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“Oh! How Modern! And... Are You Ok with That?": Consensually Non-Monogamous People's Experiences When Accessing Sexual Health Care

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ABSTRACT

The current research explored consensually non-monogamous peoples' experiences accessing sexual healthcare. Using a mixed method approach, a sample of 67 consensually non-monogamous individuals (48% Polyamorous; 42% Relationship Anarchy/Solo polyamory; 6% Swingers; 4% Uncategorized) reported having significantly lower rates of trust in healthcare professionals compared to standardized scores. Sixty-three percent of participants reported disclosing their relationship status to a clinician when accessing sexual health services, whereas 37% sometimes or never disclosed. Qualitative responses identified that some participants reported a willingness to be open about their relationships, but many chose to “pass” as monogamous to both simplify and streamline their interactions as well as to avoid potential stigma. Participants reported a wide range of experiences with clinicians from those who were accepting and professional, to some who displayed prejudice and withheld treatment. This research outlines some of the experiences and challenges presented to consensual non-monogamists when accessing sexual healthcare as well as providing suggestions for clinicians to help remove some of the barriers to appropriate patient care.

Consensual non-monogamy (CNM) is the umbrella term used to describe romantic and/or sexual relationships in which people have more than one partner, with the informed consent of everyone involved (Scoats & Campbell, 2022). Interest and engagement in CNM within Western society is substantial (Barker & Langdrige, 2010; Moors, 2017), with research estimating that of those currently in a relationship, CNM relationships (including polyamory, open relationships and swinging) account for approximately 5% of U.S. (Rubin et al., 2014) and 4% of Canadian (Fairbrother et al., 2019) relationships. Looking at lifetime engagement, Hauptert et al.'s (2017) nationally representative sample in the US found that approximately 20% of participants had at some point engaged in CNM. Another nationally representative Canadian sample also found 20% of participants had at some point engaged in an open relationship (Fairbrother et al., 2019). Engagement, public interest, and research in CNM forms of sex, such as threesomes, also appears considerable (see Herbenick et al., 2017; Scoats, 2020)

Despite considerable interest and engagement in CNM, those who participate in it are still subject to stigma (Conley et al., 2013; Grunt-Mejer & Campbell, 2016; Sheff, 2013; Stults et al., 2022). People who engage in CNM have been labeled as broken, deficient, and morally inferior to those who practice monogamy (Grunt-Mejer & Chańska, 2020; Robinson, 1997; Scoats, 2020). Such stigma is likely to have undesirable consequences, including losing one's job or even one's children (Klesse, 2019; Klesse et al., 2022; Pallotta-Chiarolli, 2010; Scoats, 2020; Sheff, 2005, 2013). Cox et al. (2013) found that over a course of ten years more than a quarter of those in polyamorous relationships had

experienced discrimination based on their relationship status. Given that there is little to no legal protection from discrimination for CNM people (Conley et al., 2013; Klesse et al., 2022; Mint, 2004; Sheff, 2016), for many staying in the closet may be seen as the safest option.

In terms of healthcare, CNM has generally been viewed as pathological by mental health and psychological wellbeing practitioners (Shernoff, 2006; Weitzman, 2006; Zimmerman, 2012). CNM has been framed as a problem needing a remedy, a phase which will pass, or the symptom of other problems (Grunt-Mejer & Chańska, 2020; Kolmes & Witherspoon, 2017; Schechinger et al., 2018; Table et al., 2017). “Expert discourses” utilizing a “veil of scientific objectivity” may further legitimize these stigmatizing claims (Grunt-Mejer & Chańska, 2020, p. 2829). Consequently, mental health providers holding prejudicial views toward those who practice CNM may feel justified in implementing health interventions grounded in assumptions of monogamy, or that are designed to promote monogamy as an ideal. These interventions based on stigmatizing assumptions are potentially harmful and may encourage individuals to be closeted in their CNM behaviors and/or identity (Levine et al., 2018).

Similarly, experiences or anticipation of stigma impacts how CNM people engage with healthcare providers in relation to their physical health (Willis, 2019). As demonstrated across various theories of health behavior, including the Social Ecological Model (Hughto et al., 2015; Ma et al., 2017) and the Capability, Opportunity, and Motivation Model of Behavior (McDonagh et al., 2018, 2020), stigma can be

a significant barrier to healthcare. Although there is less research on CNM people's experiences accessing physical healthcare than there is on mental healthcare, research suggests that similar barriers exist. For example, Vaughan et al.'s (2019) focus-group study of 20 polyamorous people reported that they were often misunderstood and pathologized by medical practitioners, and that this interfered with their receipt of "medically accurate care relevant to their unique needs and experiences" (p. 42). Vaughan et al. did, however, highlight that when medical practitioners were non-judgmental of participants' polyamory, this made it easier for patients to have specific healthcare requests met.

In the Polyamorous Childbearing and Birth Experiences Study (POLYBABES), Arseneau et al. (2019) reported that polyamorous families experienced a presumption of monogamy and subsequent discrimination when accessing pregnancy care in the U.S. For example, in healthcare settings, admission forms only provided the option to identify one partner. Participants also engaged in a cost/benefit analysis in terms of coming out to their health care providers, deciding whether it was medically relevant to do so (Landry et al., 2021). Similarly, Spauwen et al.'s (2018) study on CNM people's accessing of sexual healthcare found half of their sample of swingers did not disclose their swinging status when visiting sexual health clinics. Thus, participants appeared likely to withhold information from medical professionals to avoid stigma.

