Models

Country	Model Type	Key Characteristics	Sexual and Relational Dimensions	References
Sweden	Universal and Preventive	Free, voluntary educational programs open to all parents, regardless of vulnerability	Not explicitly included	Lundqvist (2015)
Canada	Interdisciplinary with specialization	Inclusion of perinatal sexologists in some teams; attention to desire, body image, intimacy	Explicitly integrated	De Pierrepont & Polomeno (2014)
France	Predominantly biomedical	Focus on physical recovery; short-term monitoring; lack of psychological or intimate support	Largely absent or taboo	Raymond (2021); Foucault (2011)

2.7. Conclusion of the State of the Art, Contemporary Issues and Needs

Analysis of national and international scientific literature highlights a strong consensus: the transition to parenthood brings about profound transformations in the lives of individuals and couples, simultaneously affecting relationship satisfaction, sexuality, and body image. These upheavals, although expected to some extent, are often minimized or even neglected in the support offered to young parents in France.

Research shows that relationships often weaken after the arrival of a child, due to the redefinition of roles, fatigue, stress, and a decrease in time spent on intimacy (Cowan & Cowan, 2000; Shapiro et al., 2000). At the same time, sexual satisfaction decreases, impacted by physiological, emotional, and sociocultural factors, without these issues being truly addressed in the perinatal context (Grussu et al., 2021; De Pierrepont et al., 2022). Compounding these challenges is the issue of body image, often altered by the physical transformations linked to pregnancy and childbirth, which significantly influences both sexuality and the quality of the couple's relationship (Tiggemann, 2011; Meltzer & McNulty, 2010).

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The state of the art demonstrates that these three dimensions (bodily, sexual and relational) cannot be thought of independently. Their interaction forms a dynamic system, in which a difficulty in one of the areas can affect the other two. However, no current support system in France addresses them jointly, which leaves a significant clinical and institutional gap, already highlighted by several authors (Foucault, 2011; Raymond, 2021).

In comparison, other countries such as Canada or Sweden offer more integrated approaches: the first via the inclusion of perinatal sexologist in perinatal teams (De Pierrepont & Polomeno, 2014), the second via universal parental support, psychoeducational programs that are accessible to all (Lundqvist, 2015). These examples show that comprehensive support is not only possible, but desirable.

However, it is important to note that most of the studies presented rely on self-reported data, which is susceptible to social desirability bias, especially on a taboo topic like sexuality. Furthermore, some studies may also exhibit selection bias. Few of these studies adopt a longitudinal approach, despite the fact that the transformations related to parenthood evolve over time. Finally, studies involving both partners remain rare, despite the deeply relational nature of the issues addressed. These methodological limitations are common in research on these topics and highlight the need for more diverse, inclusive, and context-sensitive studies to better understand the needs of young parents.

In light of the findings highlighted in this state of the art, it appears that young parents in France express a need for information, support, and normalization regarding their sexuality, their relationship with their body, and their marital relationship. Meeting these needs requires broadening the current concept of perinatal care by integrating the emotional, identity, and intimate dimensions of the parental experience.

This is the perspective of this research project, which aims to explore the levels of sexual, relational and bodily satisfaction among young parents in France, as well as the perceived needs in terms of support. The challenge is twofold: to describe the realities experienced and to highlight the interest of more comprehensive perinatal support, commensurate with the transformations that contemporary parenthood entails.

Based on these theoretical elements, the following hypotheses could be formulated and justified.

2.7.1. Hypothesis 1

New parents report varying levels of sexual and relationship satisfaction after the birth of their child, with a significant proportion indicating a decline compared to the pre-pregnancy period.

This hypothesis is based on the work of Grussu et al. (2021) and Meltzer & McNulty (2010), who highlight that sexual and relationship satisfaction frequently decreases after the birth of a child.

2.7.2. Hypothesis 2

A significant proportion of young mothers report body dissatisfaction after pregnancy and childbirth.

This hypothesis is supported by research by Klapilová et al. (2020) and Tiggemann (2011), which shows that a significant proportion of young mothers experience postpartum body dissatisfaction.

2.7.3. Hypothesis 3

A significant proportion of young parents report that the information they received during pregnancy or after childbirth from medical staff about sexuality, the couple's relationship and body was not clear or complete.

This hypothesis is based on the work of Raymond (2021) and Foucault (2011), who highlight that information on sexuality, the couple's relationship and the body are rarely clearly addressed in perinatal monitoring.

2.7.4. Hypothesis 4

A significant proportion of young parents report that they would have liked to receive more information on the topics of sexual, body and relationship satisfaction.

This hypothesis is supported by studies by De Pierrepont and Polomeno (2014) and Baudry (2008), which highlight the unmet information needs of young parents on sexuality, relationships and body image.

2.7.5. Hypothesis 5

There are differences in levels of sexual, body, and relationship satisfaction based on demographic characteristics such as biological sex, age, occupation, or number of children.

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This hypothesis is inspired by the results of van den Brink et al. (2018) and Shaw & Rogge (2016), which indicate that certain demographic factors influence levels of intimate and relationship satisfaction.

2.7.6. Hypothesis 6

Young parents who expressed a desire for more information about body, sexual, and relationship satisfaction tend to report the lowest levels of satisfaction in these three areas.

This hypothesis is based on the work of Elia et al. (2019) and Cash & Smolak (2011), which shows that people who are least satisfied with their sexuality, their body or their relationship are often those who express the greatest need for support and information

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3.1. Presentation of the Research Design

The study follows a quantitative method design, descriptive, and cross-sectional in nature. The main objective is to measure the level of sexual, relational and bodily satisfaction among young parents using standardized psychometric tools. The results are descriptive and not intended to explore causal relationships. This cross-sectional design was chosen because all participants had recently experienced the same life event: becoming a parent. This approach offers a snapshot of current perceptions, without aiming to track changes over time. The descriptive nature stems from the fact that no variables were manipulated. This design fits the study's purpose: to describe satisfaction levels and not to explain what causes them.

3.2. Justification of the Choice of Methodology

The research question of this study focuses on the bodily, relational and sexual satisfactions of young parents. A quantitative design, descriptive and cross-sectional type allows us to measure, through a standardized questionnaire, the levels of satisfaction of these women and men, without seeking to explore the underlying reasons for these satisfactions, which corresponds entirely to the objective of my research.

One of the advantages of this design is that it allows for statistical analysis of the collected data, which makes it easier to present the results, mainly in the form of graphs and tables. This will help make the conclusions more accessible and provide a visual representation of the data.

As previously stated, the use of a questionnaire in this study allows for the collection of standardized and easily statistically analyzed data, which is perfectly in line with the chosen study design.

Most of the literature presented in the first part of this thesis uses a design similar to the one chosen here. Choosing to reproduce this method can allow us to compare the results and observe consonance or dissonance.

3.3. Description of Data Collection Tools

The instrument used in this study to collect data is a self-administered questionnaire (see Appendix A), comprising a section for women and another for men. It was developed based on questionnaires designed by Foucault (2011) in his evaluation of the information given to couples during pregnancy and after childbirth and its impact on the resumption of sexual relations.

The questionnaire first gathers sociodemographic information such as biological sex, age, and nationality. It also explores aspects of parenthood, as well as participants' experiences with relationships and sexuality. In addition, this questionnaire includes questions about perceptions of the information received during pregnancy or after childbirth by medical staff about sexuality, the couple's relationship and corporality. Some of these questions are binary choices and others are with Likert scales ranging from 1 to 5 to assess past satisfaction, 1 being the most unsatisfactory and 5 the most satisfactory. An open-ended question was included in the questionnaire to allow participants to freely express their experiences. The responses were classified by dominant themes based on a descriptive manual reading. This approach is intended solely to illustrate the general trends revealed by the quantitative data. It is not an in-depth qualitative analysis in the methodological sense.

3.3.1. Sexual Satisfaction Scale

In order to collect the participants' levels of sexual satisfaction, a scale was used: the Sexual Satisfaction Scale (Index of Sexual Satisfaction (ISS), Hudson et al., 1981; Adaptation of the French version, Comeau & Boisvert, 1985 and validation of the French version, Wawrziczny, Doba & Antoine, 2020). The ISS is a relevant tool given its unidimensionality, but also thanks to its quick and easy administration. The scale evaluates sexual dissatisfaction within the couple by looking at behaviors, attitudes, emotional experiences, and preferences. (Pechorro, Diniz, Almeida, & Vieira, 2009). Initially composed of 25 items, the French version excluded six of its items during the validation of the version addressed to the French population. The French ISS therefore consists of 19 items. It is worth noting that five of the six discarded items were also removed from the validated Spanish and Portuguese versions of the ISS, due to similar problems of contribution or belonging encountered with the French version. (Wawrziczny, Doba & Antoine, 2020).

All items are rated on a Likert-type scale ranging from 0 = rarely or never to 4 = most of the time. Items 1, 2, 3, 9, 10, 12, 16, 17, 19, 21, 22, and 23 should be reverse scored. The overall score varies between 0 and 76. This scale treats sexual satisfaction as a continuum, ranging from very satisfying to highly dissatisfying experiences (Shaw & Rogge, 2016). Higher scores on this scale correspond to higher levels of sexual dissatisfaction. (Wawrziczny, Doba & Antoine, 2020).

This scale helped assess participants' sexual satisfaction and revealed a potential need for more support around sexuality during the perinatal period. It is important to note that the Index of Sexual Satisfaction (ISS) is a scale measuring sexual dissatisfaction. Thus, the higher the score, the greater the level of dissatisfaction. Even when the term 'satisfaction' is used elsewhere in the thesis, it consistently refers to the same dissatisfaction scores, with the interpretation direction unchanged.

3.3.2. Relationship Satisfaction Scale

In order to collect the participants' levels of relationship satisfaction, a scale was integrated: the Relationship Assessment Scale (RAS, Hendrick, 1988; Adaptation and validation of the French version, Saramago, Lemétayer & Gana, 2021). The RAS is a generic measure of relationship satisfaction. Seven items were derived from earlier measures such as the Marital Assessment Questionnaire (Hendrick, 1981), Love Attitudes Scale (Hendrick & Hendrick, 1986) and Sexual Attitudes Scale (Hendrick et al., 1985). (Hendrick, S. S., Dicke, A., & Hendrick, C., 2011).

This brief, one-dimensional scale offers a snapshot of how satisfied participants feel in their relationships. The seven items that make up this test are interrogative sentences. Responses are given on a 5-point Likert scale. Scores range from 1 (low satisfaction) to 5 (high satisfaction). (Saramago, M., Lemétayer, F., & Gana, K. (2021)).

The total score ranges from 7 to 35, higher scores indicate greater satisfaction, whereas lower scores indicate less

Here, this scale therefore provides information on the marital relationship of the participants in this study, highlighting a potential need for support from a relational point of view in the perinatal period.

3.3.3. *Body Satisfaction Scale*

Finally, to collect the participants' levels of body satisfaction, a scale was introduced into the questionnaire: the body image and pregnancy scale (Pregnancy and Weight Gain Attitude Scale (PWGAS) Palmer, Jennings & Massey, 1985; Adaptation and validation of the French version, Rousseau & al., 2015).

This scale assesses women's attitudes specifically regarding their weight gain during pregnancy. It originally consisted of 18 items in a 5-point Likert scale format, ranging from 1 (“strongly disagree”) to 5 (“strongly agree”). During the validation process, two items were excluded from the final version due to double loading, resulting in a total of 16 items. A composite score is calculated for each participant. Scores range from 1 (very negative attitude toward pregnancy weight gain) to 5 (very positive attitude). High scores reflect more positive attitudes (about body and food) toward weight gain during pregnancy, while low scores point to more negative feelings (Rousseau et al., 2015).

This scale was chosen due to its validated use with the French population. While other tools might have been a better conceptual fit, they weren't used here because they haven't been validated for use with French participants.

As such, this tool helped us understand how participants felt about their bodies during the perinatal period, and whether they might benefit from more tailored support interventions.

3.4. **Recruitment of Participants**

To reach as many participants as possible, a variety of recruitment methods and platforms were used. To disseminate the questionnaire both online and through physical channels, a recruitment poster was created. This poster (see Appendix B) included key information about the study: its theme, inclusion criteria, and its academic context. To participate, individuals simply had to scan a QR code that directed them to the online questionnaire.

These posters were placed in strategic locations where they could be seen by young parents, when display authorization was granted. A digital version of the poster was also developed for online sharing. For example, when shared via Instagram stories, the poster included a clickable link redirecting to the questionnaire. Another version of the poster was designed for platforms that do not allow clickable links in visuals (such

as LinkedIn or certain Facebook pages). In those cases, the poster served as a visual hook, accompanied by a written caption presenting the study and ending with the questionnaire link.

Physical locations were selected based on their potential to reach young parents effectively.

Digital channels, which were more numerous, enabled recruitment beyond local settings and contributed to a more diverse sample.

The recruitment request varied depending on the contact. For professionals (e.g., psychologists, midwives), who were reached by email or initially by phone, the request consisted of sharing the questionnaire via their mailing lists and/or displaying the printed poster in their waiting rooms. For professionals or managers of Instagram pages focused on perinatal topics, the request was to share the poster and questionnaire link via their Instagram stories.

The lack of responses, or responses declining to share the study, required an extension of the initial data collection period, and the identification of additional professionals and distribution channels.

A summary of the recruitment channels is provided in table format below.

Table 2

Direct Contacts of Questionnaire Distribution Summary

Contact Type	Number Contacted	Responses Received	Positive Responses
Email (professionals in contact with young parents)	64	12	4
Instagram (pages of psychologists, midwives, etc.)	45	12	7
Phone Call (Early childhood service, 1 per city)	15	15	2

Table 3

Distribution Channels (platforms or physical locations)

Channel	Number of Uses	Notes
Facebook Parenting Groups	5	Questionnaire Send Out
Linkedin Post	1	Questionnaire Send Out
Hospital Maternity Ward	1	Poster Displayed
Medical Laboratory	1	Poster Displayed
Private Midwife Practices	2	Poster Displayed
Nursery	1	Poster Displayed

3.5. Sample

The sample for this study consists of women and men, the sample size forecast was approximately 50 individuals and the final sample contains 52 participants. A small sample size was intentionally chosen due to the sensitive nature of the topics covered in the questionnaire. It is difficult to imagine that all parents would feel comfortable answering questions about their intimacy or relationship. In addition, the restricted period (having had a child during the year 2024/2025) limited the number of participants.

To participate in this study, individuals had to meet the following inclusion criteria: be at least 18 years old, be of French nationality and reside in metropolitan France, and be in a heterosexual couple for at least one year, in order to assess sexual and relational satisfaction outside of the honeymoon phase. Schmiedeberg and Schröder (2016) showed that, after a first year marked by improvement, sexual satisfaction tends to decline. The final inclusion being was having a child during the year 2024/2025. Becoming a parent during the past year was chosen as a criterion to limit the potential for reevaluation and reinterpretation of the perceptions assessed in this study. This cognitive dissonance occurs gradually, often without people being aware of it. This process depends greatly on the nature of the event, the importance of the dissonance felt and the psychological mechanisms put in place to reduce it (Aronson & Tavis, 2007).

