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ORIGINAL RESEARCH

Healthcare Experiences and Needs of Consensually Non-Monogamous People: Results From a Focus Group Study



Michelle D. Vaughan, PhD,¹ Peyton Jones, BS,¹ B. Adam Taylor, BS,² and Jessica Roush, BS³

ABSTRACT

Background: Individuals engaged in consensual non-monogamy (CNM) face broad and potentially harmful experiences of sexual stigma in society, yet no published empirical literature has examined the experiences of this population within the healthcare system.

Aim: The present investigation sought to explore positive and negative experiences of CNM individuals within the healthcare system, as well as specific needs of these patients regarding inclusive healthcare practices.

Methods: 20 CNM-identified adults from a non-profit organization serving CNM individuals completed a brief survey and participated in 1 of 3 focus groups of 70 minutes duration centered on their healthcare needs and experiences.

Outcomes: CNM patients report challenges in addressing their healthcare needs related to lack of provider knowledge, inadequate preventative screenings, and stigmatizing behaviors that impact their health and trust in the healthcare system.

Clinical Implications: Healthcare providers must monitor and work to avoid assumptions and pathologization of individuals who engage in CNM, creating an open, accepting environment to work collaboratively with CNM individuals to meet their unique sexual health needs.

Strength & Limitations: Although the present sample is diverse with respect to sexual and gender identity and socioeconomic status, it may not represent the experiences of CNM individuals outside of the midwestern United States and those who do not identify as polyamorous.

Conclusion: CNM individuals frequently experience sexual stigma in interactions with the healthcare system that interferes with receipt of sensitive, medically accurate care relevant to their unique needs and experiences.

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Key Words: Social Stigma; Multiple Partners; Consensual Non-Monogamy; Qualitative Research; Culturally Competent Care

INTRODUCTION

Characterized by an agreement to romantic and/or sexual relationships based on explicit consent of all partners involved, studies conducted by U.S. researchers indicate that between 3.5% and 5.0% of individuals are currently engaged in

consensual non-monogamy (CNM) or identify as being engaged in CNM relationships,¹ with up to 20% of single individuals reporting experience with CNM.² Incorporating polyamory, swinging, open relationships, and relationship agreements,³ scientific literature on CNM has been expanding rapidly in the past decade.⁴

CNM individuals are broadly perceived as emotionally unhealthy, immoral, and engaged in unhealthy, sexually risky relationships^{1,5,6}; however, these assumptions have been widely refuted by empirical research. Across multiple studies, CNM and non-CNM individuals score similarly on measures of relationship quality and psychological well-being.⁷ Although CNM individuals are likely to have more lifetime sexual partners than their monogamous counterparts,⁸ there is no evidence that this

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population has higher rates of sexually transmitted infections (STIs).^{8,9} In fact, evidence indicates that CNM individuals more frequently engage in STI testing.⁸ They are also more likely to discuss STI testing and partner history with sexual partners,⁹ and they report more consistent and correct use of barriers compared with other sexually active adults.^{8–10}

Individuals who engage in relationships or sexual behaviors that defy social norms (eg, lesbian, gay, bisexual [LGB]) have long faced the experience of being stigmatized, devalued, stereotyped, and/or discriminated against for deviating from these norms.¹¹ Such experiences may be contextualized as forms of minority stress and may be a critical factor in health disparities in LGB populations.^{12,13} Evidence of sexual stigma via explicit and implicit biases by healthcare providers toward lesbian and gay individuals¹⁴ and those who engage in sexually “kinky” behavior¹⁵ has been established. Physicians have acknowledged a reluctance/hesitance to conduct a thorough sexual health history with patients who may have same-gender attractions.¹⁶ Such biases may have deleterious effects on judgments/decisions about patient care, lack of trust, and poor communication with providers, especially in the context of stigmatized or sensitive topics,¹⁷ including sexuality.

As part of their Clinical Prevention Guidance, the Centers for Disease Control and Prevention (CDC)¹⁸ has called for interviewers to demonstrate respect, compassion, and a non-judgmental attitude toward patients to obtain a complete and accurate sexual history. This history should include questions about the number and gender of the patient’s recent sexual partners (and any additional sexual partners that their partners may have), sexual behaviors, as well as STI/HIV and pregnancy prevention practices. They also explicitly recommend gathering data about the sexual behavior of the patient’s sexual partners and providing STI/HIV testing services for all patients with multiple current sexual partners.