CNM status is particularly pertinent when accessing sexual health care, as a lack of knowledge around CNM from healthcare providers could mean that participants are subject to stigma and assumptions about their sexual risk profile (Frank, 2019). Flicker (2019) highlighted that a lack of knowledge, or outright negative bias, affected decisions made by health care professionals, impaired doctor-patient interactions, and undermined patient trust. Situations where people have multiple sexual partners certainly have the *potential* for increased frequencies of sexually transmitted infection (STI) transmission (Rich et al., 2016); thus, clinicians may make treatment decisions based on that. In fact, in contrast to the assumption of promiscuity and elevated STI risk around CNM (Moors & Ramos, 2022; Scoats, 2020), CNM practitioners' elevated awareness of harm reduction, STIs, and safer sex practices mean that they practice safer sex more effectively than ostensibly monogamous people (see Conley et al., 2015). Thus, they have comparable rates of STI infections and are in fact more likely to get tested regularly (Lehmiller, 2015).

Problematically, a fear of stigma may mean that some avoid seeking help from medical professionals or do not receive appropriate care (Dunkley & Brotto, 2018; Waldura et al., 2016). McDowell et al. (2020) noted that clinicians' implicit biases about gender and sexual minorities, derived from unconscious cultural stereotypes, may result in poor health care outcomes for those patients. Health care outcome disparities between the general population and minorities of all types have been extensively documented (e.g., Egede, 2006; Elliott et al., 2015; Mayer et al., 2008) and research on marginalized populations demonstrate that stigma, stigmatizing assumptions, and fear of prejudice all impact their engagement with healthcare (Logie et al., 2019). Anticipation and

experience of stigma as well as desire to hide one's sexual identity and/or behaviors have been documented in the kink/BDSM community (Dunkley & Brotto, 2018; Sprott & Randall, 2017; Wignall, 2022) as well as amongst other gender, sexuality and relationship minorities – such as gay, non-binary, and HIV positive patients (e.g., Brotman et al., 2002; Lee & Kanji, 2017; Mak et al., 2015).

Given the emerging research and discussion around the topic of CNM healthcare (see Vaughan & Burnes, 2022), and comparisons with other sexual minorities, it is reasonable to hypothesize that CNM people, as a relationship minority, experience similar problems to other marginalized groups in accessing care. At the same time, however, CNM people's healthcare needs and experiences should not be subsumed into and be presumed to be the same as sex and gender minorities' (SGMs). Indeed, Pallotta-Chiarolli (2020, p. 371) argued that "the experiences of poly/CNM and SGMs are often distinct and multiple, with even more heightened levels of invisibility and stigmatization compared to monogamous SGMs."

In relation to wider understandings of CNM, Levine et al. (2018) noted that "studies of identity categories and social perceptions vastly outnumber studies concerning health practices and outcomes [of consensually non-monogamous people]" (p. 1442). Thus, given the limited range of studies which have explored CNM and health, and the specific healthcare needs of this group, the current research builds on the work of Vaughan et al. (2019) and others (e.g., Arseneau et al., 2019; Flicker, 2019; Vaughan & Burkes, 2022) to further understanding of CNM people specifically in relation to accessing sexual health care.

Method

Participants

Participants were recruited using snowball sampling via the researchers' personal networks, connections, and posting invitations to participate on the researchers' Twitter and Instagram accounts using relevant hashtags, as well as posting links on relevant Facebook groups. Participation was not restricted to people who were currently in a CNM relationship. Potential participants were told: "There are no restrictions on the type of consensual non-monogamy that we're expecting: swinging, polyamory, relationship anarchy, for example, are all interesting to us. You also don't have to currently be in a relationship. If you consider yourself to have had, or to currently be in a consensually non-monogamous relationship, we're interested in hearing about your experiences."

Data were collected from 67 participants; Table 1 provides participants' demographic information.

The sample were mostly White, middle class, well-educated people from Britain (the location of the researchers) or other western countries in Europe and North America; most identified as cisgender and bi or pan sexual. This demographic profile is typical of published research on CNM (Scoats & Campbell, 2022). The distribution of types of CNM was: 48% Polyamorous; 42% Relationship Anarchy/Solo polyamory; 6% Swingers; 4% Uncategorized.

Table 1. Participant demographic data.

| Characteristic | n | Valid % |
|---|----|---------|
| Age | | |
| 18 to 29 | 12 | 18 |
| 30 to 44 | 38 | 57 |
| 45 to 64 | 17 | 25 |
| Gender identity | | |
| Cisgender woman | 36 | 54 |
| Cisgender man | 18 | 27 |
| Non-binary/gender fluid | 12 | 18 |
| Transman | 1 | 1.5 |
| Sexual identity | | |
| Bi/Pansexual | 45 | 67 |
| Heterosexual | 12 | 18 |
| Gay male | 7 | 10 |
| Lesbian | 2 | 3 |
| Androcentric | 1 | 1.5 |
| Race | | |
| White | 60 | 90 |
| Black/Mixed/Asian | 7 | 10 |
| Nationality | | |
| British | 38 | 57 |
| European | 11 | 16 |
| Other | 18 | 27 |
| Place of residence | | |
| UK | 51 | 76 |
| USA/Canada | 10 | 15 |
| Europe | 5 | 7.5 |
| Australia | 1 | 1.5 |
| Social class | | |
| Middle class | 45 | 67 |
| Working class | 14 | 21 |
| No response | 8 | 12 |
| Level of education | | |
| Postgraduate | 31 | 46 |
| Undergraduate | 28 | 42 |
| School | 8 | 12 |
| Type of consensual non-monogamy | | |
| Polyamory | 32 | 48 |
| Relationship anarchy/solo poly | 28 | 42 |
| Swinger | 4 | 6 |
| Uncategorized | 3 | 4 |
| Out or not | | |
| Yes | 22 | 33 |
| Yes to friends and family but not at work | 16 | 24 |
| Mixed/ partially | 25 | 37 |
| No | 4 | 6 |

