

A Qualitative Study of the Healthcare Experiences of
Consensually Nonmonogamous Adults

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University of Washington

Abstract

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Introduction: Consensual nonmonogamy (CNM) reflects a view that people can freely choose to engage in intimate romantic, sexual, and/or emotional relations with multiple other people at the same time. Very little published research exists on people who practice CNM and none of these studies focus on the healthcare experiences of members of this population. This exploratory qualitative study aimed to discover the themes that emerge from the healthcare experiences of CNM people, with study questions revolving around patient disclosure of their CNM status to their healthcare providers and the influence of this on the patient-provider relationship. **Methods:** This project used convenience and snowball sampling to recruit 20 CNM adults. Data came from a single, semi-structured interview with each participant, lasting from 19 to 79 minutes. The interviews were audio-recorded and transcribed by the main study investigator. The interview transcripts were then recursively coded and analyzed for thematic elements. **Results:** Participants gave a variety of reasons for deciding to disclose or not disclose their CNM to healthcare providers, including providers not inquiring about their personal relationships and patient desire to access appropriate care or avoid discrimination. Participants also discussed the specific importance of both sexual healthcare and mental healthcare. Additionally, participants reported on the impact of encountering inflexible processes and institutions in the healthcare system as well as the major medical decisions that they had made as a result of these encounters. Finally, themes identified were used to help develop a conceptual model of the barriers to and facilitators of obtaining healthcare for CNM adults. **Discussion:** From participants' responses, I was able to draw comparisons between the healthcare experiences of the consensually nonmonogamous and members of other sexual minority populations (e.g. LGBTQ). This comparison, along with the descriptions of the bidirectional nature of influence in patient-provider interactions, contributed to the creation of a new conceptual model. This model pinpoints several possible areas of intervention to improve the quality of care encounters and ease the burden of managing disclosure for CNM adults. **Conclusion:** The insight into the similarities in healthcare experiences between CNM people and other sexual minorities helped to spur the creation of a new model of the healthcare experiences of the consensually nonmonogamous. This new model highlights areas of possible intervention to improve care for CNM adults as well serving as a starting point for future research into the healthcare experiences of CNM people.

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INTRODUCTION

Consensual nonmonogamy (CNM) reflects the view that people can freely choose to engage in intimate romantic, sexual, and/or emotional relations with multiple other people at the same time. The practice of CNM is vastly different than those colloquially referred to as “cheating” or adultery; instead, CNM requires the full knowledge and consent of everyone involved. In contrast to polygamy, most forms of CNM require equitable power dynamics and the relationships do not necessarily require legal or religious recognition [1, 2]. The healthcare experiences of consensually nonmonogamous people, specifically related to their alternative family structures, appear to have never been formally studied. Previous academic literature on CNM people has tended to focus on either the *need for* awareness and cultural competence among therapists and social workers [3-6] or on the incidence/impact of STIs in this population [7-10]. One large, long-term ethnographic study of polyamorous families was conducted by Sheff [1]; however, her research included little information on health or healthcare.

The purpose of this phenomenological study was to describe the healthcare experiences of people in the Puget Sound area of Washington State who have engaged in consensually nonmonogamous relationships. For the purposes of this study, the healthcare experiences of CNM people were generally defined as any interaction with the healthcare system that is related to the CNM person’s health (Appendix A: Glossary of Terms). I was particularly interested in those healthcare interactions that are also influenced by or had an influence on the CNM person’s alternative family structure. These interactions included both the specific interactions between the CNM person and people within the healthcare system as well as decisions made and actions taken

regarding their health and healthcare by both the CNM person and the people within the healthcare system with whom they interact. Finally, I investigated how these experiences are moderated by disclosure, or lack thereof, of CNM status during healthcare experiences.

Research Questions

- Central Question:
 - What themes emerge from the healthcare experiences of CNM people?
- Subquestions:
 - What factors influence CNM people's disclosure of CNM status during health experiences?
 - How does disclosure of CNM people's CNM status influence their healthcare experiences?
 - How do CNM people's healthcare experiences influence their experience of an alternative family structure of CNM?
 - How do CNM people's experience of an alternative family structure of CNM influence their healthcare experiences?

METHODS

This exploratory qualitative study used semi-structured, in-person interviews to investigate the healthcare experiences of CNM adults. The University of Washington Human Subjects Division approved all study procedures prior to data collection.

Setting and Participants

The target population for this study was people who lived in the Puget Sound area of Washington State and who had been involved in a consensually nonmonogamous relationship at least once since the age of 18. Participants may have been of any gender, sexuality, race, or ethnicity so long as they could speak conversational English. Every effort was made to include a diverse representation of these demographic characteristics in this study.

Although there are many forms of consensual nonmonogamy, for the purposes of this study the target population was limited to forms that involve long-term, committed relationships. The purpose of this limitation was to specifically gain information on the way that the established family structures were influenced by or had an influence on the healthcare experiences of the CNM. For the purposes of this study, a long-term, committed relationship was defined as a relationship involving three or more people, which lasted for a year or longer. Although individuals were not required to be in a CNM relationship at the time of the study in order to participate, they must have engaged in at least one long-term, committed CNM relationship since the age of 18 to be eligible. In addition, due to the specific topic under study, participation was limited to those who had interacted with the healthcare system during the time of their CNM relationship.

The target population was specifically focused on those who had the *experience* of engaging in a CNM relationship rather than those who *identified as* CNM. This was an intentional distinction made because of the rich variations of form in which CNM relationships manifest. For example, an individual who personally identified as monogamous may have a partner who identified as CNM and who in turn has other partners who variously identified as monogamous or CNM (Figure 1. below). Although the initial person identified as monogamous, they also had the experience of being in a CNM relationship and would have been eligible for this study. Although some participants may, as a result, not personally identify as CNM, they were still collectively referred to as CNM in the context of this study due to their relationship experiences.

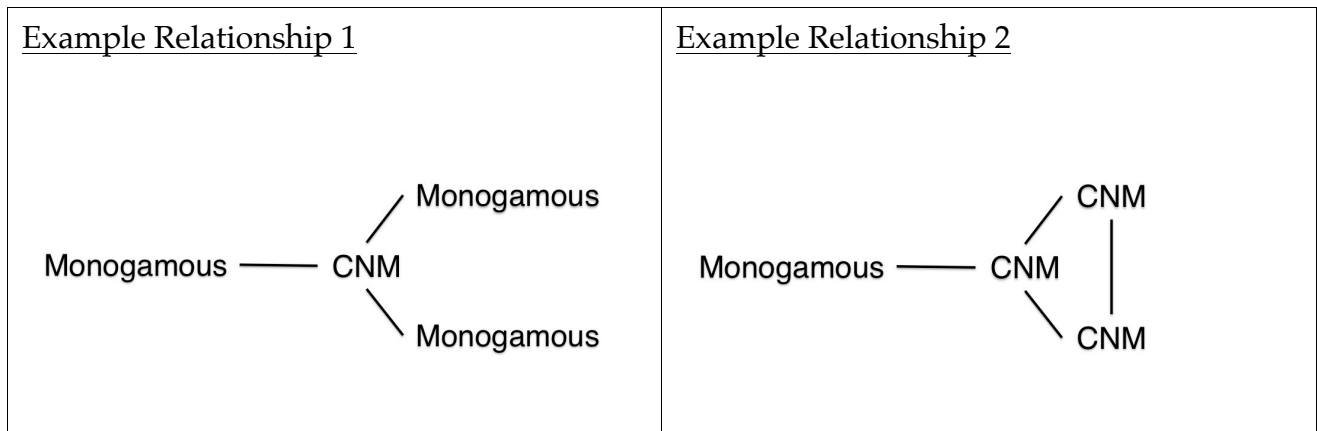


Figure 1. Diagrams of the structure of two example relationships, each consisting of four individuals. All of the individuals in these two example relationships would have qualified as participants for this study. NOTE: This figure represents only two examples of CNM relationships and not the only or exact form of CNM relationships that were targeted in this study.

The target population consisted of those age 18 and older for several reasons. As stated, this study aimed to gather information on the way that established alternative family structures are influenced by or have an influence on the healthcare experiences of CNM people. As such, the research design was intended to limit participation to those who have had the opportunity to engage in relationships that are both long-term and committed. Although the choice of a specific age limitation was somewhat

arbitrary, age 18 is legally considered the age of majority in the United States and it provides a useful cut-off point between which relationships may go from being considered childhood experimentation to socially recognized adult patterns of behavior.

Participation was limited to those in the Puget Sound area of Washington State as I was based out of the University of Washington (UW) and participation required an in-person interview. As participants came from the area local to myself, and I am a member of the population under study, one additional limitation was put in place: no one personally known to myself prior to the start of the study was eligible to participate. Due to the potentially sensitive nature of the material under investigation and the often highly interconnected nature of this population, this limitation was designed to protect both my privacy and that of all participants. As I began recruitment for the study, I found that it was necessary to extend this limitation slightly further, also excluding those known to my friends and partners. I added this precaution when I discovered during the screening process for eligibility that several potential participants shared current or previous partners with myself, my current or previous partners, or my close friends. I felt that allowing such individuals to participate in the study opened up the possibility of divulging information about a third party, who had not consented to such disclosure.

In addition, while I was conducting recruitment and faced with interconnected nature of the CNM population, I realized that it would be possible to recruit my entire study sample from just a few alternative family groups. However, my goal was not to produce a case study, but rather a study reflecting as diverse a range of voices as possible. To this end, I added a limitation early in the recruitment phase to allow only one member of any family group to participate in the study.

Finally, participation was limited to those who could speak conversational English. This study had an extremely limited budget, which did not allow for interpretation services. This was a recognized limitation of the study.