Within the context of CNM, mononormativity is a unique subtype of sexual stigma that promotes monogamy as the expectation and the only healthy standard for romantic/sexual relationships.^{19,20} These internally held biases often are expressed toward CNM individuals, who report judgmental attitudes, verbal shaming about having multiple partners, and the assumption by others that they must have or be at elevated risk for STIs.²¹ However, exceptionally little is known within the scientific literature about the needs and experiences of this unique population.²² In an unpublished doctoral dissertation, Witherspoon,²³ in a sample of more than 1,220 adults currently engaged in consensual non-monogamy, found that 20.3% reported at least 1 experience of explicit discrimination from a medical doctor, 19% reported discrimination from a mental health provider, and 9% reported discrimination from other providers associated with their CNM status. Within the domain of mental health services, another study found that 38% of CNM individuals concealed their status from their provider owing to fear of being stigmatized, and 10% of those who had

disclosed their status reported a negative response from their provider.²⁴

In the sole (unpublished) study of CNM healthcare experiences, McCrosky et al²⁵ interviewed 9 polyamorous women on their experiences with providers, barriers to access, and adaptive strategies they used to meet their needs. The women expressed a strong desire for open, honest relationships with providers and a commitment to monitoring their sexual health through frequent, broad-based STI testing. They reported a lack of provider knowledge about CNM, and a lack of provider interest in/effort to assess risk-reduction practices (eg, condom use). Most reported experiences of judgment related to CNM, including unprofessional remarks about their sexual behavior, refusal to provide treatment, and a request to not return to the provider’s office. Fear and frustration led many participants to prescreen potential providers, carefully manage decisions about disclosure, seek services outside of their primary care provider, or delay/avoid necessary care.

Based on these studies, evidence exists that CNM individuals frequently experience sexual stigma in a variety of contexts that may have important implications for healthcare practice and sexual health outcomes. However, given the dearth of published literature on the sexual healthcare experiences of CNM individuals, little is known about the specific needs and experiences of this population with respect to accessing and receiving high-quality sexual health care.

The present investigation sought to address this gap in the literature through a qualitative/focus group study to provide initial data on the needs and experiences of CNM individuals within the context of health care. Given the lack of existing empirical research on CNM health care, the present study was exploratory in nature, seeking to compare trust in healthcare providers between our CNM patient sample and other (presumably monogamous) patient samples and to explore the nature of CNM individuals’ healthcare needs, relevant experiences within the healthcare system, and recommendations for healthcare provider training and practice.

METHODS

This study was approved by the Institutional Review Board at Wright State University. The research team included a female doctoral-level counseling psychologist and researcher, a male clinical psychologist-in-training with a bachelor’s degree and graduate training (both with graduate training in qualitative methods), and 2 registered nurses (1 male and 1 female) with bachelor’s degrees. The initial research question for this project was proposed to the first author by a leader of a regional polyamory-themed non-profit organization, and feedback from members of this community was solicited during the development and refinement of focus group questions.

After providing informed consent, participants completed a demographic survey that included several questions about their

CNM style, current relationships, and trust in and disclosure of CNM to healthcare providers. Each participant was asked to provide a pseudonym to allow their responses on the survey to be matched with their focus group data. No personally identifiable information was solicited or retained, and participants were free to not respond to any survey or focus group question or discontinue participation at any time. References to names of specific providers or names of partners were deidentified to protect participant confidentiality. All focus group sessions were audio-recorded. All data/devices were physically secured by the researchers during the recording/transcription process and stored in a locked cabinet. All electronic files were maintained in a secure (private) storage system that was not accessible to individuals outside of the research team.