Measures

People who identified as consensually non-monogamous were invited to complete an online survey which asked demographic, quantitative and qualitative questions. Participants were asked to give the following demographic information: age, gender, sexual identity, race or ethnicity, the country in which they accessed health care, their socioeconomic status/class and their highest level of education. They were also asked to describe what type of consensual non-monogamy or relationship structures they practiced and were asked if they were “out” about their consensual non-monogamy. These demographic questions were introduced with the following wording, “This first section of the survey asks you to give some demographic information. We’ve deliberately left these questions as free response items because tick boxes tend not to work well for consensually non-monogamous people. There is no right or wrong way to answer these questions. Please give as much information as you think is relevant, but bear in mind that the focus of the survey is your experiences with sexual health providers

rather than, for example, the exact nature of your relationship structures.”

The “Trust in Health Care Providers” subscale of the “Multi-dimensional Trust in Health Care Systems Scale” was used to assess participants’ level of trust in their providers. This subscale was adapted from a validated instrument published by Egede and Ellis (2008) to ask participants specifically about their sexual healthcare providers. A sample item from the subscale is “My sexual healthcare provider is usually considerate of my needs and puts them first.” The subscale consisted of 10 Likert-type items ranked on a 5-point scale, with total scores ranging from 10 to 50, with higher scores indicating greater trust in healthcare providers. The full questionnaire is reproduced in [Appendix A](#). The scale had a high level of internal consistency, as determined by a Cronbach’s alpha of 0.938 for this sample.

The qualitative survey questions were produced after reviewing similar literature and a series of four pilot interviews with members of the target population. These questions asked participants to discuss their positive or negative healthcare encounters, including when and where they took place, for example, “If you have told a health care professional that you are consensually non-monogamous how did they react and how did it make you feel?” The full list of questions, along with the introductory wording is reproduced in [Appendix B](#).

Procedure

Ethical approval for this study was attained through St Mary’s University, Twickenham’s ethics review board. Informed consent was obtained from all participants. Participants accessed the survey via onlinesurveys.ac.uk between the 25th of February 2020 and the 31st of December 2020. The survey took approximately 20 minutes to complete. They were not rewarded for completion. Participants were asked to, “Answer this online survey about [your] experiences talking to [your] personal doctors, to staff in hospitals and in sexual health clinics . . . The focus of the study is on consensual non-monogamy and sexual health services but feel free to tell us about related things, e.g., fertility services or general medical appointments, if you think it might be relevant.” Participants’ names and any identifying information have been removed.

Data Analysis

Reflexive thematic analysis was chosen to analyze the qualitative data (Braun & Clarke, 2021). Thematic analysis is a flexible method which is suited to exploring how participants experience and make sense of their lives and was therefore chosen to enable the identification of patterns and themes across the data (Braun & Clarke, 2006). We implemented an inductive approach (Nowell et al., 2017), where the identified themes were based in the data collected rather than attempting to fit into a preexisting framework. The authors familiarized themselves with the data and independently generated semantic codes. This initial surface analysis was then discussed and collaboratively amended to develop latent codes at a deeper level. We coded systematically, ensuring that all the data were given equal attention. We then reviewed our codes and

interpreted how they could be developed into a set of representative and meaningful themes which the authors agreed captured the “patterns of shared meaning” within the data (Braun & Clarke, 2019, p. 592). Any disagreements were resolved through revisiting the data and discussing which aspects of our coding were supported by the data. Finally, we collaboratively worked on writing the analysis section to ensure the presentation of the themes and the data extracts used to illustrate them told the story of our data in the most appropriate way (Terry et al., 2017).

Results

Quantitative Data

The Trust in Healthcare Providers subscale indicated that participants reported a mean level of trust in sexual healthcare providers of 25.32 (SD = 8.36). This was significantly lower than the score reported by Vaughan et al. (2019) of 33.90 (SD = 6.10) for CNM participants reporting trust in healthcare practitioners in general ($t = 8.463, p = .001$; 95% CI, -10.599 to -6.5537 ; Cohen's $d = -1.03$) and significantly lower than the standardized score reported by Egede and Ellis (2008) of 40.0 (SD = 6.2) ($t = 14.482, p = .001$; 95% CI, -16.699 to -12.653 ; Cohen's $d = -1.76$) for the general population. Despite this significantly lower overall trust, 63% of participants said they still disclosed their CNM status when accessing sexual health services; 24% sometimes did and 13% did not.

Qualitative Data

We have organized participants' responses into two themes: consensual non-monogamists' approaches and clinicians' responses (see Table 2). Under the former there are two sub-themes which capture the alternate ways in which CNM participants managed their interactions with healthcare providers; these ranged from concealing their CNM status to being proudly out. We then turn to examine how they were received by clinicians, identifying three types of reactions, from ignorance to actively stigmatizing. Many of the themes highlighted in the clinicians' responses replicate the findings of Vaughan et al. (2019). The theme of consensual non-monogamists' approaches, however, extends knowledge of this area, specifically bringing attention to how and why identity is revealed or concealed by participants and the rationale behind (non)

disclosure. The information included after participant quotes includes their age and self-described sexual identity, gender identity, and relationship structure/set-up.