The selected sampling strategies are convenience sampling and snowball sampling.

It is also important to note that a selection bias may be introduced by the use of social networks to recruit participants. Indeed, some of the communities approached tend to focus on information or educational content related to pregnancy and parenthood. The members who participate may therefore already be more aware, informed or engaged with the themes addressed in the questionnaire (sexuality, relationships, body image), which could influence their responses. This bias could limit the representativeness of the sample, in particular by excluding parents who are less informed, more isolated, or less inclined to participate in online discussions on these intimate subjects.

3.6. Analysis of Results

SPSS (Statistical Package for the Social Sciences) software was used with a significance level of 0.05. Before proceeding with the application of parametric tests, a normality analysis was systematically performed to ensure that the variables met the necessary assumptions for the use of parametric tests such as the Student's t-test.

If the data did not follow a normal distribution, non-parametric tests were performed instead of parametric tests, to ensure the robustness and validity of the analyses.

Among the analyses conducted, descriptive statistics were used to describe the characteristics of the sample and the levels of sexual, relational, and body satisfaction, using frequencies, percentages, means, and medians. In addition, comparative analyses were carried out to compare subgroups using Student's t-tests to examine mean differences between two groups, Pearson's correlation tests, as well as non-parametric tests when appropriate.

3.7. Collection Planning and Constraints

Young parents were approached through managers of perinatal associations, perinatal health services, and social media groups focused on the perinatal period. Participants were then recruited via electronic invitations, a social media post, or a QR code on paper posters. These invitations included a description of the purpose of this study and a voluntary consent form to be completed in order to access the questionnaire. The questionnaire was posted online via the Google Form platform, which ensures participant anonymity.

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Data collection took place over four months, from January to April 2025. Constraints included access to participants, time and difficult contact, as well as the difficulty in obtaining the mutual assistance of key stakeholders in distributing the questionnaire (refusals due to the subjects being too sensitive, fear of non-compliance with the regulations by distributing a questionnaire in which they had not participated in creating it, etc.).

The main challenge was therefore to distribute the questionnaire and collect responses to it. This challenge was, however, anticipated and in an attempt to overcome it, an extension of the collection time was implemented to allow for the search for other ways of contacting participants.

This study was conducted by a single researcher, which means that all stages from protocol design to questionnaire distribution, including response management and data analysis, were carried out by the same person. Although this configuration is common in the context of individual academic work, it could represent a significant logistical constraint, particularly with regard to the research and contact of dissemination channels, and the time invested in overcoming the obstacles encountered during the collection.

3.8. Ethics

3.8.1. Informed Consent

First, it was a priority to provide study participants with detailed information about the research framework and objectives. This information included: the people who will have access to the data and who work on it, the selection criteria of the sample, how the data will be archived, how the data will possibly be made available to people other than the researcher, the risks and potential repercussions of the research but also their right of withdrawal (Admin, 2020).

Secondly, a consent form was offered to the participants (Appendices C & D). This form was clear and understandable. Participants were required to read and sign it before participating in the study. This form included some previously introduced points, such as the ability to withdraw at any time without penalty.

Confirmation of understanding was provided at all times, ensuring that participants understood all information before giving consent.

3.8.2. Confidentiality and Anonymity

To ensure the protection of personal data, the data has been anonymized and secured. The online questionnaire ensures the anonymity of participants, encrypting responses with codes; participants' names are not requested at any time.

Access to the original data was restricted and limited to the sole member of the research team. This limitation ensured the confidentiality of sensitive information. Furthermore, no other individuals were involved in the analysis or processing of the responses, thereby guaranteeing strict adherence to participant anonymity and the ethical management of the collected data.

3.8.3. Well-being of Participants

It is important to ensure that the study does not cause distress or discomfort to participants. Participants were therefore offered a list of psychological support resources.

3.8.4. Transparency and Communication

As previously mentioned, the study objectives and the intended use of the results were clearly stated from the initial stage of participant contact. In addition, participants were provided with a secure communication channel to reach the researcher, through the creation of a protected email address dedicated to the study.

3.8.5. Ethics Review

Before any action was taken, the research project was submitted to an ethics committee for review and approval before data collection began (Appendix E). The committee assessed compliance with ethical and regulatory standards. Additionally, a follow-up with a university professor was established to monitor compliance with ethical guidelines throughout the study.

3.8.6. Equity and Inclusion

First, it was ensured that the sampling method did not unfairly exclude certain groups and that all participants were treated fairly. Cultural diversity and individual differences among participants were respected.

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3.8.7. *Transparency of Conflicts of Interest*

Any potential conflict of interest that could influence the study, whether financial, personal or professional, will be declared.

By respecting all these measures, this study was able to be conducted in an ethical manner, respecting the rights and well-being of the participants while ensuring scientific integrity.

3.9. Potential Limitations of the Study

Despite the methodological precautions taken, this study has several limitations that should be highlighted in order to qualify its results and scope.

3.9.1. *Social Desirability Bias*

Participants may tend to respond in socially acceptable ways, particularly on sensitive topics such as sexuality, relationships, or body image. To mitigate this bias, the anonymity of the questionnaire was strictly guaranteed and data confidentiality was emphasized at the beginning of the form.

3.9.2. *Sample Size and Representativeness*

The small sample size does not allow the results to be generalized to the entire population of young parents. The target population remains difficult to access, and data collection proved to be long and complex, particularly due to the refusal of certain institutional or associative actors to relay the questionnaire. However, the widest possible dissemination was implemented to maximize the diversity of respondents.

3.9.3. *Selection Bias*

The use of social media as the primary distribution channel may have introduced a selection bias. Since some of the communities surveyed are geared toward educational objectives related to parenting, the recruited participants may already be aware of or engaged with the topics covered, potentially influencing their responses. This relative homogeneity could limit the diversity of viewpoints and therefore the representativeness of the sample.

3.9.4. *Uncontrolled Variables*

Several contextual factors, such as parental fatigue, stress levels, social support, and mental health, were not measured in this study. However, these elements can

influence body, sexual, and relationship satisfaction. They will be discussed in the discussion of the results to offer more nuanced avenues for interpretation.

3.9.5. Body satisfaction scale

The scale used in the questionnaire was selected for its validity within the French population, ensuring both the reliability of the instrument and its cultural relevance. However, other tools, although potentially more specific and relevant to the previously defined concept of body satisfaction, were not selected due to the absence of validation in the French context. This choice represents a limitation, as certain dimensions of body satisfaction may not have been fully captured.

3.9.6. Duration and Accessibility of the Questionnaire

A questionnaire that is too long or complex can lead to dropouts or less thorough responses. Particular attention was paid to the conciseness and clarity of the form to maintain participant engagement until the end.

3.9.7. Constraints Related to Individual Research

As this study was conducted by a single researcher, logistical limitations may have affected certain stages of the process: contacting participants, broadening dissemination, etc. This individual dimension necessarily restricted the scope of certain actions.

3.10. Conclusion of the Methodology

The methodology adopted in this study, a quantitative design, descriptive, and cross-sectional design, was carefully chosen to answer the research question concerning the sexual, relational, and body satisfaction of young parents. This approach allows for the collection of precise numerical data, providing a clear overview of young parents' perceptions without seeking to establish causal relationships, which is perfectly in line with the research objectives.

The choice of design is based on the need to describe satisfaction levels through measurable and comparable indicators. The use of a standardized questionnaire, including validated tools, allows for reliable data to be obtained and the results to be presented in the form of graphs and tables. By using these specific satisfaction scales and targeting a sample of young parents who have recently experienced perinatal care, this study effectively answers the research question. It highlights aspects of the intimate

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and relational lives of young parents that are often neglected in the literature and opens up avenues for possible support needs.

However, some limitations must be acknowledged. The small sample size, difficulties in accessing participants, and potential selection bias related to recruitment via social media may affect the representativeness of the results. Furthermore, some contextual variables, such as stress, fatigue, or social support, were not measured and could influence satisfaction levels. These limitations will be taken into account in the interpretation of the data and discussed later.

Thus, this methodology remains perfectly suited to providing concrete and relevant answers to the issues related to the sexual, relational and bodily satisfaction of young parents during the perinatal period, while integrating a critical awareness of the possible biases and limitations of the study. The results obtained could thus contribute to a better understanding of these issues and the needs of young parents.

4. Analysis of Results

4.1. Characteristics of the Participants

The sample was composed mainly of women (87.5%), with men making up just over 11%. The average age of participants was 30. Out of the 72 people who answered the questionnaire, 52 had a child in 2024. These 52 participants were the focus of the statistical analyses. These 52 people are composed of 45 women and 7 men. This follows the previous observation that more women responded to the questionnaire than men.

Table 4*Socio-Demographic Characteristics of Participants*

Variables	Values <i>n</i> (% / <i>M</i>)
Biological Sex	Female: 63 (87.5%) Male: 8 (11.1%) Other: 1 (1.4%)
Age	22-42 years (<i>M</i> = 30 years)
Nationality	French: 70 (97.2%) Other: 2 (2.8%)
Occupation	Farm operator: 1 (1.4%) Artisan/Business Owner: 6 (8.3%) Employee: 39 (54.2%) Worker: 3 (4.2%) Executive/Senior intellectual: 14 (19.4%) Intermediate: 2 (2.8%) Inactive: 4 (5.6%) Other: 2 (2.8%) Prefer not to answer: 1 (1.4%)
Heterosexual Couple	Yes: 68 (94.4%) No: 3 (4.2%) Prefer not to answer: 1 (1.4%)
Relationship Duration > 1 year	Yes: 68 (94.4%) Missing: 4 (5.6%)
Child in 2024	Yes: 52 (72.2%) Female: 45 (86.5%) Male: 7 (13.%) No: 16 (22.2%) Missing: 4 (5.6%)
First Child	Yes: 45 (62.5%) No: 22 (30.6%) Prefer not to answer: 1 (1.4%) Missing: 4 (5.6%)

Note: *M* = Mean.

4.2. Sexual and Relational Satisfaction Before, During and After Pregnancy

The analyses introduced here aim to investigate Hypothesis 1, which states that young parents report varying levels of sexual and relationship satisfaction after the birth of their child, with a notable proportion reporting a decline compared to the pre-pregnancy period. The data combines participants' personal reflections on their satisfaction before and during pregnancy, along with objective scores collected after birth.

4.2.1. Perceived Evolution of Sexual and Relational Satisfaction Before and During Pregnancy

Sexual satisfaction. Regarding sexual satisfaction before pregnancy, participants reported an average of 3.75/5 on a Likert scale ranging from 1 to 5 (1 being the minimum and 5 the maximum), reflecting a rather satisfactory and fulfilling sexuality. That score fell to 2.79 during pregnancy, showing a noticeable decline, something that aligns with existing research findings.

To examine whether this decrease is statistically significant, a normality test (Shapiro-Wilk) was first applied to the distribution of the differences ($n= 52$), revealing a value $p < 0.001$, indicating a non-normal distribution. Consequently, a non-parametric Wilcoxon test was used. The test reveals a statistically significant difference between sexual satisfaction before and during pregnancy ($p < 0.001$). We can therefore conclude that this drop is real and does not result from chance.

Satisfaction Relational. At the same time, relationship satisfaction appears stable or even slightly strengthened: the average goes from 4.29/5 before pregnancy to 4.33/5 during pregnancy, suggesting that the perceived quality of the couple's bond has been generally maintained or even improved.

The distribution of differences ($n = 52$), revealed a value $p < 0.001$ on the Shapiro-Wilk test, indicating a non-normal distribution. Consequently, a non-parametric Wilcoxon test was used. The test showed that there was no significant difference between relationship satisfaction before and during pregnancy ($p = 0.670$).

Table 5

Perceived Evolution of Sexual and Relational Satisfaction

Satisfaction Type	<i>n</i>	<i>M</i> Before Pregnancy (SD)	<i>M</i> During Pregnancy (SD)	Statistical Test	<i>p-value</i>	Conclusion
Sexual Satisfaction	52	3.75 (.74)	2.79 (1.13)	Wilcoxon test	< .001	Significant Decrease
Relationship Satisfaction	52	4.29 (.70)	4.33 (.70)	Wilcoxon test	.670	No Significant Difference

Note: *M* = Mean; *SD* = Standard Deviation.

4.2.2. Postpartum Assessment via Standardized Scales

To explore satisfaction levels after childbirth, we used three validated tools: the ISS, the RAS, and the PWGAS.

The specific calculation rules were respected (inversions of specific items according to the rules), and only participants who completed at least 80% of the items were included in the final calculations. We then find for the ISS ($n= 49$), for the RAS ($n= 49$) and finally for the PWGAS ($n = 41$).

Sexual satisfaction. Regarding postpartum sexual satisfaction, measured by the ISS, the average score obtained is 27.796 / 76, or 36.6% of the maximum possible dissatisfaction. As the scale measures dissatisfaction, this score suggests a moderate level of sexual satisfaction. The Shapiro-Wilk test ($p= 0.519 > 0.05$) indicates a normal distribution of the data, which validates the use of the mean as a central indicator. The results on this scale will sometimes be used as measures of satisfaction and sometimes of dissatisfaction, but the nature of the scores remains the same.

Satisfaction Relational. Finally, postpartum relationship satisfaction is measured using the RAS. The observed average is 22.428/25, or 89.7% of the maximum score, which indicates a high level of relationship satisfaction. Normality is also confirmed here ($p = 0.178$).

Table 6

Postpartum Satisfaction Scores (Standardized Scales)

Scale	<i>n</i>	<i>M</i> (<i>SD</i>)	Maximum Score	% of Maximum	Interpretation
Index of Sexual Satisfaction (ISS)	49	27.80 (11.91)	76	36.6	Moderate Dissatisfaction
Relationship Assessment Scale (RAS)	49	22.43 (3.41)	25	89.7	High Satisfaction

Note: *M* = Mean; *SD* = Standard Deviation.

4.2.3. Interpretation

The findings show that while sexual satisfaction tends to drop during pregnancy, relationship satisfaction remains relatively stable. After childbirth, levels of sexual dissatisfaction are moderate, the couple's relationship remains strong, and body satisfaction is mixed.

In order to visually and consistently compare levels of sexual and relationship satisfaction before, during, and after pregnancy, the different scales were reduced to a common scale ranging from 1 to 5.

The data before and during pregnancy come from direct self-assessments on a Likert scale ranging from 1 to 5, so it was not necessary to transform them. On the other hand, the scales used after pregnancy are psychometric tools whose raw scores vary depending on the tool, so they were recalculated to be brought back to a scale of 5. This approach allows us to visualize the changes in perceived satisfaction in a standardized way, while maintaining the rigor of the psychometric tools used.