Study participants were adults (age ≥ 18 years) who self-identified as CNM individuals or currently practiced any form of CNM (eg, polyamory, open relationship, swinging) and were fluent in English. Participants were recruited via convenience sampling from a midwestern polyamory-themed organization through in-person announcements regarding the study, its goals, and the background of the researchers at a monthly educational meeting of the group. 3 focus groups (each with 3–10 participants, for a total of 20 participants) were held between April and May 2017, were facilitated by either the first or second author (M.D.V. or P.J.) and were 40–70 minutes in length. 2 focus groups were held in private meeting rooms during a monthly meeting of the polyamory-themed non-profit organization. A third focus group was held in a private location at the request of several members of the organization who were unable to attend the original focus groups. No other individuals other than the participants and the interviewers were present during the focus groups.

The focus groups used a series of 4 semistructured questions centered on their experiences as a CNM individual relevant to (i) healthcare needs, (ii) how/where they attempt to get those needs met, (iii) experiences with healthcare providers, (iv) factors impacting disclosure of status, and (v) recommendations/needs from healthcare providers. References to names of specific providers or names of partners were anonymized to protect participant confidentiality. Audio recordings were transcribed verbatim by the second author (P.J.) and reviewed for accuracy by the first author (M.D.V.).

Outcome Measures

The Trust in Health Care Providers subscale of the Multi-dimensional Trust in Health Care Systems Scale²⁶ was used to assess participants' level of trust in their providers. The subscale consisted of 10 Likert-type items ranked on a 5-point scale, with total scores ranging from 10 to 50. The scale demonstrated high reliability ($\alpha = 0.89$) and evidence of convergent and divergent validity. A sample item from the subscale is "My health care provider is usually considerate of my needs and puts them first."

Table 1. Demographic characteristics of the study sample (N = 20)

Characteristic	n	Valid %
Age		
18–29 y	8	40
30–44 y	9	45
45–64 y	3	15
Gender identity*		
Cisgender man	8	40
Cisgender woman	9	45
Transgender woman	2	10
Genderqueer/gender non-conforming	1	5
Genderfluid	1	5
Sexual identity*		
Lesbian	2	10
Gay	1	5
Bisexual	5	25
Pansexual/omnisexual	5	25
Queer	2	10
Sexually fluid	1	5
Gray/asexual	2	10
Heterosexual/straight	6	30
Sexual orientation*		
Attracted to men	14	70
Attracted to women	15	75
Unsure of attraction	1	5
No attraction	1	5
Attracted to folks outside of binary	10	50
Race/ethnicity		
African American/black	1	5
Biracial/multiracial	1	5
Caucasian/white	17	85
Other	1	5
Type of CNM		
Polyamorous	17	85
Swinger	1	5
Relationship/sexual agreement	2	10
Socioeconomic status		
Poor	3	15.8
Working class	4	21.1
Middle class	8	42.1
Upper middle class	4	21.1
Marital status		
Single (never married)	7	35
Married	7	35
Divorced	5	25
Separated	1	5

CNM = consensual non-monogamy.

*Percentages may exceed 100% because participants could choose more than 1 option.

Data Analysis

Demographic data and analysis of the Trust in Health Care Providers scale was summarized and analyzed using SPSS version 23 (SPSS Corp, Armonk, NY, USA).²⁷ A 1-sample *t*-test

Table 2. Thematic analysis results: Healthcare needs/experiences

Theme	Subtheme
Ignorance of CNM	Pressure to educate providers Inadequate screening
Sexual stigma	Stigma reactions
Stigma-avoidance efforts/seeking CNM-inclusive providers	
Experiences of CNM-inclusive care	Open-mindedness and acceptance Meeting healthcare needs/requests

CNM = consensual non-monogamy.

(1-tailed) was used to examine whether trust in healthcare providers differed significantly from those of the standardization sample for the measure. Power analysis for a 1-sample *t*-test was conducted in G*POWER²⁸ to determine a sufficient sample size using an α value of 0.05 and a power of 0.80, assuming a large effect size ($d = 0.8$), and 1-tailed hypotheses. Based on the aforementioned assumptions, the desired sample size was 12.