Consensual Non-Monogamists' Approaches

Capturing a broad spectrum of modes and motivations, under the theme of “Consensual non-monogamists' approaches” we have identified two approaches our participants used when interacting with clinicians: “Passing” and being “Proudly out.”

Passing. We enquired whether participants revealed their CNM or not, and their rationales for non/disclosure. Some participants actively avoided disclosing their CNM status because of fear of stigmatization: explicitly lying or framing their non-monogamy as infidelity to avoid stigma. One participant said, “I always say ‘my partner is an asshole and cheats on me’ then I get tested without an issue (maybe sympathy) rather than judgment of being poly” (22, bisexual, female, triad). Participants may not have previously experienced stigma from clinicians, but they anticipated that type of response: “I haven't [disclosed] on many occasions as I felt that I would be judged negatively and treated according to ‘societal standards’” (45, bisexual, female, circle of partners and friends with benefits). Many participants reported that they had revealed this information in a past interaction and had been met with such inappropriate reactions that they had determined never to reveal their status again: “In an appointment with [my] GP when I had to discuss bleeding after sex, I disclosed the fact that I had two sexual partners, the GP was judgemental about my practices, so now I avoid disclosing it if possible” (45, heterosexual, female, nesting partner and a primary partner).

In addition to the fear of potential stigma, participants also said that they avoided telling their clinicians about their CNM lifestyle because they wanted to streamline their healthcare experience and avoid discussions they anticipated would involve additional, unnecessary effort. For example, one participant said, “When getting hormonal [birth control], I didn't mention [CNM] because I understood the risks and didn't want to waste time discussing it” (27, bisexual, woman/gray gender, polyamorous). Another said, “I like postal testing because then I don't have to talk to anyone. I find it annoying to have to justify my life choices” (42, straight, female, polyamorous).

Although these examples allude to fears of stigma, or at least misunderstanding around their CNM, they also highlight

Table 2. Themes, sub themes and indicative quotes.

| Theme | Sub-theme | Indicative quote |
|--|---------------------|---|
| Consensual non-monogamists' approaches | Passing | I generally let the healthcare professional assume that I'm not in relationships at all, but have just had “casual” sex with three people. There's no real reason for this, other than wanting to get the experience over and done with as soon as possible, with the least possible judgment. (30, female, bisexual, solo poly/relationship anarchy) |
| | Proudly out | I disclose so that they have a better idea about my sexual health risks and how I try to mitigate the risks. Most often I initiate the disclosure as they usually don't ask (37, cis female, heterosexual, polyamorous). |
| Clinicians' responses | Lack of knowledge | They didn't really react much, except maybe with a degree of curiosity . . . [I was] somewhat irritated because it was clear that the GP in question didn't quite understand what was going on (31, non-binary, queer, antihierarchical queer relationship anarchy). |
| | Matter of fact | My primary obgyn is very supportive. He is well versed in the lingo and understands the primary, secondary etc relationship hierarchy (34, female, bicurious, monogamish). |
| | Harmful assumptions | The GP was visibly shocked and I felt like he was treating me as a sex worker (43, pansexual, gender nonconforming, relationship anarchist). |

a presumed lack of knowledge on the part of the professionals and an assumption that it will simply be easier to not mention it: “I mostly say the minimum script I know will get me a full STI check-up without questions – that I’m single and heterosexually active. I’m not heartbroken by this subterfuge but a bit tired” (31, bisexual, ciswoman, hierarchical open relationship). These participants chose to sidestep the discussion of their relationship statuses because they were cautious of what will ensue: “If I were confident that healthcare professionals understood CNM relationships, I would disclose the arrangement of my relationships. But until such relationships are more generally understood, I’ll feel too wary to mention my own” (30, bisexual, female, solo poly/relationship anarchy). Clearly some participants expected that revealing their consensual non-monogamy status would invite further questions, discussion, and necessitate justifications that they wanted to avoid.

Some also feared that they might not be able to get the treatment they desired if they were honest about their situation, and thus “passing” was a simpler approach. For example, one participant said, “I mostly don’t disclose [my CNM] ... I definitely didn’t tell when I got my IUD inserted [in the UK] as I had been counselled it was only an option for settled, i.e., monogamous, couples” (31, bisexual, ciswoman, hierarchical open relationship). Another added, “I only have sex with women, so tend to be classed as ‘low risk.’ Sometimes I exaggerate in order to get tested” (45, lesbian, female, solo poly).

Some participants were making decisions to disclose in the future based on anticipated stigma, but these decisions to remain closeted can also be as a result of past unpleasant experiences. We discuss some more detailed examples of negative responses from clinicians in a subsequent theme.

Proudly Out. Despite some participants discussing negative experiences or wanting to avoid uncomfortable situations, there were a number of participants who made active decisions to disclose their CNM status. These participants spoke about wanting clinicians to have accurate information so that they could give the most appropriate care:

Last time I went for testing I was asked if I’d had any other sexual partners than my wife in the last year and I said yes, then explained that we’re polyamorous. I mainly wanted to make sure the doctor had as much information as necessary. (56, pansexual, male, poly in an MFF triad)

These decisions seemed to be made from an assumption that clinicians would need to know that information to make medical decisions: “I understood that telling a sexual health professional my relationship status was important and imperative to them in order to advise me best of how to protect myself and what I could be at risk of” (28, gay, transman, polyamorous).