Recruitment

This study consisted of convenience and snowball sampling on an on-going basis for a period of five months (June-Nov 2017), until 20 participants were enrolled. I specifically used this method for sampling because there is no established sampling frame for CNM populations [11]. I felt that CNM individuals may represent a ‘hidden’ or hard-to-reach group [12]¹ and that my insider status positioned me ideally to serve as the initial seed for the snowball sampling [13]. I conducted outreach both online and in physical places where CNM people gathered. My initial call for participants went out as a public Facebook post on my personal account (Appendix: B for full text of this post) on June 29, 2016. This Facebook post was then shared by numerous local CNM individuals on their personal Facebook accounts as well as in private Facebook groups for the CNM. In addition, I attended three different physical meet-up groups for the consensually nonmonogamous, two public and one private, in order to conduct recruitment.

¹ Browne [12] provided a valuable discussion of the position and value of snowball sampling in research with hard-to-reach populations, in particular non-heterosexual women. In Browne’s work, she specifically discussed the advantages and disadvantages of using snowball sampling with the original convenience sample base coming from the researcher’s own social network, as I have done in this study. In particular, Browne talked about the advantages of being an insider researcher in establishing trust with research participants and avoiding problems associated with methods that rely on group or identity affiliations. Finally, she pointed out the potential for snowball sampling to create additional ‘hidden populations’ within the very hard-to-reach groups we are trying to study by relying on a “white, middle class, urban researcher’s social networks” to seed the sampling process. Unfortunately, this phenomenon may have occurred in the current study (See Limitations).

I accessed spaces where CNM people gathered in order to discuss the research project topic and aims. This informal discussion allowed potential participants to express their interest or approach the researcher without undue pressure or influence. I provided a contact phone number and email address for anyone who was interested in participating in the study. Once a potential participant expressed interest in the project, I discussed inclusion/exclusion criteria to determine eligibility with them in an informal screening process. This process consisted of in-person or online discussion, depending on where the potential participant was recruited, focusing largely on the potential participant's current/past relationship structure or experience with CNM and whether or not it was appropriate for inclusion in the study. After determining eligibility, I worked with the participant to pick a convenient time and place to conduct the interview.

Data Collection

The interview was conducted in person, one-on-one with the interviewer (myself) at a quiet, private location. In order to facilitate ease of participation, the interview location was not fixed. Instead, each participant had the opportunity to discuss and agree upon a convenient location with me.

At the time of the interview, participants were first given an Informed Consent Form (Appendix C). I orally presented elements of this consent form to the participants and they were given the opportunity to ask any questions they had about participation in the study. If they had no additional questions and consented to participate in the study, the participants signed and dated the consent form, after which the investigator also signed and dated the form as a witness. Participants were then asked to complete the Demographic Information Collection Form (Appendix D).

After that, I conducted a one-on-one semi-structured interview with the participant. I used the Interview Guide (Appendix E) for all interviews. At the end of the interview, participants were given my contact information and asked to give it to anyone else they knew who might be interested in participating in the study. All interviews were audio-recorded. I transcribed the first 11 interview audio-recordings and the remaining 9 were transcribed by a professional service².

After the interviews, participants were given the opportunity for self-reflection and debriefing with me. I also handled any immediate discussion, questions, or concerns of the participants and provided contact information to participants where they could follow-up with the research team if they had later questions or concerns. In case the interview process triggered psychological distress that was not addressed by the debriefing process, I was prepared to refer participants to the 24-hour Seattle-King County Crisis Line (866-427-4747), as per the protocol approved by the UW IRB. I did not need to use this information at any point during the course of the study however.

Data Security

All electronic data were kept on devices that were password-protected, encrypted, and only accessible to myself. Audio recordings of the interviews were kept only long enough to create transcriptions that were scrubbed of any potentially

² I intended to transcribe audio recordings of all of the interviews myself; however, the transcription process was taking an excessive amount of time and delaying progress on the project. After completing eleven transcripts, I conferred with members of the University of Washington Human Subjects Division who had originally reviewed and approved my IRB application, and received their approval to use a professional service for the remaining transcription. I went on to review the professional transcripts against the audio recordings of the interviews to ensure accuracy and preserve my transcription conventions in recording false starts, flavor words (e.g. um, uh, like, you know, etc.), and punctuation to preserve or emphasize meaning. Additionally, I removed any potentially identifying information (e.g., names of people, employers, healthcare providers, etc.) from all of the transcripts. The audio recordings of the interviews were deleted as soon as the transcription process was complete.

identifying information (e.g., names, employers, healthcare providers). After transcription was complete, audio recordings were immediately destroyed. No identifiers were collected via non-electronic data sources (i.e. interview notes, demographic information collection form, printed transcripts, etc.). De-identified transcripts were made available to a fellow UW Public Health master's student for assessing inter-coder reliability.

All non-electronic data sources and material associated with this study were stored in a locked file that was only accessible to myself. The only identifiable information that was directly collected was a name on the consent form, which was not filed with or linked in any other way with the study data from the individual participant. Any other identifying information that was inadvertently or tangentially collected during the course of the study (e.g., names that participants said during the audiotaped interview, phone number or email address used for setup and coordination of the interview, etc.) was deleted as soon as possible after the interview. All remaining study material that could potentially be used to identify participants, including consent forms, demographic information collection forms that contain participants' handwriting, and handwritten notes taken during the interviews, will be destroyed in December 2020.

Data Analysis

For this study, I used a basic thematic analysis [14] to identify and describe the major themes within the data. The data analysis process commenced when I was conducting interviews with participants and I started to hear topics brought up repeatedly by participants across multiple interviews. With these subjects in mind, I began the transcription process of the audio-recorded interviews. After transcribing the first four interviews, I printed the transcripts out and hand coded for common themes.

This initial coding step was originally guided by the framework of my interview guide. In other words, I listed all of the topics discussed by each participant under each question. After initially coding these four transcripts, it became apparent that the codes would no longer fit into the organizational scheme provided by my interview guide.

At that point I shifted to using the online Dedoose software for the remaining data analysis. By entering the initial handwritten codes into Dedoose, I was able to reorganize and categorize them into similar themes, producing a preliminary codebook. By this point, I had transcribed about half of the interviews and submitted the remaining for professional transcription.

While waiting for the service to return the remaining transcripts, I worked with a fellow UW Public Health student to establish coding reliability. I selected five interviews from the set I had already transcribed to use for this process. For each interview, the other student and I independently coded the transcript and then met to calculate the percent agreement between our codes and to discuss sources of coding differences and methods of improving clarity in code definitions and application. We ultimately achieved a 73% agreement in our coding during this process.

After working to establish coding reliability in my master code scheme, I individually coded the remaining 15 transcripts. During this time, I kept a log of all changes I made to the code list, including all code additions and changes to code names or definitions that I made for clarification. After I finished coding all 20 transcripts, I performed a final reorganization of the codes in order to clarify themes. I then went back over the coded transcripts with the change log and the final coding organization to ensure accurate and uniform code application throughout all of the interviews. Finally, I was able to use the analytic capabilities within Dedoose to investigate the themes discussed across the sample data.

Ethical Considerations

Privacy and Confidentiality

There was no more than minimal risk to participants who were involved in this research. Participation in CNM itself is not illegal in the United States. In addition, Washington State is a no-fault divorce state and the only valid reason for dissolution of a legal marriage or domestic partnership in this state is a statement by one or both parties that the marriage is “irreversibly broken” [15]. This could be relevant if the legal spouse or partner of a participant in the study somehow gained knowledge of a participant’s interview responses and tried to use the participant’s participation in CNM as evidence of adultery. In this state, such “marital misconduct” is not relevant in settlement of divorce proceedings.

It is also important to note that the setting of the study, the Puget Sound area of Washington State, is a diverse and socially progressive area. Both the City of Seattle and Washington State have instituted laws to protect against discrimination on the basis of sex, gender identity, sexual orientation, and marital status [16, 17]. Each of these identity categories is inextricably intertwined with the experience and practice of CNM and their protected status in this region means that accidental disclosure of any of them as a result of participation is unlikely to result in damage to a participant’s financial standing or employability.

Demographic Data Collection and Categorization

This study collected data along a number of demographic dimensions (Table 1). I made the decision to collect this demographic information for several reasons. First, I hoped that I might be able to analyze the final results along demographic lines to determine if any patterns could be established. While the small, diverse sample that made up the final study population ultimately constrained my ability to use the

demographic information in this way, I still hope that future studies will be able to compare results with mine based on this information. Finally, and most importantly, was my use of this demographic information during the recruitment process to help me target my recruitment efforts and help ensure a more even distribution of participants along demographic lines. I considered this to be particularly important considering the stereotypes surrounding the demographics of people who engage in CNM, especially the typical media portrayals of families consisting of one straight man in a relationship with two bisexual women, as well as the fact that the few studies which have been conducted with CNM people have included little population diversity in terms of race/ethnicity, class, sex/gender, and sexual orientation [1].

As my choice to collect demographic data was made with the intent of cultivating demographic diversity among my study population while also avoiding the reinforcement of oppressive or exploitative cultural norms, I intentionally designed the Demographic Information Collection Form (Appendix D) with open fields for all categories. This allowed each participant to not only enter in their actual age, level of education, income, and occupation, but also to self-identify their race/ethnicity, sex/gender, and sexual orientation³⁴.

These open fields produced a rich variety of responses from the participants, especially for the sexual orientation and sex/gender demographics. This left me with the task of deciding whether to keep participants' responses to these open fields in their

³A typographical error caused sexual orientation to be omitted from the Demographic Data Collection Form. However, I realized this error shortly after the first interview and verbally asked participants to add this information to the form. Sexual orientation data was ultimately collected from every participant except the first one interviewed.

⁴Participants were also told that they could skip any question, for any reason; however, none of the participants chose to withhold demographic data. The only missing demographic information was the sexual orientation from the first participant.

exact words or determine if certain responses were similar enough to be grouped together. Ultimately I did decide to group responses into categories so that the data from this study would be more accessible for analysis and to add yet another layer of protection and further de-identify participants' responses. I felt that this categorical coding of the open field demographic questions was acceptable due to both the level of detail provided directly by the participants on the original collection instrument and also to the detailed memos that I made to document the conversations I had with the participants during the interview process, some of which took place outside of the recorded interviews. With such detailed information at my disposal, the categorization of the demographic information was a relatively straightforward process⁵. Though it was a relatively unambiguous task, this recategorization was done with the recognition that it had the potential to further normalize the socially created power imbalances of race, class, gender, and sexual orientation.