The researchers used a thematic analysis approach of Braun and Clarke²⁹ for the analysis of the qualitative data from the focus group interviews. Open, inductive coding was conducted independently by the first 2 authors (M.D.V. and P.J.) in an iterative process to identify candidate themes and subthemes. Discrepancies/disagreements were resolved via discussion between the coders until consensus was reached over the course of 4 coding meetings until data saturation was obtained. Themes and subthemes were independently applied to participant responses and discussed in a final coding meeting until consensus was reached on codes for each individual response. Themes and subthemes were shared and discussed with 4 focus group members for additional validation. All provided confirmation of these themes as consistent with experiences they heard described in their respective focus groups.

RESULTS

We collected qualitative and demographic data from 20 participants (Table 1). No participants dropped out of the study. The participants ranged in age from 19 to 60 years (mean age 36.15 ± 10.68 years). Most were white (85%), cisgender (90%), and had at least some college education (85%). The majority of the sample identified as polyamorous (85%), with a sample average of 4.47 ± 3.08 sexual partners (range 1–12 partners) in the past 12 months.

90% of the sample reported currently having health insurance. 90% had disclosed their CNM status at least once to a healthcare

provider, with most reporting they had disclosed their CNM status once or twice ($n = 6$; 30%) or several times ($n = 9$; 45%). Participants reported an average level of trust in healthcare providers of 33.90 ± 6.10 . Compared with the standardization sample for this subscale, CNM participants had significantly lower trust in healthcare providers [$t(17) = -4.645$; standard error of the mean 1.405; $P < .0001$, 1-tailed; 95% CI, -9.493 to -3.563 ; Cohen’s $d = -1.09$].

Analysis of the qualitative data yielded 4 major themes and 5 subthemes (Table 2).

Theme 1: Ignorance of CNM

A common negative experience among individuals in the sample centered on healthcare providers demonstrating a lack of awareness regarding the existence of non-monogamous relationships and explicit assumptions that the participants were monogamous. These participants reported never being asked about their relationship style or number of partners. This was reported primarily by cisgender men and women who were legally married to a partner of a different gender:

Mara (married, white, cisgender, bisexual polyamorous woman): My gynecologist and, you know, she offered up all the type of tests for everything and then one year—and I wasn’t out to her that I was poly—and then one year she was like, “Oh you’re in a monogamous relationship with your husband, you know, we don’t really need to give you this, this, and this.” And I was like, “Oh, you just assumed that.”

Lack of awareness or knowledge of relevant medical standards and insurance coverage for preventative care related to the sexual health of individuals with more than 1 recent sexual partner was also noted:

Jo (married, white, cisgender, bisexual polyamorous woman): And I think that’s a whole other job. That’s a whole other ball of wax. What’s covered? What isn’t covered? They don’t always know. Then you’re asking and they’re like, “Well if you’re monogamous, and that’s not going to be covered.” “But I’m not [monogamous].” “Well, I don’t know.”

Subtheme: Pressure to Educate Providers

Another experience inherently linked to the ignorance of providers regarding types of non-monogamy was the broad perception that providers appeared to lack formal education regarding diverse relationship structures and concepts/terms/experiences related to CNM. This lack of accurate knowledge often led these patients to feel pressured to/need to take on the role of educator with their provider:

Tess (married, white, pansexual, genderfluid, polyamorous person): I have pretty much the same thing as Jo said. Um,

just asking for HIV/STD testing it's like, "Well, you had one last year, why do you need one now?" "Well, because there's a possibility there could be other people involved." "Oh, if he tested negative 6 months ago, you're fine." "Uh, nooooo. Even if he tested negative, no."

Ann (single, white, transgender, lesbian/queer polyamorous woman): When we do find someone at that level, we have to educate them (nods in agreement from other participants). "So well, what's that mean?" or "Are you active with everyone? At the same time or different times?" A lot of times when I disclose that to medical professionals and others, I end up being an educator.