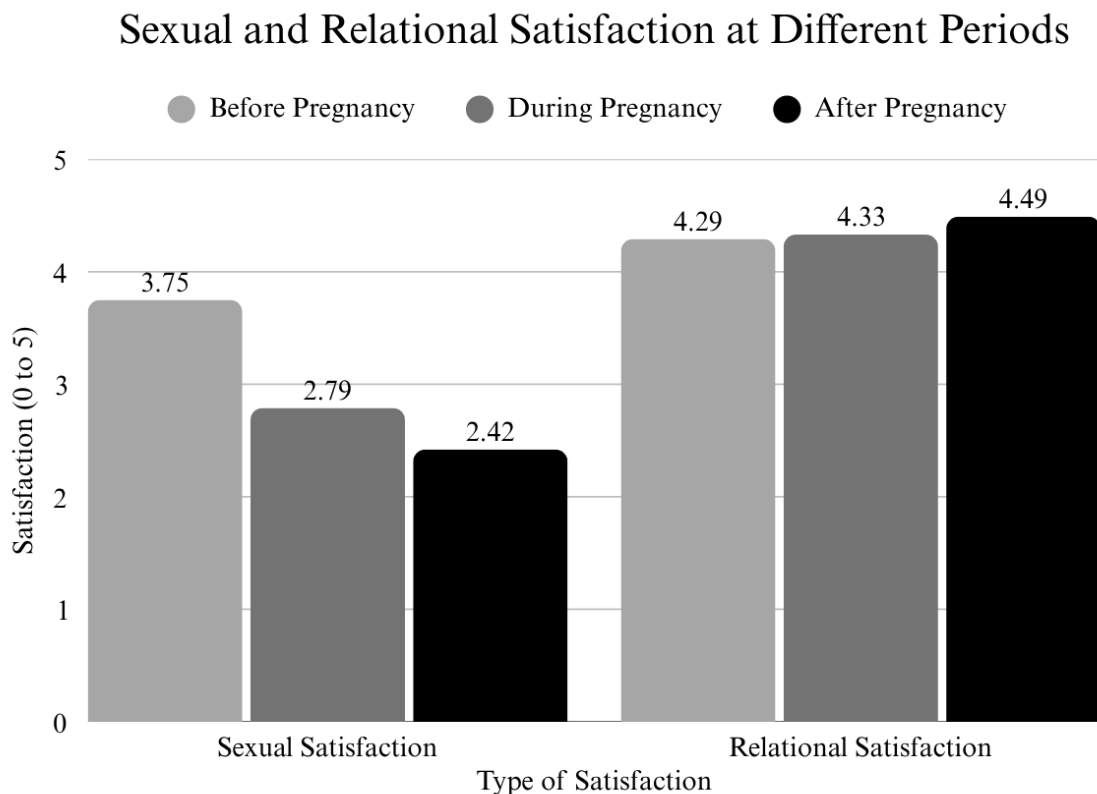


Figure 1 Levels of sexual and relationship satisfaction of young parents before, during, and after pregnancy, expressed on a scale of 1 to 5.

4.2.4. Correlation between Sexual and Relationship Satisfaction

In order to observe the link between sexual satisfaction and relationship satisfaction, a first Pearson correlation was carried out on all 47 participants (Men and Women) who completed the two scales (ISS and RAS). We found a moderate, statistically significant negative correlation between sexual dissatisfaction and relationship satisfaction ($r = -.388, p = .007$). This suggests that the more sexual dissatisfaction participants report, the less satisfied they are with their marital relationship. This link is consistent with data from the literature, which highlights the strong interdependence between sexual experience and relationship quality in the parental transition (Mark, 2015; Grussu et al., 2021).

(See Table 8)

4.3. Body Satisfaction of Young Mothers

To evaluate hypothesis 2, which is, a significant proportion of young mothers report body dissatisfaction after pregnancy and childbirth, participants completed the Pregnancy and Weight Gain Attitude Scale, which measures body image and satisfaction. A total of 41 young mothers completed at least 80% of the scale items, allowing their data to be included in the analysis. The mean observed was 54.414 / 80 (62.4% of the maximum score), with a median of 56 / 80 (64.7%). As normality is not respected ($p = 0.047 < 0.05$), the median is used here to faithfully represent the central tendency. Although slightly higher than the mean, this value still does not reflect a high level of satisfaction. In fact, it indicates that a considerable proportion of participants report only moderate or low levels of body satisfaction following pregnancy and childbirth.

Table 7

Postpartum Body Satisfaction Scores (Women Only)

Scale	<i>n</i>	Median (<i>SD</i>)	Maximum Score	% of Maximum	Interpretation
Pregnancy and Weight Gain Attitude Scale (PWGAS)	41	56 (6.89)	80	64.7	Moderate Body Satisfaction

Note: *SD* = Standard Deviation.

4.3.1. Correlations between the Three Dimensions of Satisfaction in Women

to explore the links between the three dimensions studied (body satisfaction, sexual satisfaction and relationship satisfaction), Pearson correlations were carried out on female participants, the only ones to have completed all the scales.

The results reveal a significant negative correlation between sexual dissatisfaction and relationship satisfaction ($r = -.432, p = .005, n = 40$), indicating that the more sexually dissatisfied the participants were, the less they reported high relationship satisfaction. On the other hand, no significant correlation was observed between body satisfaction and the other two dimensions: neither with sexual dissatisfaction ($r = .076, p = .646, n = 39$), nor with relational satisfaction ($r = .241, p = .145, n = 38$).

These results suggest that in this sample, relationship quality plays a more central role than body image in the postpartum sexual experience.

Table 8

Correlations Between Satisfaction Dimensions (Women Only)

Variable Pair	n	Statistical Test	Pearson's r	p-value	Significance
Sexual Dissatisfaction - Relational Satisfaction	39 - 38	Pearson Correlation	-.432	.005	Significant
Body Satisfaction - Sexual Dissatisfaction	41 - 39	Pearson Correlation	.076	.646	Not Significant
Body Satisfaction - Relational Satisfaction	41 - 38	Pearson Correlation	.241	.145	Not Significant

4.4. Clarity and Completeness of Information Concerning Sexuality, Relationships and Corporality

To assess hypothesis 3: a significant proportion of young parents report that the information received during pregnancy or after childbirth from medical professionals regarding sexuality, couple relationships and body image, was unclear or incomplete ; participants were asked whether they considered the information they received from healthcare professionals on these topics to be clear and complete. Among the 52 valid

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responses, only 36.5% ($n = 19$) of participants stated that the information received was clear and complete. In contrast, a combined 63.5% of respondents either felt the information was unclear (19.2%) or reported not having received any information at all (44.2%).

These results highlight a real lack of information, which may leave new parents feeling confused, unsupported, or uncertain during the postnatal period.

Table 9

Perception of Clarity and Completeness of Received Information

Response	<i>n</i>	Valid Percentage (%)
Yes (clear and complete)	19	36.5
No (unclear and incomplete)	10	19.2
I did not receive any information	23	44.2
Valid Total (<i>n</i>)	52	100.0

4.5. Want to Receive More Information About Sexuality, Relationships and Body

To test hypothesis 4: a significant proportion of young parents report that they would have liked to receive more information on topics related to sexual, body and relational satisfaction ; participants were asked whether they would have liked to receive more information on these themes. Among the 52 valid responses, 63.5% ($n = 33$) of young parents indicated that they would have liked to receive more information regarding sexual, body, and relational satisfaction.

Although 27.8% of participants did not respond to this question, the proportion of affirmative responses among those who did is considerable. This response points to a shortfall in the education and support offered to young parents, reinforcing the need for clearer, more targeted information on these topics.

Table 10

Desire to Receive More Information

Response	<i>n</i>	Valid Percentage (%)
Yes	33	63.5
No	19	36.5
Valid Total (<i>n</i>)	52	100.0

4.6. Link between Participant Characteristics and Sexual, Relational and Body Satisfaction

This subsection aims to explore hypothesis 5 according to which certain demographic characteristics, such as biological sex, age, number of children or even profession, could differentiate the levels of sexual, relational and body satisfaction.

Before any comparative analysis, the normality of the distributions of scores on the different scales was systematically verified using the Shapiro-Wilk test. When the conditions of normality were not met, non-parametric tests were preferred. Because some subgroups were small, especially male participants and parents with more than one child, these results should be interpreted with caution.

4.6.1. Biological Sex

Sexual satisfaction. Normality tests showed that sexual satisfaction scores followed a normal distribution in the female groups ($p= 0.293$) and masculine ($p= 0.974$). A Student's t-test revealed no significant difference between the sexes ($p= 0.689$), despite slightly higher dissatisfaction among women ($M= 27.97$) than in men ($M = 26,71$).

Cohen's effect size ($d= 0.105$) confirms a negligible effect. A Mann-Whitney test confirmed this result ($p= 0.748$), supporting the idea that biological sex is not a differentiating factor of sexual satisfaction in this sample.

Satisfaction Relational. The RAS scores also follow a normal distribution for both groups (women: $p= 0.123$; men: $p= 0.087$). The t-test indicates no significant difference ($p= 0.637$) between women ($M= 22.52$) and men ($M= 21.86$), with a very weak Cohen effect ($d = 0,194$).

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The Mann-Whitney test ($p= 0.624$) corroborates this result, suggesting that biological sex does not significantly influence relationship satisfaction.

Satisfaction Bodily. Since body satisfaction was only assessed in women, no comparison by biological sex is possible for this variable.

4.6.2. Number of Children

To ensure statistical validity, the variable was grouped into two categories: first child and at least one previous child.

Sexual satisfaction. Normality is respected in both groups ($p= 0.913$ and $p= 0.193$) and the t-test indicates a non-significant difference between the two groups ($p = 0.897$; $d= 0.056$), with very close means ($M= 27.95$ and $M = 27,27$).

The Mann-Whitney test ($p= 0.952$) confirms the absence of difference between the groups, despite the reduced size of the non-primiparous group ($n= 11$), which limits the power of the analysis.

Satisfaction Relational. Here again, the distributions are normal in both groups ($p= 0.098$ and $p= 0.340$). The t-test ($p = 0.444$; $d= 0.264$) and the Mann-Whitney test ($p= 0.380$) do not reveal any significant difference between groups, suggesting that being a parent for the first time or not has no notable impact on relationship satisfaction.

Satisfaction Bodily. Finally, normality is not respected in the “first child” group ($p= 0.027$), and taking into account the small size of the other group ($n= 9$), a non-parametric test is preferred. The Mann-Whitney test does not reveal any significant difference ($p= 0.963$). However, the reduced size of the non-primiparous group ($n= 9$) limits the scope of these results.

4.6.3. Age

Participants were divided into two groups: 18–30 years ($n= 24$) and over 30 years ($n = 25$).

Sexual satisfaction. The distributions are normal in both groups ($p= 0.877$ and $p= 0.180$). The t-test indicates a slight difference ($M= 26.08$ for 18–30 year olds; $M= 29.44$ for those >30 years old), not significant ($p = 0.329$; $d= -0.282$). These findings suggest that age, in this sample, doesn't significantly influence levels of sexual satisfaction.

Satisfaction Relational. Normality is respected ($p= 0.058$ and $p= 0.057$). The t-test reveals no significant difference ($p = 0.697$; $d= 0.112$) between the two age groups, despite very close means (22.62 vs. 22.24), suggesting stable relationship satisfaction regardless of age.

Satisfaction Bodily. Finally, normality was observed for the over-30s ($n = 20$ and $p = 0.971$) but not for the 18-30s ($n = 21$ and $p = 0.007$), so a non-parametric test was used to compare body satisfaction scores. The Mann-Whitney test did not reject the null hypothesis that the distribution of scores was the same in the two age categories ($p = 0.136$). There was therefore no statistically significant difference in body satisfaction scores between the two age groups, 18-30 and over 30.

4.6.4. Profession

The distribution of participants across various professional categories does not allow for statistical analyses, as the subgroups did not include enough participants to conduct analyses with any weight. Therefore, occupation was not included in the analyses of sociodemographic markers. However, we can observe the plurality of participants' occupations through descriptive analyses.

4.6.5 Conclusion of the Sub-Part

Overall, none of the demographic factors studied, such as sex, age, or number of children, seem to significantly affect satisfaction in the sexual, relational, or body domains. However, the sample size, particularly that of certain subgroups, limits the statistical power of these tests. As it stands, the data indicate stability in satisfaction levels regardless of these variables, but do not completely exclude the existence of potential differences, which could appear in larger-scale studies.

Table 11*Effect of Demographics on Satisfaction Levels*

Variable	<i>n</i>	Satisfaction Dimension	Statistical Test	<i>t</i> / <i>U</i> / <i>z</i>	<i>p</i> -value	Notes
Biological Sex	49	Sexual	T-Test	$t(15.498) = 0.407$	.689 (Not significant)	Slight difference in means
	49	Relational	T-Test	$t(47) = 0.475$	.637 (Not significant)	
Number of Children	49	Sexual	T-Test	$t(12.714) = 0.132$	.897 (Not significant)	Small subgroup size
	49	Relational	T-Test	$t(47) = 0.771$	.444 (Not significant)	
	41	Body (Women Only)	Test U of Mann-Whitney	$U = 142.5, z = -0.047$	.963 (Not significant)	
Age Group	49	Sexual	T-Test	$t(47) = -0.986$	.329 (Not significant)	Small subgroup size
	49	Relational	T-Test	$t(47) = 0.392$	.697 (Not significant)	
	41	Body (Women Only)	Test U of Mann-Whitney	$U = 153.000, z = -1.490$	.136 (Not significant)	
Profession	52	All	Not Tested		Not Tested	Groups too small

Note: *t* = Student's t-test statistic; *U* = Mann-Whitney test statistic; *z* = standardized value of the Mann-Whitney test.

4.7. Link between Request for Information and Levels of Sexual, Relational and Body Satisfaction

Here we will examine Hypothesis 6, which states that young parents who express a desire to receive more information on body, sexual, and relationship satisfaction have lower levels of satisfaction in these three areas.

4.7.1. Sexual Satisfaction

The two groups “Wish for information” ($n = 31$; $p = 0.427$) and “Did not express a desire” ($n = 18$; $p = 0.965$) exhibit a normal distribution of sexual dissatisfaction scores. An analysis by t-test for independent samples was conducted to compare levels of sexual dissatisfaction (ISS scores) between participants expressing need for additional information and those not expressing this need. Levene's test confirmed the homogeneity of variances, $F(1, 47) = .821, p = .370$. The results indicate a significant difference between the two groups, $t(47) = 2.557, p = .014$, with a mean difference of 8.55 points. The effect size is moderate to strong ($d = 0.76$). These results suggest that participants who wanted more information had a higher ISS score, and therefore significantly higher sexual dissatisfaction, than those who did not express no need.