Some participants reported receiving inappropriate care in the past because clinicians had not asked relevant questions, so they seemed to take the initiative in anticipation of that:

I didn’t [disclose] the first time I went, because there was no clear opportunity to do so. The information I was then given was hopelessly wrong (started with not needing a smear test and got worse).

I therefore disclose as fast as possible, to ensure I can access full testing. (40, homoflexible, femme-dyke, relationship anarchist)

Interestingly, some disclosed not for practical reasons but for personal reasons. For example: “It felt good to be open and myself when talking about sexual partners” (35, heterosexual, male, polyamorous). Another participant said:

I mention [CNM] every time as it’s vital. The GUM [genitourinary medicine] clinic also ask how many sexual partners I have as part of their routine questioning, and I wouldn’t want to be thought of as a cheat! Ethical all the way! (53, heterosexual, man, non-monogamous)

Finally, there were several participants who deliberately disclosed to increase awareness, such as one participant who said, “The reason why I told [the clinician] was mostly political – to make it clear that we’re non-monogamous and that we non-monogamous people exist” (31, queer, non-binary, antihierarchical queer relationship anarchy).

In summary, although participants regularly chose not to disclose fundamental details about their relationships, often because they anticipated negative reactions, some were willing to disclose more when they viewed it as necessary for receiving the correct treatment or they wanted to make others aware of the existence of CNM. We now turn our analysis to how participants’ disclosures were handled.

Clinicians’ Responses

Unlike some other gender, sexuality and relationship diversities, CNM is perhaps less frequently encountered by clinicians. Thus, it is not surprising that clinicians’ responses ranged across a spectrum. In terms of how participants’ disclosures were met, under the theme of “Clinicians’ responses” we have identified three styles of response: “Lack of knowledge,” “Matter-of-factness,” and “Harmful assumptions.”

Lack of Knowledge. Participants described numerous interactions with clinicians who simply lacked knowledge of consensual non-monogamy:

I’ve been lucky in that I’ve never felt particularly judged or received a negative reaction, but it’s definitely still not something health care professionals are educated on, even in the sexual health clinic. It would be great if it was more normalised. (32, bisexual, female, non-hierarchical polyamory)

Participants frequently framed this lack of knowledge as a dereliction of professional practitioners’ duties: “I think they should inform themselves as to the actual risks, but mainly that this population of people even exists!” (34, bicurious, cis-female, swinger). This lack of knowledge is presumed by CNM people to impact the quality of care that they receive:

Polyamorous folk should not rely on the information most healthcare providers offer because it is often rooted in monogamous values ... [clinicians] need to improve their knowledge of STIs, prevention, testing and the unique protocols that non-monogamous people expect and request. Healthcare providers are egregiously under- or ill-informed about STIs. (64, pansexual, non-binary, polyamorous)

When confronted with an unfamiliar behavior or identity, clinicians had a variety of potential responses, one of which was curiosity. “My family GP was surprised but did not seem

disapproving. She wanted to know more” (43, bisexual, female, social swinger). However, this lack of knowledge and consequent desire for education was not necessarily experienced benignly by our participants; instead it was identified as a source of irritation, with one participant stating, “[Clinicians] should definitely be informed on polyamory. It would help if we did not have to feel that we are educating them on that matter when we are going to see them for a specific reason” (46, heterosexual, female, 42, triad, V type).

Some framed their interactions with clinicians who were seeking knowledge in the same way micro-aggressions toward minorities are discussed, and reported feelings of being “othered” (Waldura et al., 2016). Some reported that clinicians “feeding their curiosity” felt particularly intrusive in a clinical setting:

I told the doctor (a woman in her 50s) that at the moment I had one regular partner and we are polyamorous, so he also has other people, and sometimes I also have other partners. She reacted saying “Oh! How modern! And . . . are you ok with that?” This wasn’t great as it made me feel judged and she stepped into feeding her curiosity - and I was there to get treated for an infection instead. I felt the comment was inappropriate. (40, bisexual, female, Relationship Anarchy/Polyamory.)

Finally, some felt that their clinicians’ curiosity was motivated by something more nefarious than a simple desire for education: “They were titillated. I could tell they just wanted to hear more so they could go and tell their friends later and laugh about how weird I was” (42, straight, female, polyamorous).

We discuss the possible implications of knowledge seeking by clinicians in more depth in the discussion.

Matter-of-Factness. Participants commented on their clinicians’ lack of reaction, and some indicated that this is what they were hoping for: “My doctor did not really have a reaction. She was like, oh OK” (44, bisexual, female, polyamorous). This lack of reaction was framed as ideal, with participants who were anticipating negative reactions reassured by this response: “She didn’t bat an eyelid . . . I didn’t feel judged at all, which I’d been concerned about” (29, bisexual, female, polyamory). To be perceived as authentic, it seems that the matter-of-fact response must come from a place of knowledge and experience: “The nurse practitioner at the sexual health clinic seemed happy and did not need explanations about what ‘ethically non-monogamous’ meant” (43, bisexual, female, social swinger).