Subtheme: Inadequate Screening

This lack of knowledge about the existence of multiple sexual relationships, and CNM relationships in particular, often led to experiences with providers making inaccurate assumptions regarding health risks that directly impacted the screening process. These included the assumptions that all CNM individuals always have multiple sexual partners, engage in high-risk sexual behaviors, and will invariably contract STIs and have other sexual health problems. These assumptions all directly impacted the ability to receive a thorough, accurate preventative health screening, with participants repeatedly noting that their providers failed to ask them about their safer sex practices (eg, use of barriers, testing schedule) or the practices of their sexual partners, even when they disclosed their CNM status:

Luna (single, African American/black, cisgender, heterosexual polyamorous woman): One of my partners, she kept on having medical issues. None of the doctors could figure out what it was. So the doctor... assumed it was an STI. We all got tested. We all came out clean. They were so focused on saying that it's some type of STI than trying to figure out what the actual reason was. It seemed like they were focused on that because she told them she was in a poly relationship. It's kind of like they hear "risk factor" and all medical knowledge stops until they're able to factor out the "obvious" STI that actually never existed...they focused so much energy on proving that it was an STI.

Participants also experienced a lack of provider interest in gathering relevant sexual health information critical to making an accurate, informed assessment of their sexual health risks and related healthcare needs. Several participants noted that they appeared to have greater knowledge of effective risk reduction practices regarding STIs than their healthcare providers (eg, testing, barrier use/agreements, human papillomavirus [HPV] vaccines, communication about safer sex practices among partners and their partners). They were frequently disappointed that providers failed to ask about or acknowledge their efforts to maximize their own health and safety and that of their partners:

Tina (single, white, cisgender, pansexual polyamorous man): My experience in general is to say, "I've done this, and I've had these experiences," and you just get judged for it or at least go into this talk about "Let's talk about the dangers of STIs" or stuff like that, having full knowledge of the dangers of STIs, and having long conversations with partners before I do anything with them. So at a certain point, it would be nice if I could just get tested and not have to go through these conversations. I feel like I should go to the doctor and not have to feel like I have to defend my lifestyle. But oh well.

Kinsey (single, white, cisgender, heterosexual polyamorous man): They're saying like, "Well that's risky, and you shouldn't behave in that manner." And so just being like, "Well this is my thing, and here's the things I do to minimize it," they don't care that I was using protection or any of the other kind of stuff.

Theme 2: Sexual Stigma

Explicit and implicit experiences of judgment and shock from healthcare staff were widely reported by participants and characterized as highly stressful. Several participants described "raised eyebrows" and "dirty looks" directed at them and their partners, avoidance of eye contact, and a condescending tone after the provider/staff became aware of their CNM status:

Kinsey (single, white, cisgender, heterosexual polyamorous man): I walked out of that room feeling horribly embarrassed, very shamed, very judged, and to be frank, I felt dirty from it [the visit].

Providers' inaccurate assumptions about CNM individuals and their relationships were also commonly reported, as was judgmental language. Unsolicited, unwanted advice regarding participants' relationship choices and partners were also repeatedly discussed:

Gree (single, white, cisgender, heterosexual, grey/asexual polyamorous man): I go to see my regular doctor, and they're like, "Well maybe if you came up with a more 'stable' environment, maybe these other symptoms [depression] can go away." And I was like, "No, these don't work like that... thank you for your judgment. Let's move on."

Luna (single, African American/black, cisgender, heterosexual polyamorous woman): They [my providers] told me that if I wasn't so sexually promiscuous, I wouldn't have to spend so much money to get tested and that maybe I should just find a man (laughs), and stop "sleeping around."

Subtheme: Stigma Reactions

In the context of these experiences of judgment, immediate reactions of anger/frustration toward providers and fear about the

quality and/or confidentiality of their healthcare experiences were reported:

Mischa (married, white, cisgender, pan/omnisexual polyamorous woman): I think it's especially frustrating when you come in for your STI test that is part of your safer sex practice, and you get treated like you've never heard of such a thing as an STI, or that you don't know that there are risks to having sex with multiple partners. Of course I know that, like, we talk about that all the fucking time.

Duchess (married, white, cisgender, heterosexual polyamorous man): One of my partners who was taking care of a patient, she's a healthcare provider. The cardiothoracic surgeon, the guy that operates on your heart, walked out of the room and said "What a hoe." (Gasps from other participants). Because the patient was in there with her husband and her boyfriend.