4.7.2. Relationship Satisfaction

Here again, normality is respected for both groups, with “Wish for information” ($n = 30$; $p = 0.126$) and for “Did not express a desire” ($n = 19$; $p = 0.742$). Again, a t-test analysis for independent samples was conducted to compare relationship satisfaction (RAS scores) between participants expressing a need for additional information and those not expressing this need. Levene's test confirmed the homogeneity of variances ($F(1, 47) = .003$; $p = .956$). The results do not indicate a significant difference between the two groups, $t(47) = -0.158, p = .875$, with a mean difference of -0.16 points. The effect sizes are negligible, with a d Cohen's variance = -0.046. These results suggest that there is no significant difference in relationship satisfaction scores between participants who want more information and those who do not express no need. The desire for information is therefore not associated with lower relationship satisfaction.

4.7.3. Body Satisfaction

The scores of the two groups here again follow a normal distribution (“Wish for information” ($n = 26$; $p = 0.165$) and “Did not express a desire” ($n = 15$; $p = 0.430$). It is important to note that body satisfaction was only measured in women, thus limiting the scope of the results to this subsample.

Finally, a final analysis by t-test for independent samples was carried out in order to compare the levels of body satisfaction (scores on the PWGAS) between the

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participants expressing a need for additional information and those not showing this need.

Levene's test confirmed the homogeneity of variances ($F(1, 39) = 1.132 ; p = .294$). The results do not indicate a significant difference between the two groups, $t(39) = -0.550 ; p = .586$, with a mean difference of -1.24 points. The effect size is negligible ($d = -0.178$). These results suggest that there is no significant difference in body satisfaction between participants who wanted more information and those who did not express no need.

4.7.4. Partial Conclusion

Interestingly, only sexual satisfaction differed significantly: those who wished for more information were also more dissatisfied. In contrast, relationship and body satisfaction do not appear to be linked to the expressed desire for more information, suggesting that the need for resources or support expressed by these young parents could be particularly focused on postpartum sexuality.

Table 12

Comparison of Satisfaction Scores According to Desire for Additional Information

Type of Satisfaction	Group	<i>n</i>	<i>M</i> (<i>SD</i>)	Statistical Test	<i>t</i>	<i>p-value</i>
Sexual Dissatisfaction	Wants more information	31	30.93 (10.50)	T-Test	$t(47) = 2.557$	$p = 0.014$ (significant)
	Does not want more information	18	22.39 (12.54)			
Relational Satisfaction	Wants more information	30	22.36 (3.46)	T-Test	$t(47) = -0.158$	$p = 0.875$ (not significant)
	Does not want more information	19	22.52 (3.42)			
Body Satisfaction (Woman Only)	Wants more information	26	53.96 (7.44)	T-Test	$t(39) = -0.550$	$p = 0.586$ (not significant)
	Does not want more information	15	55.20 (5.96)			

Note: *M* = Mean; *SD* = Standard Deviation; *t* = Student's t-test statistic.

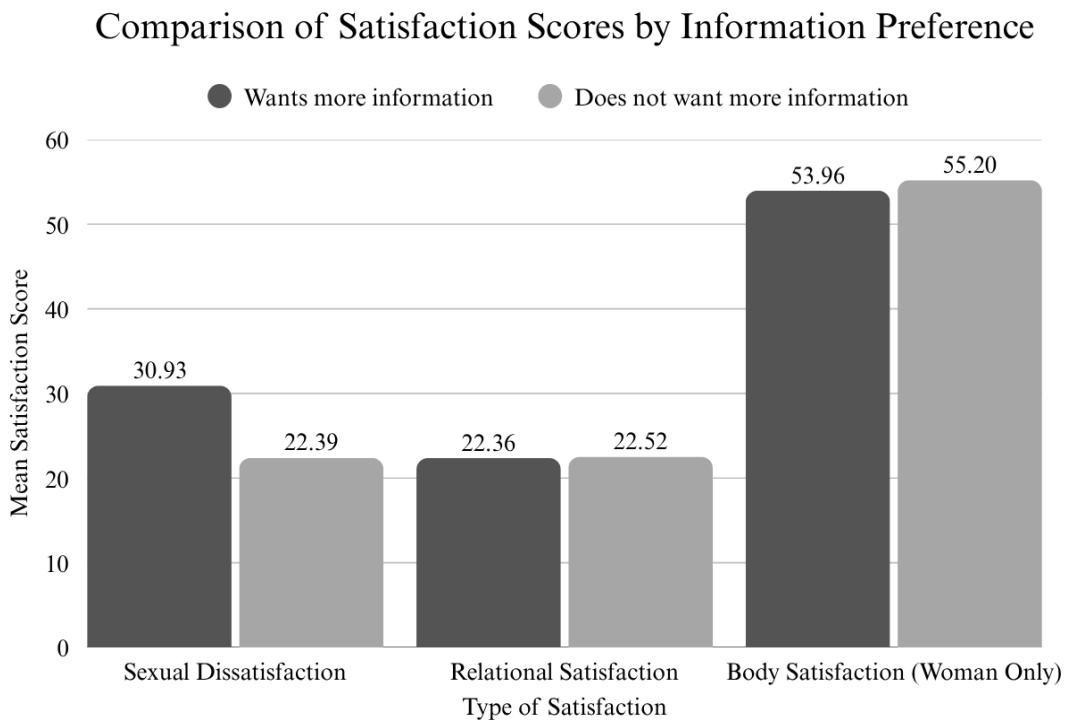


Figure 2 *Comparison of Statistical Scores by Information Preference.*

4.8. Non-Hypothetical Additional Results

4.8.1. Analysis of an Open Question on Sexuality and Couple Relationships During Pregnancy

An open-ended question “Can you explain how your sexuality and relationship during pregnancy were different?” was included in the questionnaire to allow participants to freely express their experiences. The responses were subjected to a descriptive analysis, based on the identification of recurring themes, with the aim of enriching the interpretation of the quantitative results. This is not an in-depth qualitative analysis, but rather an exploratory process aimed at highlighting the salient points spontaneously raised by the respondents. The analysis of this question identified several recurring themes regarding changes experienced in sexuality and relationships during pregnancy (see Appendix F). Most participants reported a significant decrease in libido, often attributed to physical pain, fatigue, or worries about the baby (e.g., fear of hurting, of causing a miscarriage). This sexual disinvestment sometimes appears to be shared by the partner, particularly among male partners who express a fear of disrupting the

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pregnancy. One woman writes: *"My partner was reluctant to have sex."*, while another specifies: *"We found it strange that she [the baby] be present during the act."*

A second important theme concerns the relationship with the changing body, which becomes a source of discomfort, loss of desirability, and even self-distancing. This results in a difficulty in projecting oneself into a fulfilled sexuality: *"For myself, I need to find a desire for my body that has changed after pregnancy."*

However, some testimonies highlight a maintained, or even strengthened, relationship quality, despite a declining sexuality. Several participants mentioned increased emotional closeness: *"Very good quality of relationship as a couple because we are both at home"*, *"Sexuality was more complicated, but the relationship was stronger because we were building our lives."* These responses suggest that pregnancy may act as a readjusting factor in marital dynamics, where emotional intimacy sometimes takes over from sexual intimacy.

Finally, some participants described a more unique experience, particularly in the case of a difficult pregnancy (previous miscarriages, a pregnancy unwanted by one of the partners), which marked sexuality with anxiety, or even avoidance. These responses illustrate the subjective complexity of the perinatal experience, and the need not to reduce sexuality to physiological aspects.

Regarding the question "Have you been able to discuss these possible changes as a couple?", among of the 52 respondents, 45 people (86.5%) indicated that they were able to discuss the changes experienced in their relationship during or after pregnancy, while seven people (13.5%) stated that they were not able to talk about them. This result suggests that for a majority, marital communication around relational and sexual changes was possible, which could reflect a generally open couple dynamic or a shared need to talk about changes. However, a significant minority (one in seven participants) stated that they were not able to discuss these topics, which may indicate a taboo, barriers to intimate communication, an asymmetry in the perception of the changes experienced or even an absence of changes in sexuality and the relationship.

Among the people who described changes in sexuality or marital relationships during pregnancy (decreased libido, pain, body embarrassment, withdrawal of the partner, etc.), almost all indicated that they were able to discuss them with their partner.

Of the more than 40 usable responses, only two people stated that they were unable to discuss these changes as a couple, despite the difficulties mentioned in their testimony.

This suggests a strong trend towards marital communication around sexual and emotional difficulties experienced during pregnancy, consistent with the 86.5% of respondents who ticked “Yes” to the closed question. The fact that the majority of participants spontaneously mentioned complex elements (embarrassment, pain, fears, disagreements, but also strengthening of the bond) and declared having been able to talk about them shows that sexual experiences are not systematically kept quiet or taboo in the couple.

However, the presence of a few cases where changes were marked but not discussed, or poorly integrated (e.g. fear of causing pain), testifies to areas of blockage in intimate communication.

4.8.2. Analysis of the Timing of Postpartum Sexual Resumption and Synchronization of Desires

The answers show wide variation in how soon parents felt ready to resume sex after childbirth. The majority of participants report a return of sexual desire around 1 month postpartum, but some mention longer delays, up to one year. This variability is also observed in the responses to the question on the actual time of resumption of sexual relations, with a majority at one month, but a significant proportion indicating a later resumption (three months, one year, or even beyond).

Analysis of the responses to the question “Did you have to wait until your partner felt ready to resume intercourse?” allows us to explore the dynamics of synchronization of desires in the couple. A majority report not having had to wait for their partner, indicating a shared desire. However, a significant proportion of participants indicate having had to wait for the other to feel ready, highlighting asymmetries in the rate of sexual resumption, which are common in the postpartum period. This mismatch often reflects differing physical and emotional experiences, and underlines how essential communication is during this time.

4.8.3. Link between perception of information received and levels of satisfaction

In order to assess whether the perception of information received by health professionals concerning sexual, relational and bodily-influenced satisfaction levels after pregnancy, a univariate analysis of variance (ANOVA) was performed on the

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scores of sexual dissatisfaction (ISS), relationship satisfaction (RAS) and body satisfaction (PWGAS), depending on the variable “clear and complete information received?” (Yes / No / Not received).

The results reveal a significant difference in sexual dissatisfaction according to the perception of information ($F(2,46) = 3.522, p = .038, \eta^2 = .133$). Post-hoc tests (Tukey and Bonferroni) indicate that participants who did not receive information ($n = 20; M = 32.10$) have a significantly higher level of sexual dissatisfaction than those who received clear and complete information ($n = 19; M = 22.58, p = .031$). The group that received information deemed “unclear” ($n = 10; M = 29.10$) had an intermediate mean. These results highlight the possible impact of the lack of information on postpartum sexual experience.

Regarding relationship satisfaction, the difference observed between the groups does not reach the threshold of statistical significance ($F(2,46) = 2.865, p = .067, \eta^2 = .111$), but a trend is observable: participants who did not receive information ($n = 21; M = 21.14$) report lower relationship satisfaction than those who received clear ($n = 19; M = 23.53$) or unclear ($n = 9; M = 23.11$) information.

Finally, no significant difference was observed regarding body satisfaction ($F(2,38) = 0.170, p = .844$). The means are very close between the groups: “Yes” ($n = 17; M = 55.12$), “No” ($n = 9; M = 54.33$) and “No information” ($n = 15; M = 53.67$), indicating stability of this dimension regardless of the type of information perceived.

These findings imply that better information during the perinatal period may be tied to greater sexual satisfaction, but it doesn't seem to affect how parents feel about their relationship or their body.

Table 13

Mean Satisfaction by Information Clarity

Type of Satisfaction	Clarity of Info Received	<i>n</i>	<i>M</i> (<i>SD</i>)	Statistical Test	<i>F</i> (df)	<i>p</i> -value
Sexual Dissatisfaction	Clear and complete	19	22.58 (13.43)	Anova	F(2, 46) = 3.522	<i>p</i> = .038 (Significant)
	Unclear and incomplete	10	29.10 (9.48)			
	No information received	20	32.10 (9.87)			
Relational Satisfaction	Clear and complete	19	23.53 (3.35)	Anova	F(2, 46) = 2.865	<i>p</i> = .067 (Trend)
	Unclear and incomplete	9	23.11 (3.29)			
	No information received	21	21.14 (3.21)			
Body Satisfaction	Clear and complete	17	55.12 (5.98)	Anova	F(2, 38) = 0.170	<i>p</i> = .844 (Not Significant)
	Unclear and incomplete	9	54.33 (8.93)			
	No information received	15	53.67 (6.92)			

Note. *M* = Mean; *SD* = Standard Deviation; *F*(df) = ANOVA test statistic where *df* refers to degrees of freedom (between-group, within-group).

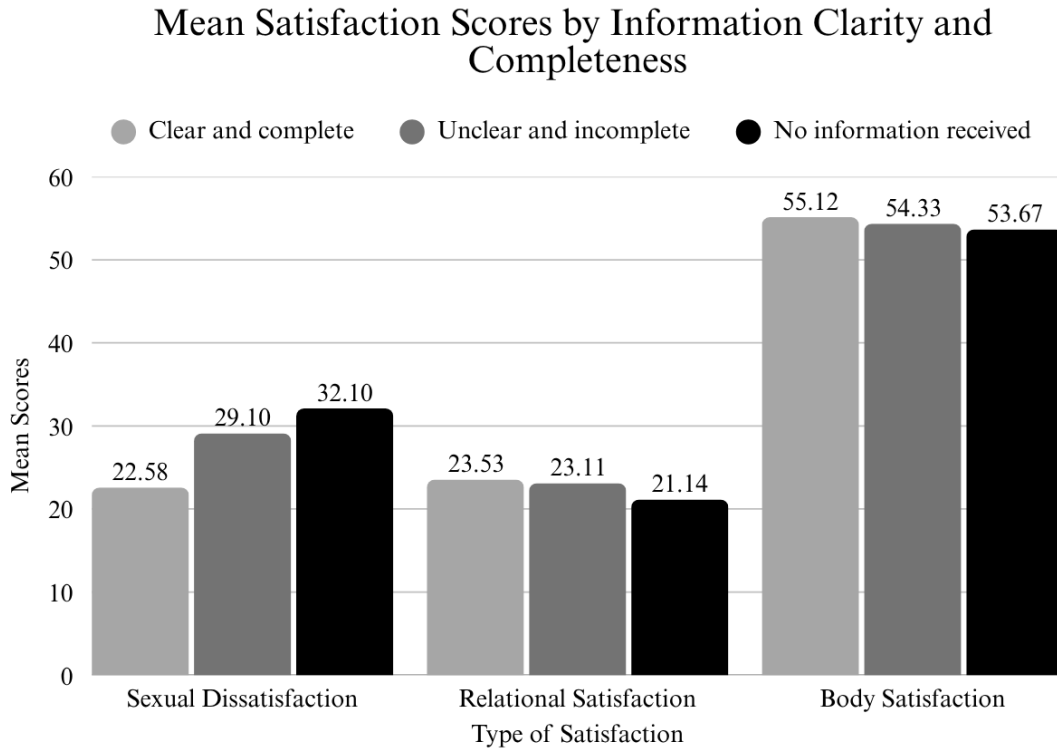


Figure 3 Mean Satisfaction Scores by Information Clarity and Completeness.