Development of the Conceptual Model

From the participants descriptions of the effects that disclosure/nondisclosure had on their healthcare experiences and the strategies with which they used disclosure/nondisclosure during interactions with providers, I began to conceptualize the idea of disclosure as a tool which participants utilized to regulate and improve both the content and outcomes of their healthcare encounters. In addition, I saw the way that participants described themselves, with the importance of their position within their alternative family structures, and their medical providers, constrained by their positions

⁵As an example of this process, I will describe the development of the race/ethnicity categories. Eighteen of the study participants reported that they were either White or Caucasian, so these participants were all categorized as White/Caucasian. The remaining two participants reported their race/ethnicity as Mixed and Native American/Caucasian. These two were recategorized at Mixed: Other and Mixed: Native American/White, respectively.

within the wider healthcare system. This image of patients and providers positions within nested layers of influence was very reminiscent of Bronfenbrenner's socioecological model of human development (Figure 2) in which the development of human behavior is influenced by multiple, increasingly larger realms of influence [18].

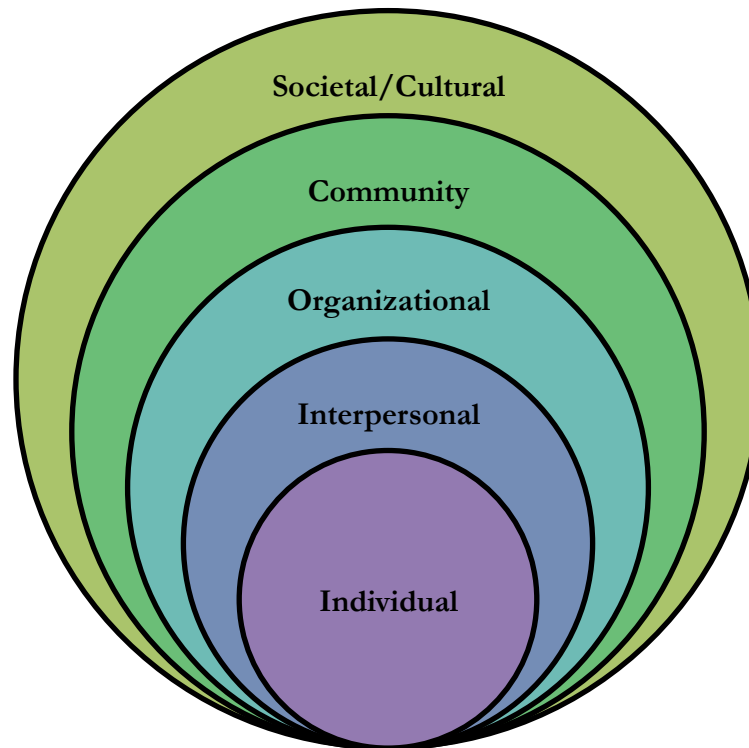


Figure 2. The socioecological model. Adapted from Bronfenbrenner's [18] original framework.

In addition, participants' depictions of their healthcare experiences included many references to the things that either hindered or helped them in accessing appropriate care. These things could easily be conceptualized as barriers to and facilitators of obtaining healthcare for these CNM participants [19]. This idea also fit well with the observation that CNM individuals and other sexual minority populations encounter similar issues surrounding disclosure in their interactions with providers (See Discussion); many of these issues could actually be reframed as barriers to and facilitators of obtaining healthcare [20]. From these two theories, the socioecological model and the idea of barriers and facilitators, and the themes I developed from the

data set, I designed a conceptual model of the barriers to and facilitators of obtaining healthcare for CNM adults (Figure 3).

RESULTS

Study Sample

The study sample consisted of 20 consensually nonmonogamous individuals between the ages of 28 and 50. Demographic data for the sample is summarized in Table 1. Five different sex/gender categories were represented in the sample. Half of the participants identified as either bisexual or pansexual and only 20% (n=4) identified

Table 1. Summary Study Sample Demographics

Demographic Characteristic	Characteristic Category	Percentage of Sample (n)
Age	26-30	20 (4)
	31-35	25 (5)
	36-40	25 (5)
	41-45	25 (5)
	46-50	5 (1)
Sex/Gender	Female	45 (9)
	Male	35 (7)
	Genderqueer Female	10 (2)
	Nonbinary Genderqueer	5 (1)
	Agender	5 (1)
Sexual Orientation	Bisexual	30 (6)
	Straight/Heterosexual	20 (4)
	Pansexual	20 (4)
	Queer	15 (3)
	Lesbian	5 (1)
	Gay	5 (1)
	Unreported	5 (1)
Race/Ethnicity	White/Caucasian	90 (18)
	Mixed: Native American/White	5 (1)
	Mixed: Other	5 (1)
Education	Some College	20 (4)
	Associate's Degree	15 (3)
	Bachelor's Degree	30 (6)
	Postbac	5 (1)
	Some Grad School	10 (2)
	Master's Degree or Higher	20 (4)
Income	≤\$20,000	25 (5)
	\$20,000<x≤\$40,000	20 (4)
	\$40,000<x≤\$60,000	25 (5)
	\$60,000<x≤\$80,000	0 (0)
	\$80,000<x≤\$100,000	10 (2)
	\$100,000<x≤\$120,000	0 (0)
	>\$120,000	20 (4)

as straight or heterosexual. In addition, 90% (n=18) of the population identified as white or Caucasian. This is notably higher than the approximately 70% of the city of Seattle population which is white according to the US Census Bureau[21]. Educationally, 65% (n=13) of the participants had attained a bachelor's degree or higher. This was slightly more than the 58.9% of the Seattle population over the age of 25 who had accessed this level of education [21].

Participants reported a variety of occupations and income sources, including: unemployed and relying on L&I compensation, government employee, graduate student, IT support, engineering, artist, and accountant. Seventy percent (n=14) reported annual incomes of approximately \$50,000 or less. The remaining 30% (n=6) reported incomes over \$80,000 per year. All participants, except one, reported incomes under \$170,000. One participant listed his income as, "\$1m+," which I interpreted for coding purposes as \$1,000,000+ per year. Due to the potential ambiguity, I excluded this data point in calculating the mean of the participants' income data. The sample income mean was just under \$54,000 per year, somewhat above Seattle's mean per capita income of \$45,673 [21].

Themes

The themes explored in the following sections capture my impression of the healthcare experiences of CNM adults. I begin with a discussion around how CNM participants navigate disclosure within their healthcare experiences, specifically focusing on the reasons for, and consequences of, their decisions to disclose or not disclose. I then move on to address the two types of care encounters, mental health and sexual health, in which participants consistently reported they felt their CNM was relevant. This will include an examination of participants' interactions with the healthcare system to access both STI testing and HPV vaccination. After that, I focus on

participants' descriptions of the differences in interacting with people versus interacting with institutions within the healthcare system, including the way that inflexible insurance coverage and inaccessible insurance can act as barriers to care. Next, I concentrate on the participants' discussions of the way that their CNM has influenced them in making major life decisions with medical consequences. Finally, I end with a description of the conceptual model that I developed from the analysis of these themes.

Navigating Disclosure

Study participants recounted a multitude of reasons for choosing to either reserve disclosure or to explicitly disclose their CNM during their healthcare encounters. In addition, they found that their choices to reveal, or not, their CNM to their providers often had profound effects on their interactions with their providers and the subsequent care they received.

Reasons for Nondisclosure

The most common reason given for not disclosing CNM to a healthcare provider, stated by 14 (70%) of the participants, was a perceived lack of relevance on their part, especially when they were seeking specialist care or the healthcare encounter was of limited scope or duration. These participants often referred to certain kinds of providers to whom they would not disclose, such as physical therapists or eye doctors, or just said that they would not disclose if the encounter was unrelated to their sexual health.⁶

It wasn't relevant. So for example, with my knee I'm in the orthopedics clinic a lot and with physical therapy and it's just not really necessary for me to bring it up. I'm not talking about my sexual health with my orthopedic doctor, you know? Or like getting hearing tested or going to the dermatologist or something. There's no reason why I would need to bring it up. If I was it'd be like me trying to come out to them in a way and that's not necessary, right? Like I might come out to my friends but does my doctor

⁶ Quotations have been lightly edited to enhance clarity and preserve participant confidentiality. Participants' wording was never changed, but some false starts and placeholder words (e.g. um, uh, like) have been removed to improve the readability of these passages. All names have been changed to protect participants' privacy.

who's not taking care of my sexual health need to know that? No, not really. It's not a matter of shame. It's more of a matter again pragmatic — like is it relevant? No.

-ID#7S9, Female

This participant even pointed out that she felt like she would be disclosing to make a point if she did so in a healthcare encounter unrelated to sexual health. Here, too, was a sense of the participant's very practical attitude toward disclosure; disclosure needed to be serving a discernable purpose for her within the healthcare interaction.

While a lack of relevancy was the most common reason given by participants for nondisclosure of their CNM, it was not the only one. Six participants (30%) said that they would disclose if asked, either about CNM specifically or their relationship structure in general, but their healthcare providers never asked about CNM or their CNM never came up during the healthcare encounter.

Interviewer: So if it's not specifically about sexual health you don't disclose?

Participant: No. I don't not disclose. It just doesn't come up generally.

-ID#5V7, Male

Two participants (10%) specifically mentioned that their healthcare providers asked about their sexual partners, but that there was no discussion of the actual context of their relationships.

I guess, you know, maybe having some sort of a, a protocol for encouraging disclosure—along these lines might have been helpful. Because, as I've mentioned, they don't seem to ask much about the ethical nonmonogamy. I think they do ask your sexual orientation and sometimes the number of partners with whom you've been over recent weeks or months. But they don't generally ask if this is done in an ethically disclosed way. So I wonder if that particular line of questioning could streamline some of these processes.