Such experiences of judgment were frequently followed by decisions to withhold sexual health information (eg, number of current partners, status as a CNM individual) from staff in future visits or reluctance to return to a particular provider/office:

Luna (single, African American/black, cisgender, heterosexual polyamorous woman): He [my provider] thought he was doing me a favor [by telling me to become monogamous]. I guess he thought he was "dadding" me, but after that I stopped telling my healthcare providers about my sexual habits.

Many sought supplementary testing services at community STI/sexual health clinics after a negative experience with another provider. Others discussed how they created emotional distance between themselves and providers after experiencing a stigmatizing interaction and chose to stay with that provider for other reasons:

Jo (married, white, cisgender, bisexual polyamorous woman): Can I kind of look at you as a medical ATM? I'll come to you when I need a specific service, and you'll spit that out for me, and it will really be a consumable transaction.

Theme 3: Stigma-Avoidance Efforts/Seeking CNM-Inclusive Providers

Participants discussed a variety of strategies to identify providers that might accept their CNM status and relationships, including asking other CNM individuals for recommendations. Others sought out public health clinics or local Planned Parenthood offices to satisfy their agreements within their sexual network for frequent, broad-based testing. Prescreening of providers was also a common strategy, including searching provider/practice websites for information that indicated open-mindedness/comfort with sexuality, LGBTQ+ people, same-gender relationships, and/or lack of explicitly religious

language. Others conducted prescreenings to evaluate whether a provider and their staff was worth the risk:

Darla (single, white, cisgender, grey/asexual polyamorous woman): I've been calling around asking people, "Well is this doctor someone that's cool with someone that's polyamorous?" "Well what does that mean?" "Well ask the doctor and find out, and call me back before I schedule this appointment." And they're like, "The doctor's not comfortable with seeing you as a patient." "Okay, thanks," and then I move on.

Theme 4: CNM-Inclusive Care

Specific wants and needs from healthcare providers and staff were highly consistent across participants in all groups, centering on the overall interpersonal approach to working with members of the sexual minority group and the specific services/practical needs that would allow them to effectively monitor and optimize their own sexual health as well as the health of members of their sexual network.

Subtheme: Open-Mindedness and Acceptance

As an overarching theme across nearly all CNM participants in the sample was a strong desire for accepting, non-judgmental interactions from healthcare providers and staff to establish a trusting, collaborative relationship with their providers:

Jo (married, white, cisgender, bisexual polyamorous woman): [If you are] asking me an open-ended question, then I don't feel like you're prejudging already...you're letting me tell you about my life. I think that's really helpful. That made me feel like, "Oh, he's really interested in me. He'll listen. He won't judge."

How staff reacted to disclosures of CNM was also seen as an indicator of open-mindedness and respect, incorporating tone and non-verbal cues around discussion of partners/relationship status, sexual behaviors, and related healthcare needs as well as thoughtful choice of language:

Abigail (divorced, white, cisgender, heterosexual polyamorous woman): I think just an open mind [is critical]. And even if you have judgment, you have those thoughts of, like, "I could never do that," or "That isn't right," or "I really don't agree with this," not letting that come out in your actions, not letting that come out in your tone of voice, or even the look that you give, because people pick up on things like that. You can really shut a conversation down, like a conversation that needs to happen.

When these needs were met, participants described experiences of genuine interest, curiosity, and commitment to expanding their own knowledge/skills about CNM relationships from providers, even when the terms and concepts were unfamiliar to them:

Ann (single, white, lesbian/queer transgender polyamorous woman): I disclosed that I'm poly, and she just stopped and she was like, "Okay, I'm not quite sure what that means. Can you explain it to me?" And I discussed on how it went, and she was like, "Okay, alright, so I'll want to do this." It's the fact that she paused and asked.

Darla (single, white, cisgender, asexual polyamorous woman): The old OBGYN that I used to see, she stopped seeing patients and started doing premi [premium] health-care, which is great for her and her practice. She was like, "I don't really care what y'all do as long as you're honest with me about doing it, because I don't want to treat you for something and then find out you have something else." Because that would totally suck.