Participants also claimed an awareness of when clinicians were reacting with comfort and ease to disclosures of CNM due to experience and authentic acceptance, versus when they were hiding initial surprise and relying on a professional persona:

Most are fine. Very occasionally there is a beat or two while they process the info and switch gears . . . I can only assume that I don’t look like someone who openly practices non-monogamy and am utterly comfortable talking about it. (37, bisexual, agender, relationship anarchy)

Participants are clearly sensitive to their clinicians’ reactions and desire to be understood and accepted. Sadly, as we saw in an earlier theme, they were often met with puzzlement or worse, as we describe below, outright hostility.

Harmful Assumptions. Participants reported being met with negative reactions from clinicians who made harmful assumptions. They reported being stigmatized because of their CNM status. One participant said, “The immediate reaction was distrust (how can you be sure they’re loyal), disgust in me (you just want to sleep around) and negative body language” (28, pansexual, female, open polyamory). Another added, “[The clinician] viewed CNM as inherently psychologically and physically unhealthy, unnecessary risk taking, and one considered it a form of cheating and IPV [intimate partner violence]” (58, straight, male, mfm threesomes). Participants reported inappropriate reactions where CNM was conflated with promiscuity and stigmatized as a result, which sometimes resulted in differential treatment decisions:

I did [disclose CNM] once when requesting birth control, because I had my female fiancée with me in the appointment so felt compelled to explain why I needed BC. GP immediately said I would have [sexually transmitted diseases] because of my “lifestyle choices” and they could not prescribe BC without doing STD testing. (23, bisexual, female, polyamorous/ fidelitous polyamory)

Participants also found that their CNM was seen as a precursory, additional problem which was causing harm and thus needed to be rectified. For example, one participant said, “Once, when consulting a GP for a sexual health matter, they insinuated that the non-monogamy was the source of the problem and refused to consider any other source.” (39, bisexual, male, non-hierarchical with one nesting partner). Another expanded:

I was not asked “Do you have multiple partners?” but “Do you have a boyfriend?”, which was a confusing question full of assumptions. And when I tried to explain my situation, I was then shamed and treated with pity by the nurse and advised to lessen my number of sexual partners. (30, bisexual, femme, open marriage with another serious partner and casual partners)

These experiences of stigma clearly connect to and explain why some participants decided to engage in acts of “passing” when talking with healthcare practitioners. However, these instances also have a potentially wider impact beyond those who directly experience them, as they have the power to become cautionary tales and a warning to others: “In some of my polyamory groups, there have been several people posting stories about healthcare professionals who treated them badly because of their non-monogamous status and basically implied that they were terrible people” (35, heterosexual, male, polyamorous). These stories may add to people’s general concerns about being open about their CNM or lead them to warn others about certain practitioners: “I hear of judgment and negative reactions of health care providers when a non-monogamous status is revealed; the health providers in question have been almost exclusively men, and I have warned friends to avoid certain services as a result” (39, bisexual, male, nonhierarchical with one nesting partner). Given these reports of distressing experiences, it is easy to see why CNM individuals may choose not to disclose their true relationship and/or sexual behaviors to clinicians.

Discussion

This study aimed to capture the experiences of CNM people seeking sexual health care. We were interested in whether

participants disclosed their CNM status, what their motivations for doing so were, and how they were received if they did. As well as collecting quantitative information on trust in practitioners, we also collected qualitative accounts of lived experiences, since it is useful for clinicians to be cognizant of the internal dialogs that their patients are having, and to appreciate the variety of experiences that CNM patients have when interacting with their fellow medical professionals.

This research extends the findings of Vaughan et al. (2019) to focus on CNM practitioners' experiences in accessing sexual healthcare, rather than general healthcare. Vaughan asked about trust in general healthcare practitioners and found that their CNM participants reported significantly lower trust than the general population. We asked our participants specifically about their trust in sexual healthcare providers and found that their mean response was significantly lower still. As we expected, our CNM participants were particularly wary when accessing sexual healthcare.

When we asked our participants if they disclosed their CNM status when accessing sexual health services, 63% of participants said they always did, but 37% said they did not routinely inform their health care professionals; that they either never did or that they were selective about when to disclose. This finding is important since decisions to withhold information may present additional problems beyond the psychological harm they may contribute to i.e., people may not receive the most appropriate medical care (Vaughan et al., 2019; Waldura et al., 2016). Turning to the qualitative data helps us to understand *why* participants took those disclosing decisions. The extremity of these experiences and the power of these stories when circulated are likely a contributing factor to the lower trust in healthcare providers demonstrated within our sample.

Our findings are organized into two inter-related yet distinct themes: consensual non-monogamists' approaches to disclosing to clinicians, and clinicians' responses to hearing disclosures. Each theme highlighted a wide spectrum of experiences and attitudes, both positive and negative, resonating with other research in this emerging area of study (See Vaughan & Burnes, 2022; Vaughan et al., 2019).

Many participants described a tactical openness (Scoats, 2020), staying closeted to avoid the additional effort it might cause as well as to avoid judgment and stigma from medical professionals. In contrast, others were proudly out, wanting to make sure they received the correct treatment and ensure that practitioners fully understood the details of their circumstances. Similar approaches to disclosure were also documented in Landry et al.'s (2021) research with polyamorous families.

Regarding participants' experiences of coming out, many clinicians were ignorant of what CNM is or how to interpret it. Responses ranged from a simple lack of knowledge and understanding, to curiosity (with mixed responses), to outright stigma and the withholding of treatment. The most positive reactions were when the clinician responded minimally or with a matter-of-factness.