-ID#1R3, Male

While most participants reported nondisclosure due to feelings that their CNM was irrelevant to a healthcare encounter, six (30%) also relayed experiences in which they hid or even lied about their CNM in order to avoid having to give explanations or face judgments.

Having the doctors be confused about so many people are in the room. That's happened on multiple occasions. I have outright lied to doctors who were sort of a come and go

doctor, as opposed to someone we were gonna have an actual relationship with about why somebody might be in the room. I just want you to accept their presence Leave us alone about it.

-ID# 9H2, Female

In four (20%) cases, this obfuscation or explicit nondisclosure directly followed or resulted from a previous poor experience. This previous poor experience during disclosure may have taken the form of disclosure of CNM with a previous provider or disclosure of some other potentially sensitive personal information with either the current or a previous provider.

Prior to ending my marriage of eight years, when we had already opened up our relationship, I did not tell my primary or I guess my OB/GYN at the time that I was exploring nonmonogamy at that time because she already didn't express an understanding of my sexual health as a self-identifying lesbian. [...] And I felt a little bit unheard so I didn't elaborate [about the CNM] at that time.

-ID#4Z7, Female

Finally, one (5%) participant described experiences in which he intentionally did not disclose his CNM in order to maintain access to family members and the decision-making processes associated with their care:

Participant: So we ended up doing a lot of non-disclosure in that situation where we had to start playing these bullshit games in order to juggle and balance medical access for other partners and other kids. So, sometimes we'd have one doctor where we'd present as a couple, and then we'd go to a different doctor who we'd present with a different partner as a couple, and, so, that allowed us access to more resources than we would have had otherwise. [...]

Interviewer: And that was specifically for the children or —

Participant: Specifically for the ability to access each other in the event of an emergency or a problem, you know, like who's the power of attorney? Who's going to, you know, make the decision when to pull the plug or not and do not resuscitate? Who's going to you know, who can have access to the emergency room in the event of an injury. [...]

-ID#5C4, Male

Often the circumstances surrounding these cases of nondisclosure involved short-term or one-off care encounters; however, as the quote above illustrates, at least one participant used nondisclosure over longer periods to manage access to family members.

Consequences of Nondisclosure

The participants' nondisclosure of their CNM during a healthcare experience had a variety of consequences. As mentioned, some participants never disclosed to their healthcare provider simply because they were never asked comprehensive questions about their relationships. Four (20%) participants expressed that a consequence of this breakdown in effective communication between provider and participant was a failure to communicate important information.

[...] maybe at a doctor or healthcare clinic or psychological evaluation this would be the type of thing they either ask about or encourage people to talk about if they suspect this might be an aspect of the situation with which they're dealing. And I did even see a healthcare professional or two as a result of the breakup with my partner. [...] And I, eventually, was able to diagnose myself with PTSD. But none of the people that I saw were really able to do that. And I think the questionnaires or the protocol that they follow just never dug deep enough to get to that point.

-ID#1R3, Male

This participant, in particular, expressed several times during his interview that he would have disclosed if he had ever been asked about it. However, when disclosing was left up to him, without a direct or specific prompt to reveal his CNM, it often did not occur to him to do so. Another participant also faced the consequences of a breakdown in doctor-patient communication as a result of her nondisclosure:

I had a psychiatrist who was treating me, did not know I was polyamorous. I had my partner with me because I was suffering from aphasia. [...] And he wouldn't listen to her as she tried to describe my symptoms and the problems that were going on. [...] He didn't give her words the attention that they needed and so he wasn't able to treat me the way I needed to be treated.

-ID#8J8, Female

In this case, the provider, not knowing to treat the participant's partner as a critical source of information, was unable to address the participant's needs in an effective or efficient manner. Similarly, one participant (ID#5C4, Male) found that he was unable to access specific health services, especially STI testing, when he did not disclose his CNM, reporting, "I have tried to get STD testing without disclosing my nonmonogamy status

and been refused.” Each of these participants found that, by not disclosing their CNM to their healthcare providers, they eventually ended up in situations where their healthcare needs were not met.

Four (20%) participants talked about healthcare experiences in which they did discuss having multiple partners, review their current sexual partners, or otherwise reveal their nonmonogamy, but felt that their provider did not adequately understand what they were disclosing.

I, again, suspect that I did [disclose], but can't say with certainty that I was honest with people about dating other people. But I did explain certain elements of the nature of the trauma and the breakup and, you know. Maybe they just filed it under "heartbroken" instead of an ethically nonmonogamous dissolution of a partnership or something. 'Cause they probably don't have a box to check for that, right? [...] Or if it came up, they just checked a box that said "other" or "I don't know" or like "WTF?" you know.

-ID# 1R3, Male

Like this participant, several others described experiences in which their healthcare provider misunderstood, misinterpreted, or miscategorized their disclosure. One participant (ID# 1E6, Female) said, "But like I said, I talk about it all the time. What people take from that is a whole another matter." Another reported that data collection at their clinic was impersonal and algorithmic:

They [STI clinic] would ask how many partners I had in the last year for instance or how many people I was seeing regularly. But it was all very clinical. It wasn't like, "Do you feel a sense of commitment with these people?" It was more like, "Are you fucking them regularly?"

-ID# 1N2, Agender

While this participant reported that they did not feel judged, they did feel that the very structured interviews used at the clinic failed to give their providers an accurate picture of what their relationships were actually like. These participants were initiating disclosure discussions; however, the actual communication of their CNM status did not occur, resulting a very different framing for their healthcare experience than might have occurred if their providers fully understood the context of their relationships.

While some participants' nondisclosure occurred because they were not asked about their CNM, four (20%) participants indicated that they intentionally managed their nondisclosure to ensure greater personal safety and to protect themselves from judgment.

I wondered if it [disclosing his CNM] was going to make things complicated between me and my doctor, because, you know, this was a primary care physician.... And it just seemed like the stuff I was seeing him about really didn't have anything to do with my relationship status or my relationship practices. And so, it seemed like he didn't really need to know about it. And I was worried that he might either react badly or decide wrong things about me as a result of knowing it

-ID#8N3, Male

These participants explicitly used nondisclosure as a way to increase their feelings of personal safety during their healthcare experiences, especially when an encounter involved other sensitive topics, like sexual assault or exposure to STIs.

I mean, I think when I went in to discuss the rape — like not talking about it, kind of helped me feel more safe with this person who just assumed that — I don't know. I think I just didn't want more judgment at the moment and I couldn't handle more explanations. And so I think I didn't say anything so that I could just get the comfort that I needed.

-ID#2I5, Female

Nevertheless, this same participant recognized that wielding nondisclosure in this manner could be a double-edged sword.

But I think in the medical profession, whether it be mental health or physical health, it's so important that a client, like myself, that a patient is able to be honest. And if I can't be honest, then I can't really get the best care, right? I can't make sure that all aspects are known so that you can look at them and say, "Oh, you need to consider these things, too." Instead, when I feel that judgment, I'm going to disclose what I think you need to know and I'm not a medical professional. You know? I don't know what you actually need to know as a medical professional. And, so there's that risk of lack of vital information because I feel judged and I don't want to feel alienated or like you're going to somehow hurt me in my medical experience because you don't like the life I live.

-ID#2I5, Female

Although she had deliberately used nondisclosure to protect herself from judgment in the past, she realized that tactic carried a definite risk because her healthcare provider did not have access to all of the potentially relevant information.

Reasons for Disclosure

As with nondisclosure, participants expressed a variety of reasons for disclosing their CNM during a healthcare experience. Chief among these was the relevance of the participant's CNM in seeking care or the necessity of disclosing to access services, which was touched on by 19 (95%) participants.

Because I knew I would need more frequent [STI] testing and I wanted to make sure I was being screened for sexual health risks for someone who was sleeping with people of both genders, I thought it was pretty important to disclose upfront in my first appointment after I started opening up relationship and being nonmonogamous.
-ID#9Z3, Nonbinary Genderqueer

Participants most often discussed disclosing due to the relevancy of their CNM in relation to their need for more frequent sexual health screenings; thirteen (65%) participants gave this reason for disclosing. Often participants disclosed their CNM in order to justify accessing these screenings more often than their provider might otherwise allow.

And so we were talking about, as I was becoming more sexually active with multiple people, it became more important to do things like more frequent STD testing. And so I found myself in a position of having to justify to my doctor, and through her and the insurance company, why they should be paying for such frequent STD testing for me. So I've actually got a diagnosis in my file of high risk sexual behavior so they can justify doing STD testing as often as, you know, once every six months because otherwise there are things that the insurance would refuse to pay for that often.
-ID#9H2, Female

Similarly, one participant just found it impossible to explain his need for certain types of care without disclosing his CNM.

It was kind of impossible to describe why it was necessary for me, or advisable, for me to be on PREP without understanding, "Hey, this is the relationship that I am in." You know especially because when we started, my primary partner was not HIV positive, but his partner was. So, trying to describe that without disclosing my polyamory would have been cumbersome at best.
-ID#4I3, Male

Though some participants disclosed out of necessity in order to access appropriate care, about half reported that they did so out of a desire to be as honest or

straightforward as possible with their provider. One participant (ID#9F4, Male) stated that he didn't want to "have to wear a mask or employ some sort of a verbal filter. [...] My policy is honesty is the easiest thing to keep track of." Another reported that this honesty allowed for better quality of care, "Well, mostly because I understand that the more information I'm able to give a provider gives them a better ability to take care of me. And maybe illuminates options that might be valid for somebody else" (ID#4Z7, Female). These participants found being open with their providers to be the easiest course of action that would result in the best care from their healthcare interactions.

Four (20%) participants went beyond the idea of honesty for honesty's sake or even honesty for the sake of better care from their provider and actually reported that they view disclosure as a method of reducing stigma. Three different participants had remarkably similar things to say regarding disclosure as a method of reducing stigma:

With the other one, it wasn't any factors that went into it other than I do my best to live my life as open as possible to try and normalize things like this. So it never occurred to me not to say, "Oh, yeah, my boyfriend. Oh, right, my husband is still around. We're good." You know, "Everybody knows. We're, we're fine. Here look, sir. Here's our family picture. We're, we're all in it."