5. Discussion

5.1. Reminder of the main results

The results from 52 young parents showed clear differences in how they experienced satisfaction after their child's birth. Sexual satisfaction decreased significantly during pregnancy, with a postpartum recovery still marked by moderate dissatisfaction (mean score of 27.8/76 on the ISS). By contrast, relationship satisfaction remained consistently high, suggesting that most couples felt positively about their bond (22.4/25 on the RAS). Body satisfaction showed more variability, pointing to an ambivalent, or in some cases, fragile, relationship with their bodies among certain mothers (*median* = 56/80 on the PWGAS).

Finally, 63.5% of participants felt they had not received clear or complete information on these topics from the professionals who followed them during the perinatal period. The same proportion expressed a need for more information. The lack of information was clearly linked to greater sexual dissatisfaction, revealing a particularly sensitive area for new parents.

While these findings reflect the experiences of the 52 participants, it's important to now place them in the context of existing research.

5.2. Comparison with Literature and Interpretation

5.2.1. Postpartum Sexual Satisfaction: An Expected, but Worrying Decline

The decline in sexual satisfaction observed during pregnancy, followed by moderate dissatisfaction after birth, is consistent with the findings of Grussu et al. (2021) and Klapilová et al. (2020), who highlight the frequency of postpartum sexual disorders. This confirms that postpartum sexuality is a key issue in perinatal health, yet it remains poorly addressed in current medical follow-up. Beyond biomedical factors (fatigue, pain, and related physiological changes), these results may reflect a temporary disinvestment from the erotic sphere in favor of the new parental function. From a psychodynamic perspective, the body becomes a place of care, which can compromise its pleasure function. In the context of physical and emotional exhaustion, postpartum sexuality is often pushed aside, sometimes even perceived as intrusive or out of place

Sexual Satisfaction and Information Received. An analysis of variance revealed a significant difference in sexual dissatisfaction according to the perception of information received in perinatal care ($F(2, 46) = 3.522, p = .038, \eta^2 = .133$). Participants who did not receive information had a significantly higher level of sexual dissatisfaction ($M = 32.10, n = 20$) than those who received clear and complete information ($M = 22.58, n = 19$). The group that received information deemed “unclear” showed intermediate dissatisfaction ($M = 29.10, n = 10$). These findings echo previous studies, suggesting that not receiving clear and relevant information may be a risk factor for postpartum sexual difficulties. They are in line with the work of Raymond (2021) and Foucault (2011), who denounce the institutional silence surrounding the sexuality of young parents, often limited to a biomedical dimension (risks, pain, contraception) and rarely addressed in its emotional or relational dimension.

Receiving information that is deemed clear appears to play a protective role here, reducing sexual dissatisfaction. This link between the quality of information and sexual experience deserves to be further explored in future studies, particularly through qualitative methodologies, to better understand parents' expectations regarding support. Furthermore, the link established between sexual dissatisfaction and the desire to obtain more information (significant effect, $p = 0,014, d = 0.76$) reinforces the conclusions of Foucault (2011) and Raymond (2021) on the persistent taboo surrounding parental sexuality in France. This lack of support leaves many parents with limited resources in the face of their intimate difficulties.

We can therefore state here that hypothesis 3 is validated, with more than 63% of participants reporting not having received clear or complete information on sexuality, the couple or the body during perinatal follow-up. Similarly, hypothesis 4 is also confirmed, since 63.5% of respondents report that they would have liked to receive more information on sexuality, relationships and the body.

The open-ended responses offer valuable insight into how young parents actually experience these issues, adding depth to the statistical findings.

Changes in Sexuality During the Perinatal Period. The responses to the open-ended questions enriched this latest quantitative analysis. They reveal that sexuality during pregnancy is often marked by a decrease in libido, physical pain, pregnancy-related fears (such as "hurt the baby"), and sometimes discomfort on the part

of the partner regarding the changing body. The participants' testimonies illustrate a temporary disengagement from sexuality, experienced as a distancing of the sexual body in favor of the maternal body. However, several testimonies qualify this observation: some participants speak of a strengthened marital relationship, notably thanks to quality time shared, showing that intimacy can be experienced in ways other than sexuality.

Although desire seemed more fragile, this didn't always mean the relationship itself suffered, other forms of closeness often took over.

The analyses also revealed that almost all participants reported having been able to discuss changes related to sexuality and relationships with their partner. These results suggest that even when sexuality is fragile, it's not necessarily a taboo subject between partners. This capacity for dialogue seems to play a protective role in the adjustment of the relational bond, and supports the hypothesis of active emotional resilience. However, some people report not having been able to talk about it, even in the presence of obvious difficulties, which reveals gaps in intimate communication and suggests the need to further support the expression of perinatal experiences in couples.

These relational adjustments are also reflected in the concrete temporality of sexual resumption, marked by differentiated rhythms between desire and action.

Resumption of Sexuality. Finally, the answers to the questions about when to resume sexual activity after pregnancy confirm a significant variability in temporalities. While the desire often returns from the first month, the actual moment of resumption is often deferred, delayed. This mismatch between wanting and actually resuming sex was often due to one partner waiting for the other to feel ready. These results illustrate the effects of the dyadic model of sexuality (Mark, 2015), which emphasizes the importance of a mutual adjustment of desires and expectations to preserve sexual harmony in a context of transition (such as here, in perinatal care).

We can therefore conclude from these results that Hypothesis 6 is partially validated: only sexual dissatisfaction scores are significantly higher among participants expressing a need for information. No effect was observed on the relational and body dimensions. Furthermore, Hypothesis 1 is partially confirmed: a significant decrease in sexual satisfaction is observed, but relational satisfaction appears generally stable, or even slightly strengthened, partly contradicting initial expectations.

5. Discussion

These results highlight the complexity of the link between sexuality and marital relationships, which the following section will examine through the apparent stability of the emotional bond.

5.2.2. *Relational Stability that Contrasts with Certain Studies*

Unlike several studies (Cowan & Cowan, 2000; Thomas, 2022) which highlight a weakening of the couple's relationship after the arrival of a child, the participants in this study reported high and stable relationship satisfaction. This might reflect a selection bias or it may reveal real signs of resilience in these couples. The couples in the sample thus seem able to maintain sufficient communication and emotional support despite the upheavals. This phenomenon has indeed been highlighted by Shapiro et al. (2000) as a protective effect of emotional support perceived during pregnancy, emotional intimacy acts as a "protective buffer" during the postpartum period: it protects the relationship against the negative effects of stress or lack of sexuality.

However, this stability could also reflect a temporary adjustment. This relative stability might also be understood in light of the *risk regulation system* described by Murray, Holmes, and Collins (2006). According to their model, individuals adjust their level of emotional engagement in a relationship based on how secure they perceive the bond to be. In a period of transition like the postpartum phase, some partners may unconsciously withdraw or minimize conflict not because the relationship is fully harmonious, but as a protective strategy. This helps preserve emotional safety when vulnerability is high, especially in the absence of open communication or safe spaces to express dissatisfaction.

Some couples may avoid conflict to maintain marital peace, without necessarily resolving it. Furthermore, high relationship satisfaction could also result from a social desirability bias, or a tendency to minimize tensions in the absence of a safe space to express them. A developed qualitative approach would have allowed these nuances to be explored more clearly.

In order to go further in the analysis of satisfactions, the following part will focus on the body satisfaction of young mothers.

5.2.3. *Relationship with the Body: Mixed Body Satisfaction*

The median score at the PWGAS (56/80) indicates a moderately positive body attitude. This ambivalence is consistent with the observations of Cash & Smolak (2011)

and Tiggemann (2011), who emphasize the vulnerability of postpartum body image and refer to identity dissonance; the fact of having become a mother does not protect against the injunction to “rediscover” a silhouette that conforms to dominant aesthetic standards. The bodies of young mothers, although socially valued during pregnancy, remain subject to contradictory aesthetic injunctions after childbirth (Bordo, 2003).

This weakened bodily experience could lead to avoidance behaviors (refusal to look at oneself naked, avoidance of mirrors or intimacy) which harm the reappropriation of the body of young mothers. This disengagement contributes to the vicious circle described by Meltzer & McNulty (2010), where a negative body image fuels sexual avoidance, in turn reinforcing relational distance.

However, in this study, body satisfaction was not statistically linked to the desire for more information, which may be explained by less awareness or verbalization of body issues, in contrast to the more easily expressed sexual concerns. Future research could explore whether psychoeducational interventions on postpartum body image might help surface unmet needs in this domain that remain less explicitly expressed.

Nevertheless, the testimonies collected in this study illustrate a wide variability in postpartum body image experiences. Some participants expressed significant discomfort with their body image, while others seemed to accept it more serenely. These observations echo the findings of DiPietro et al. (2003), who emphasized the importance of psychosocial determinants such as perceived stress, social representations of the maternal body, and emotional support (factors not assessed in the present study). According to their work, body satisfaction cannot be understood independently of the emotional and social context in which the young mother evolves.

Hypothesis 2 is therefore weakly confirmed, although in a nuanced manner: the scores reveal moderate body satisfaction, which supports the idea of an ambivalent relationship with the body.

If the various states of satisfaction diverge, it remains to be questioned to what extent sociodemographic profiles influence the experiences of participants.

5.2.4. A Dynamic System, but Little Differentiation According to Sociodemographic Variables

Sociodemographic Variables. No significant differences were observed based on sex, age, or number of children across the three dimensions of satisfaction. These

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findings, although consistent with some recent studies (van den Brink et al., 2018), contrast with others (Klapilová et al., 2020) that, for example, identified greater body dissatisfaction among women.

While these results should be interpreted with caution due to the small size of the subgroups, the homogeneity of the sample in terms of demographic and psychosocial characteristics, as well as a recruitment bias through platforms focused on perinatal education, may help explain this contrast.

Hypothesis 5 is therefore not confirmed in the context of this study. Since no significant difference was observed according to sex, age or number of children. However, again, the small size of certain subgroups limits the scope of this conclusion.

Dynamic System. As seen previously, van den Brink et al. (2018) emphasizes the importance of dyadic approaches to understanding the complex interactions between bodily experience, sexual satisfaction, and relationship quality. This circular model seems to be partially verified here. Indeed, dissatisfaction in one area is not systematically associated with another, but the association between sexuality, information received, and the need for support suggests that an imbalance can play a triggering role in the entire system.

The correlation results allow us to further nuance the dynamics between the bodily, sexual, and relational dimensions. Among the women in the sample, only the relationship between sexual dissatisfaction and relational satisfaction appears significant, which reinforces the idea of a direct interaction between these two dimensions. However, the absence of a significant link between body satisfaction and sexuality is surprising in light of the literature, which often highlights the central role of body image in postpartum sexual satisfaction (Meltzer & McNulty, 2010; Tiggemann, 2011). This absence of a link (which may simply be due to a sample size effect) does not mean an absence of effect, but rather a complexity in the relationships between these dimensions, potentially due to emotional or contextual factors.

These results are also found in the analysis carried out on all participants, where a significant correlation between sexual dissatisfaction and relationship satisfaction is observed. The fact that this trend is also observed among women confirms the robustness of this link, and reinforces the idea of a relational core influencing postpartum sexuality.

Nevertheless, the absence of a significant correlation between body satisfaction and sexual satisfaction despite being well-documented in the literature (Meltzer & McNulty, 2010; Tiggemann, 2011), calls for a more in-depth analysis. While a limitation related to sample size is possible, other hypotheses can also be considered. This missing link might simply reflect how differently each participant experiences her body and sexuality.

It is also possible that mediating factors, not measured here, are mitigating this relationship. As previously discussed, partner support may act as a buffer: a woman who feels dissatisfied with her body may still experience a fulfilling sexual life if she feels supported, valued, and desired by her partner. The earlier findings also highlight the quality of intimate communication (largely present among study participants) as a potential moderator that could neutralize the negative impact of body image. Lastly, internal resources, such as overall self-esteem, may also serve as protective factors for young mothers.

Moreover, it is important to note that the instrument used to assess body satisfaction (PWGAS) primarily evaluates attitudes toward weight gain during pregnancy, without directly exploring perceived sexual desirability, which is central to the dynamics between body image and sexuality. The use of a different tool could provide greater insight into this interaction.

These findings emphasize the relevance of incorporating a more developed qualitative approach in future research, to better explore the underlying mechanisms of these complex relationships.

5.2.5 Underrepresentation of Men in Perinatal Research and Care Pathways

Men represent a clear minority in this study (11% of total respondents). Their underrepresentation, both in scientific literature and in support systems, reinforces the idea that parenthood, and particularly the upheavals it brings, is primarily a female experience. This gender bias can lead to concrete consequences, such as the invisibilization of fathers' psychological, relational, and sexual needs, and a perceived lack of legitimacy to express these difficulties in public or medical settings.

Yet, several studies show that men also undergo significant emotional and identity-related changes during the perinatal period (Raymond, 2021). Their low

presence in care settings does not reflect a lack of needs but rather highlights a cultural and institutional gap that must be addressed.

Despite efforts to involve fathers, this study shows how hard it remains to engage men in perinatal research. It highlights the need to view parenthood as a shared experience, to include men more actively in perinatal research and care, and to provide them with the recognition and space they need to legitimately express their experiences.

5.3. Hypothesis Statements

To make the link between the empirical results and the hypotheses formulated beforehand, a synthetic assessment can be proposed.

Table 14

Hypothesis Summary Table

Hypothesis	Description	Validation	Comment
H1	Variation in sexual and relational satisfaction after childbirth, with a notable decline.	Partially confirmed	Sexual satisfaction decreases, relational satisfaction remains stable.
H2	A significant proportion of mothers report body dissatisfaction postpartum.	Generally confirmed	Moderate dissatisfaction; results align with expectations.
H3	Most young parents perceive the information received as unclear or incomplete.	Confirmed	Over 63% did not receive clear or complete information.
H4	Most young parents would have liked to receive more information.	Confirmed	63.5% expressed a wish for more information.
H5	Satisfaction levels vary according to sociodemographic variables.	Not confirmed	No significant differences found by sex, age, or number of children.
H6	Lower satisfaction among those expressing a desire for more information.	Partially confirmed	Only sexual satisfaction differed significantly by information need.

5.4. Conclusion of the Discussion

Thus, the results of this study highlight the plurality of adjustments experienced by young parents in the areas of sexuality, marital relationship and relationship to the body. The findings are consistent with several recent studies on the fragility of sexuality in the postpartum period (Grussu et al., 2021; Klapilová et al., 2020), while qualifying the idea of a systematic marital deterioration (Cowan & Cowan, 2000) by highlighting potential emotional resilience strategies or emotional support factors or even an emotional social desirability bias.