Subtheme 5: Meeting Healthcare Needs/Requests

Participants repeatedly voiced the specific need for providers to work with them to provide frequent, customized STI testing to fulfill agreements made within their sexual networks. Protection of confidentiality as well as easy access to sharing official copies of testing results for members of participants' sexual networks was also repeatedly mentioned as part of this inclusive approach to care:

Red (single, white, transgender pansexual woman): Actually, I think I have a little bit different side of that. So every 6 months, I get bloodwork for other issues, but the nice part about it is...[that] when my doctor sends my bloodwork, I'm like, "Okay, I need all of this [STI tests] extra." They're aware of my relationship status, and they're like, "Okay! Whatever."

Kinsey (single, white, cisgender, heterosexual polyamorous man): Sexual health tends to be of a premium concern of making sure, not just for myself, but for all of my partners, not just that I am...but being able to verify and provide that type of information and security that everything is good with my sexual health.

Incorporating a strong desire for an open and collaborative relationship with providers about their sexual health, participants repeatedly requested that providers conduct a comprehensive assessment of their actual STI risk (eg, type/frequency of sexual behaviors, barrier use, STI status of partners) and work with them to access affordable coverage of frequent testing and/or relevant vaccines (eg, HPV):

Kinsey (single, white, cisgender, heterosexual polyamorous man): Become a better advocate for me, to help assist me in terms of I'm gonna make my life choices, help me make my health choices. So instead of saying, "Well, don't be involved with a particular behavior," say "How can we make healthier choices within those behaviors?" Since this is going to be my lifestyle, how can we do that [prevent transmission of infections]?

DISCUSSION

The present empirical study provides critical insight into the impact of mononormativity and sexual stigma on the healthcare experiences of CNM patients. Consistent with findings from other sexually stigmatized populations,¹⁵ our CNM participants were committed to promoting the health of their sexual health network through a collaborative relationship with providers who demonstrated respect and open-mindedness for their relationships and sexual choices. Experiences of mononormativity and sexual stigma from providers and staff served as major obstacles to these goals. These experiences of minority stress produced negative emotional and behavioral reactions in the CNM participants that compromised their relationships with providers and their access to sexual health services. These instances of anticipated and experienced stigma have been identified as predictors of negative health outcomes in individuals with other concealable stigmatized identities,³⁰ including LGBT-identified³¹ and kink-oriented patients.¹⁵

These results demonstrate a critical need for training and recommendations about CNM-inclusive practices/skills for healthcare providers and staff. Foundational training on human sexuality/relationships within healthcare curricula must include CNM and relevant subgroups (eg, polyamory, open relationships, swingers, relationship agreements, relationship anarchy) and explicitly address CNM myths and other mononormative assumptions regarding STIs, sexual behavior, safer sex practices, and relationship dynamics. Incorporation of scientific research refuting these myths and addressing widespread implicit bias against CNM people/relationships is critical,^{10,32-34} as is work that highlights the potential strengths and benefits of CNM relevant to health and well-being.⁶

Given that higher levels of provider knowledge and more positive attitudes toward sexual minorities predict the likelihood of conducting comprehensive sexual health histories in LGBT patients,³⁵ CNM-specific education in these domains is warranted. Exposure to CNM individuals during professional training may also be highly beneficial to develop a base of scientifically accurate knowledge and reduce implicit bias and stigmatizing reactions,¹⁷ while maintaining the responsibility on providers and their supervisors (as opposed to patients) for enhancing their education.

Promoting sexual health is a shared responsibility between providers and patients. According to Kitts,¹⁶ physicians should routinely obtain a comprehensive sexual history from patients to help those who identify as a sexual minority feel more comfortable disclosing certain identities and behaviors. Recommendations from both Sabin et al¹⁵ and Zestcott et al¹⁸ include more education on sexual minorities and their specific health concerns in clinical training programs to reduce the likelihood of implicit biases. Physicians also should gain greater familiarity with members of marginalized groups through community outreach (eg, local CNM organizations, speaker's panels),

because personal contact has been found to foster accepting attitudes and diminish prejudice.¹⁷