-ID#5V7, Genderqueer Female

Well, first, I'm somebody who's – you know, I'm kind of out and proud. And I think that more people who are nonmonogamous need to speak up about it so that we can have, not just in healthcare, but in life, in everywhere. So that we can have better equity and a better representation, and, and decrease the judgment, increase awareness and understanding. And that includes in healthcare.

-ID#1E6, Female

Well part of my decision to disclose is based on the fact that I'm pretty open just in general and I feel like if there are things in my life that I do that other people might have judgments on or are stigmatized in our society, me staying in the dark about it just perpetuates that. If I want my lifestyle, quote unquote "lifestyle," to be accepted in society then I can't act like it's something to hide.

-ID#6U7, Female

These participants all reported that they had consciously disclosed their CNM in many areas of their lives, including during healthcare experiences, specifically to normalize

the idea that consensual nonmonogamy was a viable alternative to traditionally monogamous relationships.

Another group of six (30%) participants indicated that they had disclosed their CNM specifically when they had multiple partners present or when a non-spousal partner was present during a healthcare experience.

And also with having my girlfriend present during medical conversations because then sometimes the doctor might assume that she's just my friend, and, you know, "Do you want to talk privately, or —?" I'm like, "No, she's my girlfriend; she's my partner. She can be here and hear this."

-ID#1E6, Female

One participant even reported that she had disclosed her CNM to her healthcare team during her pregnancy so that her partner could all come with her to visits throughout the pregnancy:

I mean, nobody even — no one cared. It was like, "Hey, you know, this other partner that I have is going to come with me." I mean the long-distance girlfriend came and visited and went to a couple of appointments with me. And it was just — nobody even cared. It was like, "Oh, okay." [...] No one else [snaps] — it didn't even faze them. You know, "Who's with you here today." "This is my girlfriend." "Oh, okay. Nice to meet you!" You know, and we joked with the doctor because I got pregnant during the week that she had come to visit. And so, of course, the joke was, "Oh, is this *your* baby!?" [Laughs]

-ID#1Z4, Female

In this case, the participant disclosed preemptively, before her additional partners were present for care encounters, in order to ensure that her providers had an accurate understanding of her relationships with the people who accompanied her to her appointments.

Consequences of Disclosure

On disclosing their CNM during a healthcare encounter, participants also reported a variety of results. Interestingly, these consequences seemed to fall into distinctly positive or distinctly negative patterns. Fourteen (70%) participants discussed

healthcare experiences in which they were surprised at the ease with which their providers handled their disclosure.

I guess, on my end, personally, I've been so delightfully surprised by almost the nonchalance that's been surrounding this entire experience in the healthcare system, uh, as a polyamorous person. I don't believe I've seen anyone yet at this particular location have that face of taken aback when they find out that I have two partners. It's just a, 'Okay, that's good information. Thank you.' It's treated as a reality and not as an oddity and I appreciate that. And it's almost like I'm the one who's surprised more often than they are. And part of that is, this is their job and I am sure they see plenty of nonmonogamous people coming in and asking for healthcare, so it is their reality. And it is my reality. And it's nice that those line up.

-ID#4I3, Male

In addition, five (25%) participants recalled instances when their disclosure helped to build rapport between themselves and their providers.

I feel fortunate as a relatively younger person to enter into a healthcare system that is already supportive of people in my situation and not judging. My primary provider is basically — she's like, "I'm here to take care of you and I'm gonna help you make the healthiest choices for your life and not judge you." Right down to one of the nurses when I first went in, I don't know exactly how it came up, but I said, "Oh, yeah, I have two boyfriends." And she got really excited and lit up and said, "I have my first outside relationship. We just opened up ourselves and I'm so excited to see somebody else who's here and taking care of themselves. Because, you know, I feel that solidarity with you." So it's nice to just know that people like that exist, and are, you know — we're here for each other. [...] It was very touching 'Cause, you know, that's never required.

-ID#4I3, Male

This participant said that he actually found the experience in which his disclosure prompted the disclosure of his provider to be very affirming. And he was not the only participant who had mutually disclosed CNM with their healthcare provider:

I started going to [name of current medical clinic] after our thruple started. I didn't like going to [name of STD clinic] because it felt like it was just sort of a bandaid patch like, go here in case things happen. I actually wanted to get some managed healthcare and develop a rapport with somebody that I could talk to about just my normal healthcare needs. And when I found out that my doctor was also poly that just made the chair even more comfortable for me. I got to put my luggage down and just be able to be me in front of my doctor. So I do believe that me being in my current relationship helped influence where I wanted to get my medical care from.

-ID#9F4, Male

The rapport that this participant developed with his doctor allowed him to establish a stable, on-going relationship with a healthcare provider.

The positive effects of disclosure could have been immediate or they could have had a lasting, long-term impact. Twelve (60%) participants reported that disclosing their CNM helped them to access appropriate care, especially related to STI testing. One participant (ID#1N2, Agender) said, “Yeah, I think I received better care if I’m honest with my doctors. So even though it was a little stressful to disclose that, I think that I probably received more appropriate care.” Another participant talked about the validation that her family got for their alternative family structure after they disclosed:

So the best experience we had was with our doula recommending us to our pediatrician. Our doula absolutely flipping loved our family and was like, “You guys are the best. I can’t believe you did this.” My husband and I came in pretty late to the game. [...] So we spent the last two months going to all of these appointments and when we were trying to pick a pediatrician we went to the doula and said, “Hey, do you have any recommendations?” She’s like, “I know exactly the person you need. You will be my gift to him.” And essentially, she said, “Your family will be a gift to this person because you guys are so well-suited to this doctor.” That support of our family and that clarification of ‘your family is great the way it is and you’re worth it and you’re going to make people really happy with your family,’ that was really powerful to me. It was a huge thing to have our family recognized for what it was. Cause at that point in time it wasn’t legal. Neither me or my husband were the birth parents. That, just that recognition was flipping everything.

-ID#5V7, Female

This validation clearly conveyed to the participant that her family structure would be both recognized and affirmed by the healthcare team during the birth of her child and through her daughter’s ongoing care. Yet another participant discussed the long-term positive impact that their first disclosure experience with a provider produced.

Participant: I guess, since I came out to my GP it's easier for me to talk to other doctors about it. [...] You know, it's kind of like coming out as gay. If you have a couple of negative experiences that's gonna color your future experiences. But, you know, the more out I am about my relationship structures the more comfortable I am with coming out about it just in general. [...] And [the good experience disclosing CNM to a doctor] kind of also reinforced that if someone has a negative response then that's the abnormal response. I don't expect to get a negative response and I know that if they act shocked or in any way try to put me down for it then that's them giving bad care. I think that if my GP had reacted negatively then I would see that as the standard of care. That like, oh, the doctors will act negatively to me and that's just something to expect. 'Cause I was young when I came out to him and so I think you know, I would have made that kind of assumption.

-ID#1N2, Agender

In this case, the participant's experience in disclosing defined their expectations for future interactions with healthcare providers by establishing a positive interaction during disclosure as the norm.

All of the previous participants described positive effects from their disclosure of their CNM to some of their healthcare providers; however, that was not always the case. Four (20%) of the participants reported having to educate their providers about consensual nonmonogamy after disclosing. One participant (ID#6L5, Genderqueer Female) reported, "I actually taught my psychotherapist about polyamory because I was the first person she had treated who was poly. [...] pointed her at reading material and things of nature." While these encounters were sometimes merely straightforward education of the healthcare provider by the participant, they often also involved the participant facing the judgment or bias of their provider.

The one I really remember was like the first time I went to the doctor to get an STI test after opening. [...] And so I said, "Well, I'm opening my marriage. I hear I'm supposed to do STI tests. Can I get some?" And he's like, "You're having sex with other people?" And I said, "Yes." And it was all sort of very awkward. And then he was like, "Well, so, like, tell me why you do that. How does that work?" And so I essentially had to spend like the first, I don't know, 10 or 15 minutes educating him on what this relationship style was, which was interesting. And then it was kind of funny because, his initial response was essentially like, "Are you gonna keep doing this? Because we're gonna have to keep giving you tests. And I don't know that we want to do that." [...] Like, "Yes, I [plan to] continue to keep doing this. And I'm assuming that I'm going to need to come in for tests more than once in my lifetime." [...] that was definitely, right out of the gate, was a bit of a hurdle to realize like, 'Oh, I need to educate my healthcare person about this while I'm learning about it.' And he wasn't super judgy, but there was definitely like a little bit of judgment about, like, he thought we were introducing a lot of risks, sort of unnecessarily, was the way he was viewing it.

-ID#4B7, Female

Two (10%) participants also expressed a desire to not have to spend time educating their doctors about CNM.

[Sighs] There is always a conversation where you have to explain and justify yourself. And, frankly, I try and have that conversation as infrequently as possible with anyone. [...] it's just a lot of effort, and I tend to feel really judged, like people don't understand, they don't understand the value. They think we're like sister wives. [Laughter] I find it exhausting to put in that effort to educate people.

-ID#9H2, Female

Half of the participants reported instances in which their disclosure was met with the judgment or bias of their healthcare provider.

I have had nurses sort of, you know, you saying “multiple partners” and they kind of [clears throat]. They don’t really say anything, because they’re a little more professional than that. But you can tell, like, there is one nurse who’s at my primary’s office who clearly does not agree. She doesn’t say anything. She just sort of goes from being very friendly to not being friendly at all and very professional ‘I’m just going to get this job done’ and then out she goes.

-ID#1Z4, Female

In this case, the provider’s judgment upon the participant’s disclosure clearly impacted the rapport that was able to develop between the two. Eight (40%) of these participants also reported incidents in which the providers’ judgments had a deleterious effect on the quality of patient care.

I’ve been slut-shamed by a previous doctor who suggested that getting tested every six months is ridiculous because if I’m putting myself that at risk then why even bother getting tested at all because I’m just gonna end up with something.