Furthermore, some analysis made it possible to make visible little-explored subjective experiences, particularly with regard to the differentiated relationship to the body, the temporalities of sexual desire or the adjustments made within the couple. These contributions are in line with recent calls to consider parental sexuality as a contextual and dialogical construction (Mark, 2015; Raymond, 2021), rather than as a simple indicator of recovery or performance.

This work therefore contributes to enriching the literature by integrating the subjective experiences of young parents, often neglected in traditional quantitative approaches. Its results highlight the need to adopt a global and contextualized approach to perinatal health, which is not limited to biological or functional issues, but fully integrates the emotional, sexual and bodily dimensions of the parent.

5.5. Strengths and Limitations of the Study

Among the strengths of this study, we can cite the integrated and multidimensional approach to postpartum satisfaction, including relational, sexual and bodily dimensions. In addition, this study includes components allowing us to understand the experiences of the participants and objective quantitative components based on validated psychometric tools. Finally, it addresses information needs, a rarely explored dimension, as well as the feelings and experiences of fathers, which are still too little present in studies of this type.

However, several limitations must be mentioned, such as the limited representativeness due to the low proportion of men (13.5% of participants) and the restricted sample ($n=52$) or the fact that the analyses are mainly quantitative, which limits the detailed understanding of the subjective experience. In addition, the method of recruiting respondents could bias the results due to potentially having parents who

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are more involved or aware of these issues (recruitment mainly via social networks). Some of the methodological limitations identified in the literature may therefore also apply to this study. Acknowledging them reinforces the need for more diverse future research on the topic.

5.6. Clinical implications and practical recommendations

The results of this study reveal clear needs expressed by young parents regarding sexuality, couple relationships, and body satisfaction during the perinatal period. More than 63% of respondents reported not receiving clear and complete information on these topics, and a similar proportion indicated they would have liked to receive more. This lack of information is correlated with higher sexual dissatisfaction, highlighting a specific vulnerability in this area. These findings underline the urgency of rethinking perinatal support by fully integrating intimate, emotional, and relational dimensions into existing care pathways.

5.6.1. Integrating Sexuality, Relationships, and Body Issues into Perinatal Care

It is essential that health professionals working closely with young parents, such as midwives, general practitioners, gynecologists, and psychologists, address issues of sexuality, couple dynamics, and body image without taboo, and with empathy and competence. These professionals should receive appropriate training during their education, but also be encouraged to pursue independent learning in order to meet the specific needs of parents.

Inspired by the Swedish model, it would be relevant to offer comprehensive perinatal support that is universally accessible to all parents, without requiring a prior condition of vulnerability. Intimacy, sexuality, and body image should not be addressed only in the presence of detected problems or explicit requests, but should instead be fully integrated into a systematic and inclusive approach to parental health.

Following the Canadian model, incorporating specialized professionals, such as perinatal sexologist-psychologists within maternity teams would provide a space for listening and support to couples facing difficulties in their intimate lives.

5.6.2. Development of Accessible Psychoeducational Materials

This study highlights a strong need for information. Written, visual, or digital materials, adapted to everyday language and scientifically validated, could be offered to

future and new parents. These resources could address topics such as resuming sexuality, changes in desire, transformed body image, and communication within the couple. Such tools should be provided as early as pregnancy and remain available postpartum, either in consultations or through public health platforms.

5.6.3. Encouraging Communication

With healthcare professionals. While this study emphasizes a lack of communication from healthcare providers, it also suggests that some parents may feel uncomfortable or hesitant to raise intimate concerns. It is therefore important that professionals make themselves explicitly available for these discussions, actively encourage openness, and create a safe, non-judgmental space in which parents can express their needs and be guided toward appropriate support if necessary.

Within the couple. Results reveal that most parents were able to communicate with their partners about the changes they experienced, which appears to be a protective factor. Group workshops or couple consultations that support intimate communication could reinforce this dynamic. Even occasional interventions may help align sexual expectations, reduce tension, and foster a climate of trust.

5.6.4. Recognizing and Including Fathers in Care Pathways

It is crucial to develop specific strategies aimed at men, who remain largely absent from perinatal support systems. Targeted approaches, such as couple consultations or dedicated father support groups, should be considered to help them express their own needs. These interventions must also work to deconstruct stereotypes of fatherhood, which often reduce men to a logistical or secondary role, and instead recognize that fathers, too, may experience vulnerability during the transition to parenthood.

5.6.5. Institutional Awareness and Evolving Practices

Implementing these recommendations requires a shift in public health paradigms. Bringing sexuality, relationships, and body issues into perinatal care could help lift the silence that still surrounds these topics in French health systems. Health policy must acknowledge that young parents' sexual, relational, and bodily well-being directly impacts their mental health, the strength of their couple bond, and their overall individual and family well-being.

5.7. Avenues for Future Research

In the future, it would be relevant to conduct longitudinal studies to objectively assess the evolution of the three dimensions over time. Furthermore, integrating a developed qualitative approach (interviews, life stories) in addition to a quantitative component to delve deeper into lived experiences would be interesting. Too few studies focus on orientations other than heterosexual couples, just as studies on young parents living in French overseas territories are rare. Studies including these characteristics would be relevant. Finally, future research could develop psychoeducational interventions and rigorously evaluate them in order to offer them to future and young parents.

6. Conclusion

This thesis set out to better understand how young parents experience sexual, relational, and body satisfaction after the birth of a child, as well as the role of the information they receive during the perinatal period. The aim was twofold: to document experiences that are often overlooked, and to identify ways to improve support for couples navigating this significant life transition.

The findings show a clear drop in sexual satisfaction during pregnancy, which tends to persist moderately after childbirth, while relationship satisfaction remains mostly stable. Body dissatisfaction was present, but generally moderate. Most participants felt the information provided during perinatal care was vague or insufficient, and those reporting the lowest satisfaction levels also expressed a stronger need for better guidance.

This work brings several contributions. It reinforces some findings already described in the literature, such as the decline in sexuality and the medical silence that often surrounds it, while challenging others, like the assumption that the couple's bond systematically weakens. It also sheds light on personal, intimate experiences that remain underexplored in French research. By combining self-reported insights with standardized psychometric tools, this quantitative method approach offers a more nuanced understanding of the postpartum experience.

Naturally, this study has its limits: a relatively small sample, a strong majority of female participants, and a self-report format that could introduce bias. Still, it opens up promising avenues for future research, especially longitudinal studies and in-depth qualitative work centered on lived postpartum experiences. It also calls for practical changes in clinical settings, particularly in how health professionals are trained to address sexuality and intimacy during perinatal care.

Ultimately, these findings support the idea that sexuality, relational dynamics, and body image deserve a central place in perinatal support. They encourage us to rethink how care is offered, toward a more human, inclusive, and responsive model that truly reflects what today's parents need. Psychosexual well-being, emotional intimacy,

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and gender equality should be recognized as key pillars of parental health and fully integrated into public health policies.

Finally, no reflection on parenthood today would be complete without a call for more inclusive research, one that amplifies the diverse voices shaping modern parenting, beyond the boundaries of the normative heterosexual couple.

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Appendix A

Questionnaire Self-Administered



EGAS MONIZ SCHOOL
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Satisfaction sexuelle, relationnelle et corporelle chez les Jeunes Parents : Enjeux et besoins périnataux.

En remplissant ce questionnaire dans son intégralité et le plus honnêtement possible, vous contribuez à la réalisation de l'étude « Satisfaction sexuelle, relationnelle et corporelle chez les Jeunes Parents : Enjeux et besoins périnataux. ». Ce questionnaire prend environ 10 minutes à remplir, si vous avez des doutes sur sa compréhension, n'hésitez pas à me contacter via l'adresse mail : katell.bourdon.egasmoniz@gmail.com. Une partie de ce questionnaire est réservée exclusivement aux femmes et une autre aux hommes, veuillez donc respecter leur remplissage en fonction de votre sexe biologique.

Dans le cadre du programme de Master en Psychologie clinique et de la santé de l'Université d'Egas Moniz, sous la direction du professeur Dr Marta Reis, l'autorisation est demandée pour participer à l'étude "Satisfaction sexuelle, relationnelle et corporelle chez les Jeunes Parents : Enjeux et besoins périnataux." ciblant les jeunes parents ayant accueilli un enfant en 2024. L'objectif est de décrire l'état de satisfaction sexuelle, relationnelle et corporelle des jeunes parents (satisfaction corporelle uniquement pour les femmes), cherchant ainsi à montrer qu'il existe un réel intérêt pour les inclure dans le suivi périnatal et l'accompagnement sexo-périnatal. Les insatisfactions étant courantes et normales.

Pour participer à cette étude, il est demandé de remplir ce questionnaire en ligne. Toutes réponses, qu'elles soient positives ou négatives, sont utiles à l'étude. La participation à cette étude est volontaire. Votre non-participation ne vous causera aucun préjudice.

Cette étude pourrait apporter des bénéfices tels qu'une meilleure compréhension des besoins des jeunes parents, ainsi que des enjeux de sexualité, de relation de couple et de corps en périnatalité, à l'avancement des connaissances. L'objectif est d'améliorer les pratiques et non de juger les participants.

Appendices

Cette étude peut impliquer des risques potentiels tels que le retour à des souvenirs pénibles que les participants n'ont peut-être pas complètement traités auparavant. En fin de questionnaire est donné un listing de ressources aidantes.

Les informations collectées sont destinées uniquement à un traitement statistique et/ou à une publication et seront traitées par le(s) encadrant(s) et/ou leurs délégués. La collection est anonyme et confidentielle.

J'ACCEPTÉ de participer à cette étude, confirmant que j'ai été informé de ses conditions et que je n'ai aucun doute.

JE N'ACCEPTÉ PAS de participer à cette étude, confirmant que j'ai été informé de ses conditions et que je n'ai aucun doute.

Partie commune à tous participants

1- Quel-est votre sexe biologique (caractéristiques biologiques et physiques d'une personne à la naissance) ?

Féminin

Masculin

Autre

Préfère ne pas répondre

2- Quel est votre âge ?

3- Quelle est votre nationalité ?

Française

Autre :.....

Préfère ne pas répondre

4- Dans quel pays résidez-vous ?

France métropolitaine

Autre :.....

Préfère ne pas répondre

5- Quelle est votre profession ?

Agriculteur exploitant

Artisan commerçant, chef d'entreprise

Employé

Ouvrier

Cadre et profession intellectuelle supérieure

Profession intermédiaire

Retraité

Sans activité professionnelle

Autre

Préfère ne pas répondre

6- Êtes-vous en couple hétérosexuel ?

Oui

Non

Préfère ne pas répondre

7- Depuis combien de temps êtes-vous en couple ?

Plus d'1 an

Moins d'1 an

Préfère ne pas répondre

8- Avez-vous eu un enfant au cours de l'année 2024 -2025?

Oui

Non

Préfère ne pas répondre

8 bis- Cet enfant est-il votre premier enfant ?

Oui

Non

Préfère ne pas répondre

Appendices

9- Votre dernière grossesse fut :

Désirée

Inopinée

Préfère ne pas répondre

10- Quand avez-vous accueilli votre dernier enfant ?

Préfère ne pas répondre

11- Votre dernière grossesse fut-elle induite par des thérapeutiques (traitement hormonaux, FIV, ICSI...) ?

Oui

Non

Préfère ne pas répondre

12- Si oui, durant cette phase d'attente de grossesse, votre sexualité de couple a-t-elle été perturbée ?

Oui

Non

Préfère ne pas répondre

13- Si oui, en discutiez-vous en couple ?

Oui

Non

Préfère ne pas répondre

14- Votre religion interdit-elle les rapports sexuels pendant la grossesse ?

Oui

Non

Préfère ne pas répondre

15- Votre religion interdit-elle les rapports sexuels durant les mois suivant l'accouchement? Oui Non Préfère ne pas répondre

16- Notez la qualité de votre sexualité avant cette dernière grossesse :

1 Insatisfaisant	2	3	4	5 Très épanouissante
<input checked="" type="radio"/>				

17- Notez la qualité de votre sexualité pendant cette dernière grossesse :

1 Insatisfaisant	2	3	4	5 Très épanouissante

18- Notez la qualité de votre relation de couple avant cette dernière grossesse :

1 Insatisfaisant	2	3	4	5 Très épanouissante

19- Notez la qualité de votre relation de couple pendant cette dernière grossesse :

1 Insatisfaisant	2	3	4	5 Très épanouissante

20- Pouvez-vous expliquer en quoi la sexualité et la relation de couple pendant la grossesse ont été différentes ?

Préfère ne pas répondre

21- Avez-vous pu discuter de ces éventuels changements en couple ?

Oui

Non

Préfère ne pas répondre

22- Si NON, pourquoi ?

Préfère ne pas répondre

Appendices

23- [Vous avez plusieurs enfants] - Votre sexualité durant cette grossesse était-elle identique que lors de la (les) grossesse(s) précédente(s) ?

Oui

Non

Préfère ne pas répondre

24- Si NON, pourquoi ?

Préfère ne pas répondre

25- À quel moment, après la naissance de votre dernier enfant, avez-vous eu envie de reprendre les relations sexuelles ?

Préfère ne pas répondre

26- À quel moment, après la naissance de votre dernier enfant, avez-vous repris les relations sexuelles ?

Préfère ne pas répondre

27- Avez-vous dû attendre que votre conjoint(e) se sente prêt(e) pour reprendre les rapports ?

Non, nous en avons envie au même moment

Oui

Préfère ne pas répondre

28- Les informations reçues pendant la grossesse ou après l'accouchement, par le personnel médical, à propos de la sexualité, de la relation du couple, de la corporalité vous semblent-elles claires et complètes ?

Oui

Non

Je n'ai pas eu d'informations

Préfère ne pas répondre

29- Auriez-vous voulu avoir davantage d'informations à propos de la sexualité, de la relation du couple et de la corporalité ?

Oui

Non

Préfère ne pas répondre

Vous êtes presque à la fin !

Choisissez, pour chaque question, la réponse qui vous paraît la plus appropriée dans la liste ci-dessous, 0 correspondant à rarement ou jamais et 4 à la plupart du temps ou toujours.

30- 0 correspondant à rarement ou jamais et 4 à la plupart du temps ou toujours.