CNM people accessing sexual healthcare are engaged in a constant dance of disclosure; calculating whether it is safe or necessary to come out in each situation (Pallotta-Chiarolli,

2020). In the case of CNM, where practitioners can frequently choose to pass as monogamous, disclosure is a decision and it is understandable, when reading about the negative experiences, why people may choose not to divulge. As various studies with other marginalized populations have shown, a distrust of medical professionals and a fear of judgment, stigma, and bias may mean patients are less likely to disclose their sexual activities to a clinician (Fisher et al., 2018; Liddon et al., 2021; Stults et al., 2020). Participants highlighted previous experiences of prejudice and stigma and these incidents often fed into future behaviors. Stults et al.'s (2022) research on CNM and stigma found there to be a greater fear of anticipated stigma for those with actual experiences of stigma related to their non-monogamy. This fear is something we also found in our research and some participants clearly adopted strategies that would help them to avoid a repeat of previous negative experiences, such as selectively disclosing to avoid stigma.

The inability to disclose may mean that these people do not, or are unable to, bring up information that is pertinent to their healthcare and treatment needs without compromising their identity (Vaughan et al., 2019). Even if individuals attempt to mitigate this situation and frame their circumstance to justify their healthcare desires (e.g., pretending to have been cheated on) and yet remain closeted, there is no guarantee that they will receive the most appropriate care or be able to access the treatment they need or want. Indeed, some participants described experiences where they had to "out" themselves when presented with resistance to their care wishes.

Furthermore, approaches that rely on subterfuge have the additional problem of distorting institutional perspectives on who patient populations (and what their relevant needs) are. It is not the authors' intention to chastise the CNM population and put the burden of disclosing solely on their shoulders (especially as CNM practitioners are not a homogenous group, see Hamilton et al., 2021), but instead to highlight the importance for healthcare providers to create an environment which is actively welcoming to these people and thus allow for good patient-provider trust to develop (Stults et al., 2020).

Turning to how our participants were received, we characterized clinician responses in three ways, from most to least desirable: "matter-of-factness," "lack of knowledge" and "harmful assumptions." We feel that matter-of-fact responses are the gold standard in any health care interaction, particularly any which encompass discussions about lifestyle and/or identity where patients may feel particularly exposed to judgment (Vaughan et al., 2019). Achieving the desired matter-of-fact response can only be realized if clinicians are exposed to information about CNM, understand what it means, and subsequently understand the appropriate questions to ask. Unfortunately, whilst clinicians frequently receive training on working with gender and sexuality minority populations (Sekoni et al., 2017; Streed & Davis, 2018), there is often little to no provision for training health care professionals on how to work with CNM patients, and thus frequently a gap between research findings and clinical practice (Moors et al., 2021).

Within mental health settings, it has been recommended that practitioners inquire about relationship structure on their demographic forms as it may help signal to clients an institutional awareness of CNM, help validate client identities/

experiences, and raise awareness among staff (Schechinger et al., 2018). Arguably, this suggestion can be expanded to include physical health care settings also, particularly those settings where relationship structure and sexual behavior may have notable bearing on the type of healthcare provided/ offered, such as those related to sexual and reproductive health (Landry et al., 2021; Vaughan et al., 2019). The American Psychological Association Division 44 Committee on Consensual Non-Monogamy has created several resources for clinicians, including guidance on asking about relationship structures (Inclusive Practices for Assessing Relationship Diversity on Demographic Forms) and tools to help aid providers in delivering inclusive clinical practice, including sexual health settings. These evidence-based resources provide clinicians and organizations with practical steps to implement and a starting point to interrogate the inclusivity of their practice.

More broadly, there is also clearly a need for more training around the topic of CNM. As Schechinger et al. (2018, p. 887) argued, assumptions of monogamy and a lack of knowledge around CNM might be addressed through “routinely including CNM in continuing education and training programs.” But, given the emerging nature of this topic, what constitutes effective training with long-lasting impact is still to be determined (Burnes & Kropf, 2022). Embracing CNM-affirmative care may also require reflection and change at an institutional level (Burnes & Kropf, 2022) which may conflict with individual and/or wider cultural values around monogamy (Schechinger et al., 2018), as well as wider issues found more generally in sexual healthcare, such as funding cuts (British Association for Sexual Health and HIV & Terrence Higgins Trust, 2020). Without over-arching structures and guidance for practice, approaches may vary in their effectiveness and inclusivity, likely drawing from individual’s personal knowledge and experiences (see: Byers et al., 2019).

Although clinicians seeking to address a knowledge deficit around CNM is an important step for helping provide better care (Pallotta-Chiarolli, 2020) our findings suggest that while some consensual non-monogamists may be willing to be open and even educate others (Landry et al., 2021), others find this burdensome. Accordingly, it is more appropriate that necessary and important information regarding CNM is provided through standardized educational channels (Knight et al., 2014; McNeill et al., 2021; Pallotta-Chiarolli, 2020) rather than relying on asking patients for information. Clinicians should also be aware that asking too many questions can make patients feel like a spectacle; thus, clarifying questions should be asked in a way that gathers appropriate information for treatment rather than to solely feed the individual’s curiosity.

Finally, we are discouraged to note some of the extremely distressing discriminatory experiences that our participants had when attempting to access sexual health care. Some clinicians may be carrying implicit bias about CNM practitioners. It has been observed that unconscious beliefs may negatively affect the quality of patient care (McDowell et al., 2020). Although it is beyond the scope of this study to analyze the healthcare outcomes of our sample, the nature of the encounters, and the anticipated stigma, has likely caused patients to experience minority stress, with all its concomitant negative

implications for health outcomes (Borgogna et al., 2021; Witherspoon & Theodore, 2021).