-ID#5V7, Genderqueer Female

One participant even had an encounter in which she ended up with an incorrect diagnosis in her medical record due to the bias of her healthcare provider.

The minute I said “multiple partners” she just was like, “Oh, well here’s what you have.” Without any further examination or questions or, you know, she didn’t ask, “When was the last time you were tested? How often do your other partners get tested?” She didn’t ask any of those other questions. Just, “Here’s your diagnosis.” It was like, “Okay, now you need to take that off my chart.”

-ID#1Z4, Female

Finally, four (20%) participants described a long-term impact on their continuity of care as a result of facing judgment from their provider upon disclosure of their CNM.

Participant: I have felt judged, but I guess feeling judged has made me more hesitant to share. So, here’s the real impact to me is that I go to this doctor and this doctor, you know, makes me feel uncomfortable, so I go to a different doctor, and, so, that’s basically I think the impact to me is that when I’ve gone to doctors and they have had difficulty understanding or, you know, I feel judged or otherwise they don’t make me feel comfortable, then I would go somewhere else. [...]

Interviewer: Fair enough. Do you think that process of feeling judged and like you need to go to a different doctor to get care has impacted — we call it continuity of care — where you are with the same provider and able to establish a relationship. Do you think that’s impacted that? And your ability to get care because of it?

Participant: Absolutely. Yeah, especially once the Obamacare Affordable Care Act went through and we were more restricted in doctors that our insurance would cover. This made us feel much more restricted in terms of what our options were, for our healthcare, and made it much more difficult to — basically it upped the risk for pissing off a doctor....

-ID#5C4, Male

This participant particularly pointed out the potential risks of damaging a relationship with a healthcare provider through disclosure when that provider was one of a limited set accessible through a particular insurance plan.

CNM and Mental Health

Participants in this study discussed several types of healthcare encounters in which they felt their CNM had become relevant. Half of the study participants discussed mental healthcare, many of them emphasizing the importance of finding a good mental health provider. One participant (ID#8N3, Male) said that, “That’s a good 40 or 50 percent of what I talk to therapists about, is relationship stuff. And because of the aforementioned relationship structure, it’s usually not my direct relationships.” For this participant, CNM made up a significant portion of what he discussed in therapy. Six (30%) participants discussed the difficulty in finding a mental health provider who was welcoming of and competent in working with CNM clients.

So I definitely talk with my therapist about my polyamorous experiences and whatnot. It was one of the criteria when I looked for her that I ask people, like, “Do you have any experience? Do you feel comfortable?” [...] So I absolutely disclosed that and talk about that because polyamory’s complicated and you come up against a lot of stuff in it and you need somebody to talk through with it and you need to talk with somebody who’s not going to judge you, especially on mental health issues. So that was really, really important to me to find somebody who was amenable to seeing someone who was polyamorous and I definitely had some replies back from people who said they weren’t experienced and they weren’t comfortable. So, I mean, it was good that I asked, you know, and asked that up front.

-ID#7S9, Female

These participants generally recognized that disclosure was going to be necessary in their interactions with a mental health provider. One participant also brought up the

idea that judgments about and biases against CNM might have an even greater impact on mental healthcare than on physical healthcare:

But it's really hard finding therapists that don't want to point to that [CNM] as you know, the reason why you're depressed and anxious, for instance. So I think that if I could pick one thing to change about healthcare it would be to improve accessibility of mental health services. 'Cause, like I said, the podiatrist doesn't know I'm poly because it doesn't matter. And so, podiatry is largely accessible regardless of your relationship structure. Mental health is not. Because that's where judgment is most going to come into play and really make a difference in the quality of care that you receive.

-ID#1N2, Agender

Indeed, another participant concisely summarized the tendency of mental health providers to attribute the root of all relationship or emotional difficulties to CNM:

[...] you know, in some ways I feel like nonmonogamy is to therapists as weight is to medical doctors. In that, with a therapist, you always worry that they're going to make all of your problems about nonmonogamy. And with a medical doctor, the tendency certainly is to make all of your problems about weight, at least in my experience.

-ID#8N3, Male

Finally, one study participant had even seen this propensity of mental health providers to hold biases against CNM from behind the scenes:

So I worked in a behavioral health clinic for a few years. I was an admin there. And I walked into the break room to people discriminating against people who are polyamorous. These are therapists. These are people who see polyamorous patients. And saying things like, "Oh, they must have ADD in order to be able to keep up with all of that. I never see polyamorous relationships work." You know, like those kind of comments.

-ID#7S9, Female

This participant went on to discuss the deep impact that hearing this discrimination: she was physically shaken in the moment and later she knew that she could never again trust these providers to provide quality care for CNM patients.

As frustrating as the participants above found it to be unable to find a mental health provider who was explicitly comfortable or experienced in working with CNM clients, they could often immediately move on from a provider, realizing that the therapeutic relationship would not be a good fit. Providers who held unexamined biases or who hid their judgments in the break room created situations for participants

wherein they were already involved in a therapeutic relationship with the provider before the problems became apparent.

Actually, so I think that therapist interaction was probably a good example of that, where her impression of this being essentially like, “Well, of course every guy is gonna want to go fool around with some other people” And like, “It’s always the guys who want to open the relationship,” I think was the exact comment she made with sort of that implication. Definitely affected my experience of nonmonogamy at the time, because having sort of an authority figure say that this was a thing that was put on women, sort of was the implication, was something I had actually been actively trying to counter prior to that. [...] And so not getting that definitely sort of — I would say sort of slowed my progress into nonmonogamy and my comfort level with it early.

-ID#4B7, Female

This participant had sought out therapy to help overcome her own bias and had instead had it reinforced by that of her provider. Another participant faced judgments from her mental health providers that were much less subtle:

When I was nineteen, so twenty-odd years ago, I had a therapist who told me that the practice of consensual nonmonogamy was a sign that I was suffering from severe mental health problems. And that it was not a healthy way to have a relationship. And that I needed to stop practicing that. She also told me that BDSM — I practice BDSM as well — she told me that BDSM was unhealthy and, “It was a cry for help.” So I subsequently left that particular practitioner and found a new healthcare practitioner.

-ID#8J8, Female

In these cases, the providers’ biases and judgments affected both the participants’ progression within therapy as well as their continuity of care.

Despite the difficult that many participants talked about in finding mental health providers who were competent in working with CNM clients, most participants who mentioned mental health (n=7, 35%) went on to discuss the value of this type of healthcare in supporting healthy relationships. One participant found that the support he received from his mental health care helped him to successfully attain his goal of reframing his feelings about jealousy:

I mean, certainly therapy has helped me come to terms with jealousy to a large extent, which was a goal I had anyway going in. [...] I knew I wanted to deal with jealousy, and I knew that that didn't fit into my conception of an ideal family structure for me. You know, not that we shouldn't have it, but just that we shouldn't let our jealousy define our family structures. So I guess it didn't really change my viewpoint so much as it changed my feelings about it.

-ID#8N3, Male

Another participant was directly able to address some relational discord within the therapeutic setting because her therapist was aware of her alternative family structure and could accommodate it within therapy.

I was having problems in my relationships and problems in talking to them [participant's partners] at the time and having them come in to the therapy room and being able to talk to them both at the same time in the safe space of the therapy room was a benefit. If my therapist didn't know I was polyamorous and in a relationship with both of them, I don't think she would have invited both of them to come into the room at the same time.

-ID#8J8, Female

In addition to the value that mental healthcare had in supporting strong relationships with others, three participants (15%) also highlighted the potential this type of care had in fostering a healthy relationship with oneself.

Well, I would definitely say my mental health and my therapy has greatly influenced my nonmonogamy. [...] It has helped me identify my boundaries and when I need to take personal responsibility for things or when I'm taking too much responsibility for something and help giving me perspective to complex situations. [...] It's really been very important for me to have a therapist while I've been going through this. And there's a lot of things that have kind of co-occurred with my mental health that are not necessarily a direct result of nonmonogamy. But that have impacted it and I needed to deal with them. So, I'm dealing with my own mental health issues while being polyamorous. I think with polyamory you get more reflections back of who you are as a person, and so that's both good. Like you get to see the good, right? And that's kind of cool. But you also get to see the areas you need to work on. And so if you're getting that reflected back from two or three people, you're like, "Oh, oh. I need to work on this. Okay. So how do I do that?" And that's where mental health has been extremely important for me.

-ID#7S9, Female

Here, this participant illustrated the complex relationship between mental health, CNM, and mental healthcare, detailing the way that the multiple relationships inherent in CNM can amplify both one's positive character traits and one's flaws as well as the potential advantage of working through one's issues in an environment that is

supportive of one's alternative family structure. Another participant agreed regarding the value that a supportive mental health provider could have in exploring one's relationship with oneself:

And it was just really amazing. Like, her acceptance of who I was, or who I am, and encouragement to be myself and that these are feelings that are valid. That really, the concern should always be, "Am I hurting myself? Am I crossing my own boundaries? Is this detrimental to my health? Is this detrimental to somebody else's health or physical well-being? Am I crossing somebody else's boundaries?" She's like, "It's not a matter of right or wrong or traditional or nontraditional or weird or not weird. It's about maintaining everybody's ability to decide what happiness looks like for themselves. And when you can respect your own needs and you can respect other people's needs and they can respect yours, then the possibilities are endless."

-ID#215, Female

CNM and Sexual Health

STI Testing

While half of the participants mentioned mental healthcare, every participant in this study brought up sexual healthcare in relation to their CNM. Thirteen (65%) participants recognized that their sexual healthcare needs might not line up with the expectations that their providers might have about those needs.

I'm actually much more concerned about things we don't consider STDs — scabies, molluscum contagiosum, lice, things that you get from cuddling with lots of people. [...] If you go and get an STD test, they're not going to check for any of those things. You can absolutely transfer these things by the sex you've had. A cold — you know, if one person gets a cold and we're all making out, guess what? Everybody gets the damn cold. Like the cold is a clear, sexually transmitted infection, but nobody considers it that way.