	0	1	2	3	4	Préfère ne pas répondre
J'ai l'impression que mon(ma) partenaire apprécie notre vie sexuelle.						
Ma vie sexuelle est passionnante.						
Les relations sexuelles sont plaisantes pour mon(ma) partenaire et moi						
C'est devenu une corvée pour moi d'avoir une relation sexuelle avec mon(ma) partenaire.						
Ma vie sexuelle est monotone.						
Nos relations sexuelles sont trop précipitées et rapidement complétées.						
Je trouve que ma vie sexuelle manque de qualité.						
Mon(ma) partenaire est très excitant(e) sexuellement.						<input type="radio"/>

Appendices

J'apprécie les techniques sexuelles que mon(ma) partenaire aime ou utilise.	<input checked="" type="radio"/>					
Je trouve que la sexualité, c'est merveilleux.						
J'essaie d'éviter les contacts sexuels avec mon (ma) partenaire.						
Mon(ma) partenaire est un(e) compagnon(compagne) sexuel(le) merveilleux(se).						
Je considère la sexualité comme une composante normale de notre relation.						
Je considère que notre vie sexuelle ajoute vraiment beaucoup à notre relation.						
Il m'est facile d'être excité(e) sexuellement par mon(ma) partenaire.						
J'ai l'impression que mon(ma) partenaire est satisfait(e) sexuellement avec moi.						
Mon(ma) partenaire est très sensible à mes besoins et à mes désirs sexuels.						
Mon(ma) partenaire ne me satisfait pas sexuellement.						
Je trouve que ma vie sexuelle est ennuyante.						<input checked="" type="radio"/>

Pour chacune des questions ci-dessous, veuillez cocher l'affirmation qui décrit le mieux comment vous vous sentez maintenant, en ce moment.

31- 1 étant le + FAIBLE et 5 le + HAUT

	1	2	3	4	5	Préfère ne pas répondre
Dans quelle mesure votre compagnon/compagne répond-il/elle à vos besoins ?	<input checked="" type="radio"/>					
Globalement jusqu'à quel point êtes-vous satisfait de votre relation de couple ?						
Quelle est la satisfaction de votre relation de couple comparativement aux autres ?						
Combien de fois vous est-il arrivé de regretter de vous être engagée dans cette relation de couple ?						
Dans quelle mesure votre relation correspond-elle à vos attentes initiales ?						
À quel point aimez-vous votre compagnon/compagne?						
Combien de problèmes y a-t-il dans votre relation de couple ?						<input checked="" type="radio"/>

Partie réservée aux Femmes

Si vous êtes un Homme, merci d'avancer à la prochaine partie, sans répondre aux questions réservées aux femmes.

Choisissez, pour chaque question, la réponse qui vous paraît la plus appropriée (suivant ce que vous ressentez/pensez maintenant et ce que vous avez pu ressentir/penser au cours de cette grossesse) dans la liste ci-dessous, 1 correspondant à «pas du tout d'accord» et 5 à «tout à fait d'accord».

32- 1 correspondant à «pas du tout d'accord» et 5 à «tout à fait d'accord»

Appendices

	1	2	3	4	5	Préfère ne pas répondre
Je crains de devenir grosse au cours de cette grossesse.	<input checked="" type="radio"/>					
J'aimerais prendre entre 9 et 14 kg au cours de cette grossesse.						
J'ai essayé de garder mon poids habituel afin de ne pas avoir l'air enceinte de trop.						
J'aimerais prendre entre 5 et 9 kg au cours de cette grossesse.						
Tant que j'ai une alimentation équilibrée, je ne m'inquiète pas du poids que je peux prendre.						
Je suis fière d'être enceinte.						
J'aime pouvoir prendre du poids, pour une fois.						
Je suis gênée d'avoir autant grossi durant cette grossesse.						
J'accepterais de prendre 18kg si cela permettait à mon bébé d'être en bonne santé.						
J'aime porter des vêtements de maternité.						
Je ne me sens pas séduisante à cause du poids pris au cours de cette grossesse.						
Cela me dérange de ne pas pouvoir porter ce qui est à la mode quand je suis enceinte.						
Je pense que les femmes doivent faire particulièrement attention à ne pas grossir durant la grossesse.						<input checked="" type="radio"/>

Si je prends trop de poids en un mois, j'essaie d'éviter d'en prendre le mois suivant.	<input checked="" type="radio"/>					
Avant d'aller chez le médecin, j'essaie de ne pas manger.						
J'accepterais de prendre 16 kg si cela permettait à mon bébé d'être en bonne santé.						

Partie réservée aux Hommes

Si vous êtes une Femme, merci d'avancer à la prochaine partie, sans répondre aux questions réservées aux hommes.

33- Avez-vous été perturbé par les changements psychologiques/psychiques de votre conjointe ?

Oui

Non

Préfère ne pas répondre

34- Si OUI, en quoi ?.....

Préfère ne pas répondre

35- Avez-vous été perturbé par les changements corporels de votre conjointe ?

Oui

Non

Préfère ne pas répondre

36- Si OUI, en quoi ?.....

Préfère ne pas répondre

37- Etiez-vous présent au moment de la naissance de votre enfant ?

Oui

Non

Préfère ne pas répondre

38- Si OUI, l'accouchement a-t-il modifié l'image que vous aviez de votre conjointe ?

- Non
- Oui, positivement
- Oui, négativement
- Préfère ne pas répondre

Merci d'avoir été au bout de ce questionnaire, votre participation à grandement aidé au développement de mon étude ! Si vous avez quelconques questions, retours, remarques ou tout simplement l'envie de recevoir la rédaction de ce mémoire, vous pouvez me contacter via l'adresse mail : katell.bourdon.egasmoniz@gmail.com | Merci de partager ce questionnaire à de jeunes parents si vous en connaissez, le plus de réponses il y aura, le plus précis sera mon mémoire !

Parce que cette période périnatale n'est pas évidente, et que partager ses doutes et ses craintes permet de la rendre moins difficile, veuillez trouver un listing non exhaustif de différentes aides.

- **Le médecin généraliste** qui est souvent le premier interlocuteur pour les problèmes de santé. Il est en capacité de poser un premier diagnostic afin de proposer un traitement/accompagnement adapté,
- **La sage-femme** qui a suivi la maman tout au long de sa grossesse ; la sage-femme qui s'est occupée du suivi post-natal,
- **Les services de PMI accompagnent** les parents avant mais aussi après la naissance de l'enfant. Les sages-femmes et puéricultrices sont à l'écoute et peuvent se déplacer à domicile au besoin,
- **Le gynécologue** qui a participé au parcours de grossesse, à l'accouchement ou suivi post-natal,
- **La maternité** dans laquelle la maman a séjourné ou celle proche du domicile,
- **Le/La pédiatre** qui effectue le suivi de l'enfant,
- **Un(e) psychologue ou psychiatre** que le parent aura choisi ou vers qui un professionnel pourra l'orienter,

- **Un(e) sexologue** que le parent aura choisi ou vers qui un professionnel pourra l'orienter,
- **L'association Maman Blues** à but non thérapeutique propose soutien, échange et informations autour de la difficulté maternelle : <http://www.maman-blues.fr/>
- **L'association enfance & partage** – <https://enfance-et-partage.org/>
- **Numéro Vert « Allo Parents bébé »** d'aide et de soutien à la parentalité. Il a pour mission d'écouter, de soutenir et d'orienter les parents inquiets dès la grossesse : **0800 00 3456** (service & appel gratuit).
- **Les TISF (Technicien(ne)s d'Intervention Social et Familial)** peuvent venir en soutien dans les tâches quotidiennes et peuvent être un réel soutien dans le rôle de parent. Il faudra déposer une demande auprès de la Caisse d'Allocations Familiales.
- **Les LAEP (Lieu d'Accueil Enfant-Parent)** sont des lieux conviviaux pour les petits et pour les grands ! On peut passer du bon temps avec son bébé, partager ses expériences avec d'autres parents, et rencontrer des professionnels formés à l'écoute.
- **Les travailleurs sociaux** peuvent venir en aide pour la gestion d'une situation complexe suite à la déclaration d'un changement de vie (séparation, divorce, perte d'un emploi, décès d'un proche...). Pour en savoir plus, il faudra contacter la Caisse d'Allocations Familiales.
- **Le numéro national de prévention du suicide 3114.** Un professionnel du soin, spécifiquement formé à la prévention suicide, sera à l'écoute en cas de pensées suicidaires et de peur de faire mal à son enfant.

Appendix B

Participant Recruitment Poster

Appel à participants

Dans la cadre de mon mémoire de master

QUESTIONNAIRE PORTANT SUR LA
SATISFACTION DES JEUNES PARENTS

! RÉPONSES ANONYMES !



10 minutes

- Vous avez 18 ans et plus
- Vous avez eu un enfant durant l'année 2024 (Père & Mère)

CHAQUE PARTICIPATION COMPTE ET EST
IMPORTANTE !

Appendix C

Informed Consent



Informed Consent

Code| IMP-EM-PE-17_03

Monte de Caparica, 21/10/2024

Dear Madam or Sir,

As part of the Master's program in Clinical and Health Psychology at the University of Egas Moniz, under the guidance of Professor Dr. Marta Reis, permission is requested to participate in the study "**Sexual, relational and bodily satisfaction in young parents: Perinatal issues and needs.**" targeting young parents having welcomed a child in 2024. The objective is to describe the state of sexual, relational and bodily satisfaction in young parents (bodily satisfaction only in the case of women), thereby seeking to show that there is a genuine interest in including them in perinatal monitoring and sex-perinatal support. To take part in this study, the need is to fill in an online question.

Participation in this study is voluntary. Your non-participation will not cause you any harm.

This study could bring benefits such as a better understanding of the needs of young parents, as well as the issues of sexuality, the couple's relationship and the body in perinatal care, to the advancement of knowledge.

This study may involve potential risks such as revisiting distressing memories that participants may have not processed fully before.

The information collected is intended solely for statistical treatment and/or publication and will be handled by the supervisor(s) and/or their delegates. The collection is anonymous and confidential.

I ACCEPT/DO NOT ACCEPT to participate in this study, confirming that I have been informed about its conditions and that I have no doubts.

(Signature of the participant or, in the case of minors, of the father/mother or legal guardian)

Appendix D

Consentimento Informado



Consentimento Informado

Code| IMP-EM-PE-17_03

Monte de Caparica, 21/11/2024

Exmo(a) Senhor(a),

No âmbito do Mestrado em Psicologia Clínica e da Saúde da Universidade de Egas Moniz, sob a orientação da Professora Doutora Marta Reis, solicita-se autorização para participar no estudo “Satisfação sexual, relacional e corporal em pais jovens: Questões e necessidades perinatais”, dirigido a jovens pais que tenham tido um filho em 2024. O objetivo é descrever o estado de satisfação sexual, relacional e corporal dos jovens pais (satisfação corporal apenas no caso das mulheres), procurando assim mostrar que existe um interesse genuíno em incluir o casal no acompanhamento perinatal e no apoio sexo-perinatal. Para participar neste estudo, é necessário preencher um questionário online.

A participação neste estudo é voluntária. A não participação não causará qualquer prejuízo. Este estudo poderá trazer benefícios, tais como uma melhor compreensão das necessidades dos jovens pais, bem como das questões da sexualidade, da relação do casal e do corpo nos cuidados perinatais, para o avanço do conhecimento, o que poderá ser útil para a sua saúde.

Este estudo pode envolver riscos potenciais, tais como a revisitação de memórias angustiantes que os participantes podem não ter processado totalmente.

As informações recolhidas destinam-se exclusivamente a tratamento estatístico e/ou publicação e serão tratadas pelo orientador. A recolha é anónima e confidencial, garantindo que a identidade não será revelada em quaisquer relatórios ou publicações.

ACEITO/NÃO ACEITO participar neste estudo, confirmando que fui informado(a) das condições e que não tenho dúvidas

(Assinatura do participante ou, no caso de menores, do pai/mãe ou do tutor legal)

Egas Moniz – Cooperativa de Ensino Superior, CRL
Campus Universitário - Quinta da Granja 2829-511
Monte de Caparica,
Portugal
NIF 504 218 611

Appendix E

Ethics Committee Approval



Proposta de Tese

Dados do Aluno

Nome do proponente	Katell Anne Bourdon		
Nº do Aluno	118335	Data do pedido	21/11/2024
Email do Aluno	118335@alunos.egasmoniz.edu.pt		
Nº do telemóvel	+33638842668	Nome do Curso	MPCS
Unidade Orgânica	IUEM	CNAEF	311 (Psicologia)

Dados da Tese

Ano letivo de defesa da tese	2024/2025
Título da tese (PT)	Satisfação sexual, relacional e corporal em jovens pais: Questões e necessidades perinatais.
Título da tese (EN)	Sexual, relational and bodily satisfaction in young parents: Perinatal issues and needs.

Resumo da tese

According to INSEE (French National Institute for Statistics and Economic Studies), 678,000 babies will be born in France in 2023. The question of intimacy and newness in the postnatal couple relationship affects all these young parents in one way or another. Recent studies have highlighted the many sexual fluctuations that can occur during the perinatal period. Changes in sexual function can be observed, with a decrease in orgasm, sexual desire and satisfaction, and an increase in dyspareunia (Grussu, Vicini, & Quatraro, 2021). These may be caused by socio-cultural influences, numerous physiological factors (fatigue, discomfort, pain, pregnancy illness, lacerations/tears, breastfeeding) and psychological factors (depression, fears and anxieties, beliefs, body problems and feelings of desirability), (De Pierrepont, Brassard, Lessard, Gingras, & Péloquin, 2022). It has thus been shown that there are changes in sexual behaviour during pregnancy, but also that these changes are partly linked to the inadequacy or absence of professional advice on sexuality (Grussu, Vicini, & Quatraro, 2021).

Sex perinatalidade is a new field which deals with the couple's intimacy in the post-partum period, more specifically the period extending from the beginning of the twenty-eighth week of gestation to the seventh day after birth. The perinato-sexologist is a psychologist whose role is to inform, discuss, normalise, reassure, raise awareness and support couples. They also address women's body image and sense of desirability, sexual problems and fluctuations in sexual desire (Dubeau & Polomeno, 2009).

Interviews with midwives and 128 questionnaires with couples have shown the usefulness and importance of the information given to couples during pregnancy and after childbirth, and its impact on the resumption of sexual relations and sexual well-being (Foucault, 2011). The relevance of studying the implementation of sexuality counselling in maternity units for pregnant women, men and couples was also highlighted in order to offer greater sexual satisfaction to as many couples of young parents as possible. (Foucault, 2011). Thirteen years after this study and conclusion, this type of support is still not available in France. Perinatal interventions specifically targeting sexuality are still rare (Byers-Heinlein, McCallum, Byers, & Pukall, 2019).

The transition to parenthood causes a major upheaval in the couple's relationship (Favez, 2013). A survey carried out by IFOP (a French organisation responsible for carrying out opinion polls and market research) showed that 50% of parents questioned felt like breaking up with their partner after the birth of their youngest child (Thomas, 2022).

No other time in a woman's life requires such rapid and intense adaptation to the many physical and psychological changes that take place during these nine months as pregnancy (Andre, 2018). It has been shown that 40% of women react negatively to pregnancy-induced bodily changes (Fairburn et al., 1990). Body satisfaction among young mothers remains a subject that has received very little attention in the world of research. Yet it is so important for these young mothers.