Limitations

Similar to other research that utilizes open-text responses, said responses may suffer from a lack of context and an inability to follow up on participants’ responses to clarify details (Decorte et al., 2019). Thus, there is the risk that researchers may misinterpret or even over-interpret responses (Scoats et al., 2021). However, whilst acknowledging the subjective nature of qualitative interpretation and the possibility for misaligned understanding, the broad similarities of many participants’ experiences and perceptions do still point to common thematic trends. Furthermore, the results of this research should be situated and understood within the wider context of research in this area which comes to comparable conclusions (e.g., Vaughan et al., 2019).

As the majority of the sample were from the U.K., we need to take into account the potential impact of cultural variation in attitudes toward CNM. Indeed, although there is not yet comprehensive data regarding attitudes toward CNM in the U.K., preliminary reports from the CNM-Moves project comparing the U.K. to Portugal suggested that coverage of CNM is more both more frequent and more negative in the U.K. (Cardoso, 2020, 2021), potentially representing both a greater awareness but also greater stigma. Accordingly, national, local, and indeed individual variations in acceptance and awareness will influence patients’ experiences.

Snowball sampling is also likely to generate biased sample of respondents who may be similar to the initial “seed” contact(s). Scoats and Campbell (2022) noted that this is a widespread problem in the research literature on CNM, which is focussed on White, middle-class samples. Our study replicates this lack of diversity given that the sample was 90% White and 67% middle class. As race and class are known to have an impact on healthcare access and experience (e.g., Cohn & Harrison, 2022), it is clear that further research on this topic is needed, and it should not be assumed that the results of this study necessarily represent the experiences of other groups. Nevertheless, snowball sampling is an effective method to access hidden populations. Furthermore, qualitative research is not a nomothetic approach.

Implications and Conclusion

This research demonstrates that although many consensual non-monogamists were open with their sexual healthcare providers, we still found a significant minority (37%) who did not always disclose their status. Although some were happy to disclose their CNM and received inclusive care, there were many examples of negative experiences, prejudice, clinicians lacking knowledge and understanding, and the withholding of care. These negative experiences impact not just those subject to them, but also have the power to travel via the stories and warnings individuals give to others. Clearly, patient fears

around their CNM in a sexual health setting have implications regarding the quality and accuracy of patient care.

It is anticipated that the findings will have practical implications for healthcare professionals engaging with this minority population. As well as disseminating the findings as widely as possible through academic and public facing outputs, the data will feed into a future educational project to produce guidance on how to work with this population. Like McDowell et al.'s (2020) work with sexual and gender minority patients and Vaughan et al.'s (2019) work on CNM general healthcare, we hope that the findings presented in this paper will encourage clinicians to engage in self-reflection and foster more affirming care experiences for their relationship minority CNM patients.

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Appendix A. The Trust in Sexual Healthcare Professionals Questionnaire

This final section of the study asks you about the trust you have in your sexual health care providers. These questions are taken from a preexisting validated questionnaire. Please answer thinking about your general experience of sexual health care, rather than one provider in particular.

[All items to have radio buttons for scoring from 5 – strongly agree to 1 – strongly disagree]

My sexual health care provider is usually considerate of my needs and puts them first

I have so much trust in my sexual health care provider that I always try to follow their advice

I trust my sexual health care provider so much that whatever they tell me, it must be true

Sometimes, I do not trust my sexual health care provider's opinion and therefore I feel I need a second one

I can trust my sexual health care provider's judgments concerning my medical care

My sexual health care provider will do whatever it takes to give me the medical care that I need

Because my sexual health care provider is an expert, they are able to treat medical problems like mine

I can trust my sexual health care provider's decisions on which medical treatments are best for me

My sexual health care provider offers me the highest quality in medical care

All things considered, I completely trust my sexual health care provider

Quantitative surveys can often be quite frustrating to answer because they limit your available responses. Is there anything you would like to say about trust that wasn't captured by the questions above?

Appendix B. Survey questions

The following questions are about your experiences accessing sexual health care as a consensually non-monogamous person. These questions are open ended, you can write as much or as little as you want to. You might end up writing an essay for one question and then not answering any of the others, that's fine. These questions are intended as prompts only. In general, the more you can tell us about specific examples and events, the better for our research.

The focus of the study is on consensual non-monogamy and sexual health services but feel free to tell us about related things, e.g., fertility services or general medical appointments, if you think it might be relevant.

How frequently do you use sexual healthcare services and what sort of services are they (GP, sexual health clinics, postal testing)?

Is there a reason you choose one type of service over another?

Do you disclose your consensual non-monogamy status when accessing sexual health services? Can you tell me about a time you did and/or a time you didn't and what prompted your (non)disclosure in each case?

If you have told a health care professional that you are consensually non-monogamous how did they react and how did it make you feel? (Please feel free to talk about as many interactions as you can recall.)

What, in your opinion, do sexual healthcare providers do well or need to improve when interacting with consensually non-monogamous people?

We're interested in hearing about general perceptions and "folk tales" that are in circulation in the community. Have you heard any stories about other people's experiences with sexual health services that have impacted on your own behavior in those same settings? (Maybe partners have told you about particularly good services, or have warned you not to reveal your consensual non-monogamy.)

Do you have anything else you'd like to tell us that you haven't covered already?