-ID#5C4, Male

Every participant was currently, or had in the past been, sexually nonmonogamous, so they were all particularly concerned with appropriate screening for sexually transmitted infections (STIs, some participants used the alternative term STDs). Eleven (55%) participants explicitly recognized that they received STI testing more frequently than their peers.

I get blood drawn a lot more than most people. I get tested a lot more than a lot of people. Which is kind of a norm in the lifestyle to begin with. But you don't see my co-workers coming in with a test every three months.

(ID#1Z4, Female)

Another participant (ID#1N2, Agender) similarly reflected, “I think if I was monogamous I would not be going to the doctor for STD tests so often. So, it certainly, you know, sexual nonmonogamy changes my healthcare needs.” These participants were clearly aware of the influence their CNM was having on their health needs relative to a sexually monogamous person. Some participants also expounded on their reasons for seeking these extra screenings; for example, one referred to the potential for increased risk of STIs with within a larger sexual network:

I used to do testing every six months and as I started to have more partners who had more partners and have realized the breadth of the network of people I’m connected to, I definitely thought more about the frequency and which kinds of tests I needed. And most recently I’ve upped that to every three months just because I have partners who sleep with other partners without protection. And even though I use protection with those partners, I’m aware of a lot more risk within my network. So I do go in more frequently, I think.

-ID#9Z3, Nonbinary Genderqueer

Eight (40%) participants discussed not just their need for increased frequency of STI screenings, but also the pushback that they encountered when trying to get this healthcare need met by their providers.

Every time I try to go in for STD testing. Every single time I go in they are like, “Well do you feel that you’ve been exposed?” And my answer is always, “Well no.” And they’re like, “Well then you really don’t need to get tested.” Yeah, I really do. You know, I have multiple partners. And they are like, “Well that’s, that’s, that’s risky behavior. You should probably not do that.” I have had the same gynecologist because I have some other gynecological issues and, but it’s not been just in her office. It’s pretty consistent that when getting testing, I get a lot of pushback about, “Oh, you don’t really need to get that test.” Well no, I wanna get all of the tests because it’s very easy for your risk factors to multiply as people dating people dating people dating people happen.

-ID#5V7, Genderqueer Female

This resistance sometimes took the form of pushback against both the frequency with which participants tried to access STI testing as well as the type of testing that they requested:

And this was really, really difficult to try and explain to a standard doctor, who felt that my getting tested on a regular basis was a waste of money. And even asking for an STD test was a difficult thing to do, and that was really challenging to get them to do that. And then even once I got them to agree to an STD test, trying to get them to test for all the things that I wanted to get tested for became a significant problem, specifically,

HSV1 and 2. It was probably my third or fourth STD test before I finally got somebody to actually test me for HSV1 and 2. At which point they confirmed what I already knew, which was that I was having cold sores, they were type 1, and, so [sighs] it was really challenging.

-ID#5C4, Male

This participant was not alone in discovering the difficulty in accessing some types of STI testing. Another participant found that her previous screening, which she thought included 'full panels' of STI tests, had failed to screen her for herpes simplex virus (HSV):

I was at my doctor's office, and I asked him for a full STD panel, and it was apparently the first time that I told him that we were not monogamous. I don't know that I had even thought about it before. [...] And so he did the full panel, which apparently was the first time I'd had that done, and I didn't know that. And the results were that I have herpes. I've never had an outbreak or anything like that, so I never knew. And in talking with my doctor about it, and with others, and doing a little research, I discovered they don't normally do that particular blood test. [...] You know, I mean I've never been tested before even though I've had — supposedly, I've had a STD testing before. But I think the fact that I said that I was nonmonogamous, that made him really do a full panel instead of what they called a full panel before.

-ID#1E6, Female

In this both these cases, the participants were actually positive for an STI before they were ever even able to access testing.

The issue of HSV testing, mentioned by 12 (60%) participants, was one of particular concern. They experienced instances of pushback on performing the testing, of not having the test performed even when they thought they were being fully screened for STIs, and of providers failing to respond appropriately to a positive HSV diagnosis.

Oh! Another thing that happened to me that was really upsetting, related to my doctor and realizing that he had a poor bedside manner, is I contracted HSV-1, orally, from a former partner and was very, very upset about it. And he was relatively dismissive of it. Because he's like, "You know, seventy, like eighty percent of people have it. It's not a big deal." And whatever else. And that felt bad to me. I didn't think was an appropriate response for someone who's contracted a disease you can't get rid of and was upset about it.

-ID#9L8, Male

Similarly, eight (40%) participants also reported numerous cases in which their providers failed to understand the impact that accessing HSV testing would have on their CNM.

[...] so the community that I'm part of, it's very common that people know what their HSV status is so that they can communicate that to others. And I have not been able to convince Group Health to give me an HSV test. Like, they simply will not do it, because from their perspective, it's like something that's not treatable. There's — the tests are not, you know, super — there's false positives from the test. All things that are reasonable and understandable, but it's very hard to convey to them like, "You are limiting my opportunities for relationships because you are unwilling to give me this test that in the community that I'm in, it's expected that you can state whether you are or not positive for it. So I ended up going and getting STI tests sort of in between elsewhere just to get status of that. [...] But it was definitely the case that, like, from a medical perspective, what I was hearing was not, "We won't pay for that," but, "Well, there's really no point, unless, you've had a breakout. And, you know, maybe if you've had a breakout. But then really, like, we can't really do anything about it. So what would be the point?" And I would be like, "Well, so I can tell other people that I'm about to have sex with that maybe they want to take some different precautions or maybe they don't want to have sex with me," or whatever it is. And it was sort of like, "Well, there's lots of false positives."

-ID#4B7, Female

These participants found it apparent that “the ability to get STD testing would have impacted who we have partners with” (ID#5C4, Male); their healthcare was clearly effecting their ability to meaningfully engage in CNM.

HPV Vaccination

Participants in this study repeatedly mentioned only two types of STIs: HSV, discussed above, and human papillomavirus (HPV). One participant (ID# 5C4, Male) expressly referred to his concern regarding these STIs, saying, “I think the biggest STD concern is probably HPV. We’ve all been vaccinated and, yeah- HPV, even though we’ve all been vaccinated and genital herpes. Since herpes is forever.” However, the four (20%) participants who brought up HPV during the study all did so in the context of discussions about their efforts to access the HPV vaccination, Gardasil.

I tried for while to get my health insurance to pay for Gardasil for me. Randi [participant's wife] and I both thought was a very important thing to get. And I just could not get health insurance to cover it. Partly – well, so she actually was able to get her health insurance to cover it past age 30, and it's the same health insurance.

-ID#8N3, Male

This participant was not alone in his failure to successfully access the HPV vaccination.

The HPV vaccine — and Group Health doesn't do it for people who are over 25. And even though some healthcare systems will, right? And I haven't had like — before polyamory I hadn't had a lot of partners. I'd had, uh, Kyle and Steven, my ex-husband, you know? So it's not like I had a lot of exposure because, Steven hadn't had any other partners either. So really I had had one partner that had had more than one partner. So that's kind of upsetting because I am more sexually active now that I'm polyamorous than I was when, you know — and you're seeing more people. So I feel like there's a higher risk there, so that that's kind of upsetting.

-ID#7S9, Female

Both of these participants were unable to acquire the vaccine, even though their CNM put them at high risk of HPV and it's deleterious sequela.

Two (10%) of the participants were able to access the HPV vaccination, but only after much difficulty. One participant discussed the challenges in trying to find a provider who would give the vaccination to a male over age 26 in the early days after Gardasil was released:

I think the primary reason why nonmonogamy was such a big issue for them is because they basically said, "Look, the Gardasil vaccine is useless if you've already had sex, then there's no point in getting the Gardasil vaccine. You've already got HPV," and I was like, "Well, the Gardasil vaccine covers six or seven types of HPV,⁷ and I've had actually a very limited number of partners, and I would like to get it anyway. So, is there any downside to my getting it? If it turns out that I already had five of the six types, then I would still be protected against the sixth, and it would do no harm for the five." And they said, "Well, yes." "So, fine. So, I'd like to get it." It was a process, and they felt that because I was nonmonogamous that I was infected. I was diseased. There was no point in giving me the Gardasil vaccine — that they were wasting a vaccine on me — and the same for my girlfriend. They didn't want to give it to her either because the same situation — nonmonogamous. They felt that it was inappropriate to give the Gardasil vaccine to somebody who was nonmonogamous. I know a lot of monogamous people who've had more partners than I've had. I've had nine intercourse partners in my life and I know a lot of monogamous people who've had substantially more than that. But I'm not eligible for that because I'm nonmonogamous whereas as other people are.

-ID#5C4, Male

⁷ This participant later acknowledged that the original Gardasil vaccine only covered four strains of HPV and that it was a newer formulation of the vaccination that protected against a wider number of strains.

Although this participant was ultimately able to get vaccinated, he had to face suspicion and judgment to do so. That encounter occurred shortly after the HPV vaccine first became available, approximately a decade ago; however, things appear to have changed little in the intervening years, as illustrated by the much more recent experience of another participant:

I realized that I was never given the opportunity when I was younger to get the HPV vaccine. No one had even mentioned to me that it was possible for men to get it. So, last year I sought it out because I hadn't had much sexual activity before age 25 and I knew that, although they said statistically you should be exposed to HPV by 26, that was unlikely to be the case for me. And my anchor partner had HPV-related throat cancer, so she's very aware about the risks and, you know, concerned about getting it again. 'Cause there are so many strains. So, I went to my doctor, asked for it. He was hesitant because the guidelines all say after 26 you can't take it and I was 27 at that time. So, he said I could take it if I want, but he wasn't sure if it would be covered. So I called Group Health, who was my insurance provider at the time and went through a roundabout way of calling multiple different numbers to get an estimate. Eventually I think I talked to the local Group Health department that did billing and they couldn't provide me an estimate over the phone but they sent me, several weeks later, an estimate in the mail that said it wasn't covered and I would have to pay the full cost of — it was over \$200 a shot. For three shots. I decided to go for it anyway, because the risks I perceived were so high. And so I went into the vaccine clinic there, got it. Again I got the lecture about how it's not recommended. But they submitted to insurance and they paid for it. So I got the first two through Group Health. Then I switched insurance providers when I started a new job this year. And when it's time to get the third shot, obviously couldn't go back to Group Health for it. So I talked to my new primary care physician. She was all for doing it. She gave me a prescription for it, which would hopefully help it get covered. But they didn't carry it in their office. They called all over the place trying to find a place that did have it. They sent me to a pharmacy and because, again, I was outside the accepted area, they couldn't give it to me at the pharmacy. Their standards said you have to give it to someone 26 or under. So then I had to get special permission from my doctor to take it back to them on ice and get it given to me in the clinic. But, I finally got the last shot. New insurance covered it, too. Everything ended well. But I would definitely say that's poly-related because my risk is much higher of getting HPV with multiple partners.