Among the dimensions of married life, sexuality, which involves both a rapprochement involving major relational issues and the unveiling of the body, can prove particularly difficult for people who are dissatisfied with their bodies (Cash, Maikkula & Yamamiya, 2004). Women who are dissatisfied with their bodies tend to decrease their adoption of emotionally engaging behaviours, such as self-disclosure, which can lead to less intimate and satisfying relationships. (Meltzer & McNulty, 2010; Murray, Holmes & Collins, 2006).

Compared with other countries, France seems to be lagging behind in terms of support for sexual satisfaction, relationship satisfaction and bodily satisfaction during the early parenthood experience. In Canada, for example,



perinato-sexologists are present in some perinatal interdisciplinary teams (De Pierrepont, C., & Polomeno, V., 2014). Including more psychological support during the perinatal period would make it possible to address various themes such as sexuality, the couple's relationship and physicality, all of which would benefit the well-being of future or young parents. Martine Spiess supports these recommendations, advising the contribution of a psychologist to the work of the obstetric team. (Spiess, 2002)

It is therefore important to examine the needs of young parents in the perinatal period in France today in terms of support and information on sexuality, relationships and the body. The main aim of this study is to describe the state of sexual, relational and bodily satisfaction among young parents (women only), in an attempt to show that there is a genuine interest in integrating these issues into perinatal monitoring and sex-perinatal support.

Metodologias

Methodology :

This study uses a descriptive quantitative design.

Sample :

The sample for this study will be made up of men and women, with an expected sample size of around 50 individuals.

In order to take part in this study, participants will be asked to meet the inclusion criteria of being at least 18 years old, living in mainland France, and having been in a heterosexual relationship for at least one year in order to assess the level of sexual and relational satisfaction outside the honeymoon phase. Schmiedeberg and Schröder (2016) have shown that after a positive first year, sexual satisfaction tends to decline. The final criterion is to have had a child during the year 2024. Having become a parent in the last year is a criterion chosen to limit the re-evaluation and reinterpretation of the perceptions evaluated in this study. This cognitive dissonance occurs gradually, often without people being aware of it. This process depends very much on the nature of the event, the extent of the dissonance experienced and the psychological mechanisms put in place to reduce it. (Aronson & Tavris, 2007).

The sampling strategies selected are convenience sampling and snowball sampling.

Instruments :

The instrument used in this study is a self-administered questionnaire in French, with one section for women and another for men. It was inspired by those used by Foucault C. in her evaluation of the information given to couples during pregnancy and after childbirth and its repercussions on the resumption of sexual relations (Foucault, 2011).

- Sociodemographic questionnaire and questions relating to sexual satisfaction.

The questionnaire aims to analyse socio-demographic factors (biological sex, age, nationality, country of residence, employment status, relationship status), questions relating to parenthood (number of children, questions about pregnancy). Questions relating to sexuality (relationship to religion, satisfaction with sexuality before and during pregnancy, time of desire to resume and resume sexuality). There will also be questions about how you feel about the information provided by medical staff during pregnancy or after childbirth, about sexuality, the couple's relationship and corporality. Some of these questions will be binary-choice, while others will use Likert scales ranging from 1 to 5 to assess past satisfaction, with 1 being the most unsatisfactory and 5 the most satisfactory.

- The Sexual Satisfaction Scale (Index of Sexual Satisfaction, Hudson et al., 1981); Adaptation of the French version, Comeau & Boisvert, 1985 and validation of the French version, Wawrziczny, Doba & Antoine, 2020).

The ISS is a relevant tool given its unidimensionality, but also thanks to its quick and easy administration. This scale measures the degree of dissatisfaction with the sexual dimension of the couple's relationship by assessing different aspects such as sexual behaviours, attitudes, events, affective states and preferences. (Pechorro, Diniz, Almeida, & Vieira, 2009).

Initially composed of 25 items, the French version refuted 6 of its items during validation of the version intended for the French population. The French ISS therefore consists of 19 items. It should be noted that 5 of these 6 refuted items were also removed from the validated Spanish and Portuguese versions of the ISS, due to similar problems of contribution or membership encountered with the French version. (Wawrziczny, Doba & Antoine, 2020).

All items are evaluated on a Likert-type scale ranging from 0 = rarely or never to 4 = most of the time or always. The score for items 1, 2, 3, 9, 10, 12, 16, 17, 19, 21, 22, 23 must be inverted. The overall score varies between 0 and 76 (100 being the maximum score in the original 25-item version). This measure considers sexual quality as a



Proposta de Tese

single dimension of a continuum with high levels of sexual satisfaction at one end and high levels of sexual dissatisfaction at the other (Shaw & Rogge, 2016). Higher scores on this scale correspond to higher levels of sexual dissatisfaction. (Wawrziczny, Doba & Antoine, 2020).

Here, this scale therefore provides information on the sexual satisfaction of the participants in this study, making it possible to highlight a potential need for support from a sexual point of view in the perinatal period.

- The Relationship Assessment Scale (RAS; Hendrick, 1988; Adaptation and validation of the French version, Saramago, Lemétayer & Gana, 2021).

The Relationship Assessment Scale (RAS; Hendrick, 1988) is a generic measure of relationship satisfaction. Seven items were developed on the basis of previous measures such as the Marital Assessment Questionnaire (Hendrick, 1981), Love Attitudes Scale (Hendrick & Hendrick, 1986) and Sexual Attitudes Scale (Hendrick et al., 1985). (Hendrick, S. S., Dicke, A., & Hendrick, C., 2011).

This scale is a brief, unidimensional measure of satisfaction with relationships with others. The 7 items that make up this test are interrogative sentences. The items are answered using a 5-point Likert-type scale. Scores range from 1 (low satisfaction) to 5 (high satisfaction). (Saramago, M., Lemétayer, F., & Gana, K. (2021)).

The total score varies from 7 to 35, with a high score indicating greater satisfaction with the relationship and a low score indicating lower satisfaction with the relationship.

This scale therefore provides information about the marital relationship of the participants in this study, highlighting a potential need for support from a relational point of view during the perinatal period.

- Body image and pregnancy scale (Pregnancy and Weight Gain Attitude Scale (PWGAS) Palmer, Jennings & Massey, 1985; Adaptation and validation of the French version, Rousseau & al., 2015).

This scale assesses women's attitude solely in relation to their weight gain during pregnancy. It initially consists of 18 items in a 5-point Likert scale format ranging from 1 'strongly disagree' to 5 'strongly agree'. During validation of the scale, 2 items were excluded from the final version because of double saturation, bringing the total number of items to 16. A composite score was calculated for each participant. These scores are distributed on a scale ranging from 1 (very negative attitude towards weight gained during pregnancy) to 5 (very positive attitude towards weight gained during pregnancy). A high score on this scale indicates positive attitudes (physical and dietary) towards weight gain during pregnancy, while a low score indicates negative attitudes. (Rousseau et al., 2015).

Four factors were highlighted in this scale by DiPietro et al. in 2003:

* Positive body image during pregnancy

* Negative body image during pregnancy

* Indifference to weight gain

* Restrictive behaviours to limit weight gain

Here, this scale provides information about the body image of the participants in this study, highlighting a potential need for body support during the perinatal period.

Analysis of results :

SPSS (Statistical Package for the Social Sciences) software will be used with a significance level of 0.05.

- Preliminary analysis of the socio-demographic characteristics of each participant (mean, minimum, maximum and standard deviation).

- Descriptive analyses: Describe the characteristics of the sample and the levels of sexual, relationship and body satisfaction.

Frequencies and percentages: To describe categorical variables (biological sex, age, number of children, etc.).

Means, medians and standard deviations: To summarise sexual, relationship and body satisfaction scores.

Diagrams or histograms: To visualise the distribution of satisfaction scores and responses to questions.

- Comparisons: To compare according to sub-groups (for example, parents who have received information on these subjects versus those who have not).

Student's t-test (for two groups): To compare means between two groups, such as women who received information about body satisfaction versus those who did not.

Analysis of variance (ANOVA): To compare means/scores for more than two groups.

Procedures :

Young parents will be approached via the managers of perinatal associations, perinatal health services and social networking groups focusing on the perinatal period. Participants will then be recruited via electronic invitations or a post on social networks. The invitation and post will include a description of the purpose of the study and a free consent form to be completed in order to access the questionnaire. The questionnaire will be put online via the Google Form platform, which will ensure the anonymity of participants. Once the consent forms have been



returned and all the questionnaires have been completed, the data will be collected and analysed.

Palavras-Chave Perinatal sexuality; Couple; Support; Needs

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Proposta de Tese

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- Local de Realização do Estudo Online questionnaire for french population.

Objetivo de trabalho

Alinhamento estratégico da tese

Transferência de conhecimento pra sociedade

Dados da Instituição

Dados da Instituição **Egas Moniz**

Tipo de Trabalho

Tipo de investigação **Primária** Investigação primária Aplicada

Metodologia de investigação **Quantitativa**

Desenho estudo **Descritivo**

Grupo de investigação

Enquadramento nos ODS

Informação relativa ao registo PT-311/24 que se encontra no estado **Aprovado**

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19 de dezembro de 2024



Proposta de Tese

Comissão de Ética

O trabalho submetido nesta proposta requer aprovação pela Comissão de Ética? **Sim**

Projeto Científico

Dissertação / Investigação Associada a Projeto Científico? **Não**

Clínica Dentária

Necessita de utilizar a clínica dentária Egas Moniz? **Não**

Necessita de utilizar o banco de dentes? **Não**

Clínica Fisioterapia

Necessita de utilizar a clínica fisioterapia Egas Moniz? **Não**

Necessita de consultar os registos clínicos? **Não**

Clínica Almada

Necessita de utilizar a clínica Almada? **Não**

Necessita de consultar os registos clínicos? **Não**

Laboratórios Egas Moniz

O trabalho requer utilização de Laboratórios Internos? **Não**

Cronograma

1-	Atividade: Bibliographical Research	Mês: Setembro	Ano: 2024
2-	Atividade: Bibliographical Research	Mês: Outubro	Ano: 2024
3-	Atividade: Preparation of the Project Proposal	Mês: Setembro	Ano: 2024
4-	Atividade: Preparation of the Project Proposal	Mês: Outubro	Ano: 2024
5-	Atividade: Project Proposal input	Mês: Outubro	Ano: 2024
6-	Atividade: Narrative revision of Literature	Mês: Outubro	Ano: 2024
7-	Atividade: Narrative revision of Literature	Mês: Novembro	Ano: 2024

Informação relativa ao registo PT-311/24 que se encontra no estado **Aprovado**

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19 de dezembro de 2024



Proposta de Tese

8-	Atividade: Narrative revision of Literature	Mês: Dezembro	Ano: 2024
9-	Atividade: Drawing up the Intervention Protocol (Questionnaire)	Mês: Novembro	Ano: 2024
10-	Atividade: Drawing up the Intervention Protocol (Questionnaire)	Mês: Dezembro	Ano: 2024
11-	Atividade: Submission of the First Report	Mês: Dezembro	Ano: 2024
12-	Atividade: Application of the Online Questionnaire with Collection of Answers	Mês: Dezembro	Ano: 2024
13-	Atividade: Application of the Online Questionnaire with Collection of Answers	Mês: Janeiro	Ano: 2025
14-	Atividade: Application of the Online Questionnaire with Collection of Answers	Mês: Fevereiro	Ano: 2025
15-	Atividade: Statistical Analysis	Mês: Março	Ano: 2025
16-	Atividade: Statistical Analysis	Mês: Abril	Ano: 2025
17-	Atividade: Submission of the Second Report	Mês: Março	Ano: 2025
18-	Atividade: Elaboration of Results	Mês: Abril	Ano: 2025
19-	Atividade: Elaboration of Results	Mês: Maio	Ano: 2025
20-	Atividade: Elaboration of the Discussion and Conclusion	Mês: Maio	Ano: 2025
21-	Atividade: Elaboration of the Discussion and Conclusion	Mês: Junho	Ano: 2025
22-	Atividade: Submission to Scientific Committee	Mês: Julho	Ano: 2025
23-	Atividade: Dissertation Submission	Mês: Julho	Ano: 2025
24-	Atividade: Estimated Date of Completion	Mês: Julho	Ano: 2025

Financiamento

Custos Não Estimativa de Custos 0,00€ Fonte de Financiamento? Não

Dados dos Orientadores

Orientador Marta Sofia Reis

Nº de Co-orientadores 0



Proposta de Tese

Tem co-orientador externo

Parecer Orientação

Lista de pareceres dos Orientadores

	Tipo de parecer	Orientador	Atual	Estado
1-	Orientador	Marta Sofia Reis	Sim	Parecer positivo

PC

Aprovado por José Grillo Data 24/10/2024
Proposta aprovada? Sim

Comissão de Ética

Aprovado por Filipa Vicente Data 19/12/2024
Proposta aprovada? Sim

Appendix F

Thematic Summary to the question on sexuality and relationships during pregnancy

This thematic summary provides a descriptive overview of the most common elements mentioned in participants' responses to the question "Can you explain how sexuality and the couple's relationship during pregnancy were different?". The themes were identified manually based on recurring topics, and the number of mentions is included to indicate relative frequency. The objective is to enrich the quantitative findings by highlighting salient experiences shared by respondents.

Main theme	Representative extracts	Number of mentions
Decreased desire / libido	<ul style="list-style-type: none"> - No desire / no libido - For sexuality, I had to rediscover a desire with a body that had changed after pregnancy. - There was less sexual intercourse even though I felt the desire for it 	15
Body change / self-image	<ul style="list-style-type: none"> - Hormonal variations, body changes, worries about the future - Sexuality was less intense for a few weeks during the pregnancy (he needed time to get used to the idea of a changing body). - With changes in the body, it's sometimes more complicated. 	5
Pain / physical fatigue	<ul style="list-style-type: none"> - Fatigue and difficult positions with a big belly - Some aches and pains - Decreased libido, physical changes 	4
Frequency of sexual relations	<ul style="list-style-type: none"> - less frequent - less fulfilled sexuality due to pregnancy, stomach aches - we had very little intercourse during the pregnancy, we found it strange that she was present during the act, and at the beginning we were afraid that the pregnancy wouldn't last if we had intercourse 	3
Concerns about pregnancy	<ul style="list-style-type: none"> - Fear of hurting the baby - We were afraid that the pregnancy wouldn't last if we had intercourse 	2
Strengthening or weakening of the couple bond	<ul style="list-style-type: none"> - Sexuality was more complicated but the relationship was stronger because we were building a life. 	1
Spouse's reluctance	<ul style="list-style-type: none"> - My partner was reluctant to have sex 	1

Appendices

Other / not categorisable	- Difficulty conceiving, several miscarriages, fears during pregnancy - These are 2 different things - We didn't experience the 9 months in the same way: still not very concrete for the father	6
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