Consistent with the descriptions of inclusive and affirming provider behaviors among those with little CNM training or experiences, training rooted in development of cultural humility may be particularly valuable for healthcare providers serving this population.³⁶ Built on mutual respect and collaboration, this framework focuses explicitly on valuing the patients' expertise, acknowledging the power imbalance between provider and patient, and cultivating a commitment to lifelong self-reflection and self-critique on behalf of the provider.³⁶ Cultural humility training has been successfully incorporated into training for medical residents, with evidence of increased provider attentiveness to patient experience and patient involvement in care.³⁷ Given that numerous studies have found a positive relationship between collaborative, patient-centered communication (eg, empathic physician responses, provider–patient agreement, shared decision making), patient satisfaction with care,³⁸ and health outcomes (eg, symptoms, functioning, physiological measures),³⁹ approaches centered in cultural humility may be particularly useful in building trust between CNM patients and their providers and promoting relevant health outcomes.

Provider and staff commitment to inclusive language and respect for diverse relationship structures is also essential, as is sexual history-taking practices that promote open, honest communication.⁹ Consistent with the aforementioned published recommendations from the CDC,^{18,40} the National Coalition for Sexual Health,⁴¹ and others,⁴² explicit, open-ended questions regarding sexual behaviors, number and gender(s) of sexual partners, and the use of risk-reduction/safer sex strategies should be included. Because having multiple sex partners or having a partner with multiple other partners is considered a *de facto* risk factor for STIs by the CDC,⁴⁰ providers should work with CNM individuals to support their commitment to frequent, broad-based STI testing to maximize sexual health. Explicit, non-judgmental questions regarding the sexual behaviors, safer sex practices, and testing practices of other members of the sexual health network may also be beneficial to ensure more accurate risk assessment.³² Other CNM-inclusive healthcare practices may include secure sharing of test results with members of the patient's sexual health network, identifying multiple emergency contacts, and exploring needs for long-term highly effective birth control, preexposure prophylaxis, and/or HPV vaccines depending on the gender of their partners and specific risk factors and needs.

Limitations

This largely qualitative investigation relied on a small sample from a single geographic area, with predominantly white, polyamorous-identified participants. Moreover, because the sample was drawn from a polyamory-themed social/educational non-profit in a larger Midwestern city, these participants'

experiences might not be representative of individuals practicing types of all types of CNM (eg, swingers, those in open relationships), those who are less “out” about their CNM status, those in rural settings, or those in other areas of the United States. Significant caution should be exercised in any attempts to generalize these results to all CNM individuals.

Future Research

Research on providers' attitudes, knowledge, training, and experience with CNM patients and their behaviors will be essential for documenting their ability to provide inclusive/competent care. Foundational literature identifying possible health disparities that may exist in CNM individuals is needed to provide a wider context to the healthcare needs of this population. Quasi-experimental work may be particularly useful in investigating the degree to which providers can accurately perceive/assess the sexual health risks of mock CNM patients³¹ and identify predictors of CNM-inclusive providers/behaviors.

Work in this area should seek to explore healthcare experiences engaged in other geographic areas, those practicing other forms of CNM (eg, open relationships, swinging), and CNM individuals who are members of other stigmatized groups. In particular, it may be highly valuable to conduct qualitative investigations of the needs/experiences of CNM individuals who are people of color, transgender, and/or of lower socioeconomic status to understand how intersecting factors impact their healthcare needs and experiences. Explicit use of the minority stress model^{12,13} and literature on sexual stigma and mononormativity may be particularly useful in this context.

CONCLUSION

CNM patients have unique healthcare needs that can be addressed through a commitment to an open, collaborative relationship rooted in a foundational understanding of CNM individuals and relationships while incorporating existing evidence-based recommendations for inclusive sexual health assessments and services. Healthcare offices will enhance the education of their providers and staff by providing training that includes information about CNM and exposure to CNM individuals. Healthcare providers and staff should commit to using respectful, non-judgmental language while discussing sexual behaviors, number and gender of sexual partners, and safer sex strategies with patients. Additionally, asking open-ended questions provides patients with opportunities to advocate for themselves and fosters a collaborative, open provider–patient relationship. As scientific research on CNM continues to rapidly expand, more patients may disclose CNM relationships or behaviors to their healthcare providers. Providers have a duty to educate themselves on this population and implement evidence-based practices to better serve CNM individuals.

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