-ID#9Z3, Nonbinary Genderqueer

These participants both had to fight inflexible procedures and institutions to access care that they considered vital.

Interacting with People vs. Institutions

The theme of interacting with rigid systems that were unable to adapt to the differing needs of CNM patients was woven into most (75%, n=15) of the participant's

narratives. This was true, even if participants generally had good experiences in interacting with individual people within the healthcare system.

I mean, most people I've dealt with in the healthcare system have been pretty great. And most institutions I've dealt with in the healthcare system have been pretty not great. And I think the experience I've had as a healthcare consumer has been directly proportional to the extent to which I feel like the other person is interacting with me as a person as opposed to as an institution.

-ID#8N3, Male

Participants described an array of experiences in which their CNM did not fit into the preconceived expectations of the healthcare system. One participant described an encounter during which she was not allowed to list both of her partners as emergency contacts:

The healthcare influencing the nonmonogamy — I had gastric bypass surgery in 2012. And they wanted me to list my emergency contact. And they said, "It needs to be your, your spouse." And I said, "I have two." They're like, "You can't. You can only have one." I said, "I have two." And I couldn't pick one of my partners over the other. I think it frustrated me. And made me want to fight harder to say, "No, I have more than one person." Because I had more than one person.

-ID#8J8, Female

Five (25%) other participants experienced similar difficulties when they found that they could not choose who to designate as legal next of kin.

So like, trying to explain these things — because there's like the insurance aspect and then like the next of kin aspect. And because I was married, he [participant's husband] was my legal next of kin. And they're like, "Well, you have to put your legal next of kin down." And I was like, "I understand that, but I have a restraining order against my legal next of kin. So, I kinda need to put somebody else down that doesn't have the legal right to say anything about my healthcare." It's like, "That's not gonna work." I'm like, "It's gonna have to right now. I have nothing else to give you."

-ID#2I5, Female

In this case, the reality of the participant's alternative family structure was actually at odds with her legal relationships and the healthcare system was unable to provider her an alternative solution.

Insurance

One realm where the theme of interacting with rigid institutions was most prominent in the participants' narratives was in their discussions of health insurance.

Half of the study participants brought up inflexible processes related to insurance coverage. Three (15%) merely referred to the difficulty in getting the insurance company to pay for STI testing; one participant (ID#1R3, Male) said, "They [insurance companies] don't like paying to have HSV tests done." Others discussed the lack of adaptability in insurance company policies in a more general manner.

It would be nice to walk into the doctor and feel like they knew anything about me and my situation. It would be nice to be able to call the insurance company and say, "Look, this is why I'm trying to have this done," and, you know, a human being could make the decision of, "Oh, that makes sense," or, "That doesn't make sense."

-ID#8N3, Male

This participant honed in on the fact that insurance companies often follow very strict guidelines with little room for variation on a case-by-case basis. Another participant was more explicit in linking difficulties with insurance to the legal standing of CNM.

Well, one, I think insurance companies will only adapt to what the legal aspects are, right? And consensual nonmonogamy is not legally protected. And because it is not legally protected people have a lot of judgments about it and they have a lot of like, "Oh, well, you need to do it this way." Because this is not only the law but this is our culturally acceptable norm. And so I get that more from paperwork people, like the front desk or somebody calling like, "This is how it has to be" than somebody who has the education and training and experience to really be dealing with case by case, right?

-ID#2I5, Female

The lack of legal recognition for CNM relationships actually created a dilemma for one participant's family when they tried to access health insurance for one family member:

He [participant's partner] got really wound up when he went — so him and Mel, uh, they're not married. They're just dating. But he works at [company] and [company] offers domestic partnership coverage for health insurance. And that's a big deal because Mel's workplace has terrible health insurance coverage. It's expensive and wouldn't cover the things that she really needs. And it's just — it's crap. So the [company] coverage is great and so they had to sign some papers saying that they were in a committed relationship, but the verbiage actually was a committed exclusive relationship and me and Mel are like, "Sign the fucking papers." And he's like, "I don't want to lie to my employer." I'm like, "What are you gonna do, not let Mel have health insurance? Sign the fucking papers. Agonize after you've signed the papers because we're not gonna let you not sign the papers." Like we're both sitting at the car glaring at him. So he signed the papers and it was fine. [...] Yeah, you know, some certain polyamorous communities like to bitch a lot about polyamory being an oppressed minority. And I think this is largely intersectional and not something that, for instance, white men really experience to any great deal. But actually for once there was an actual,

on the books rule that said nonmonogamous people don't get something tangible. And I'm like, holy shit. I finally saw it. The wild elusive — actual polyamory oppression.
-ID#1N2, Agender

This participant found that, while some employee health plans would extend benefits to unmarried partners, the only way to access these benefits was to lie about the nonexclusive nature of their relationship on a legally binding document.

CNM Influencing Major Medical Decisions

A quarter of the participants (n=5) reported contemplating or making major life decisions with medical consequences as a direct result of the threat of or actual inability to obtain appropriate healthcare as a consensually nonmonogamous person. As indicated in the previous section, the lack of legal recognition for consensually nonmonogamous relationships made accessing health insurance difficult for some CNM families. One participant reported that the members of her alternative family structure had considered rearranging their legal relationships in order to obtain health coverage:

I mean a lot of it has been finagling around getting people access to healthcare, just being able to get in the door, and be able to have insurance that's gonna cover things. We've considered — if we had folks living together — that we would arrange who was legally married based on the best way to obtain health insurance for everyone. But we haven't actually done that. It's just it's something that has been tossed around as an idea. But it hasn't actually come up yet as something that we would actually be able to do. But that would affect sort of the legal structure of our relationships, not the functional structure.

-ID#9H2, Female

This participant was careful to qualify that entering into legal relationships in this manner in order to access insurance would not change the relational dynamics of her alternative family structure. Another participant also noted the constraints placed on consensually nonmonogamous families in accessing insurance, but she additionally went on to express her frustration with being unable to designate who could legally have visitation rights or make medical decisions for her.

It is frustrating to not be able to have insurance for multiple partners. Because if I were to form a family, we are all financially intertwined. It makes sense to be able to have insurance through whoever has the best. It is scary to think that I could be denied access to Ralph [participant's partner] if he got sick. Or essentially that the people that are a part of my family could be denied the ability to help and be there for me if something happened. I've made a lot of decisions to try and avoid things like that. I am really bothered by the way that family is interpreted. Like my family, I'm not biologically related to them but I've had the same family since I was 14 years old. They are the people who have actually been there for me and they are the people that I would want to show up in these cases. The fact that you cannot denote who is your family and who is not seems ridiculous to me. Like these are the people I trust. These are the people I don't trust. On that side, my biological father. I never want him anywhere near my, my anything. Like the fact that I cannot say this person should never be able to make any decisions for me because he ejaculated once. You know that's the stupidest thing in the world.

-ID#5V7, Genderqueer Female

In this case, the participant's alternative family structure explicitly excluded members of her biological family who might have a legal claim to participate in the healthcare decision making process if she were incapacitated. And though she had merely expressed worry about the possibility of losing access to family members during a healthcare encounter, another participant reported actually experiencing such outcomes:

[...] inability to get emergency access to a loved partner who is sick or in the hospital. [It] has happened to us and influenced us in contemplating moving to California — influenced in contemplating adjusting domestic partners, contemplating getting divorced, contemplated significant life changes because healthcare is important. Healthcare is more important than being married, at least to us. Everybody who — in the group — who was married or not felt that medical access to their partner in the event of an emergency or death or other situation was more important than legally being married. In some cases, being legally married helped support that goal, but everybody agreed that if we could abandon marriage and actually have access to our partners when we needed them, to have access to the kids when we need them, to be able to have the rights that a spouse normally has — a legally married spouse normally has — in terms of medical emergencies was more important, and that impacted how we structured things in terms of the domestic partnerships and in terms of marriage — in terms of not getting married, frankly.

-ID#5C4, Male

Again, this participant discussed the legal alternatives contemplated by his consensually nonmonogamous family in order to access care and maintain recognition of their family structure while engaging with the healthcare system.

While multiple participants discussed the major decisions their CNM families had considered to obtain culturally competent care, three (15%) participants detailed the actual changes they had made to address their CNM within an inflexible healthcare system.

One thing I did have to do was change my emergency contact from my father to my husband because my father probably would not let my boyfriends in to see me. Things like that. Like he would not include the needs of my other partners. And that's part of why I got married in the first place was so that my next of kin would not actually have any control. Or any ability to make decisions.

-ID#5V7, Genderqueer Female

This participant made the major life decision of entering into marriage to ensure that her CNM family, rather than her biological family, would have the legal right to participate in her care.

The Model: Barriers to and Facilitators of Obtaining Healthcare for CNM Adults

The final result of this study was the development of the conceptual model of the barriers to and facilitators of obtaining healthcare for CNM adults shown in Figure 3. This model summarizes the way that CNM participants in this study used disclosure as a tool to heighten the beneficial elements of the facilitators of care, and also ameliorate the negative effects of barriers to care, in their interactions with their healthcare providers. The model also emphasizes the importance of positions of the patient within their alternative family structure, the provider within the healthcare system, and the patient-provider interaction within the wider cultural setting.

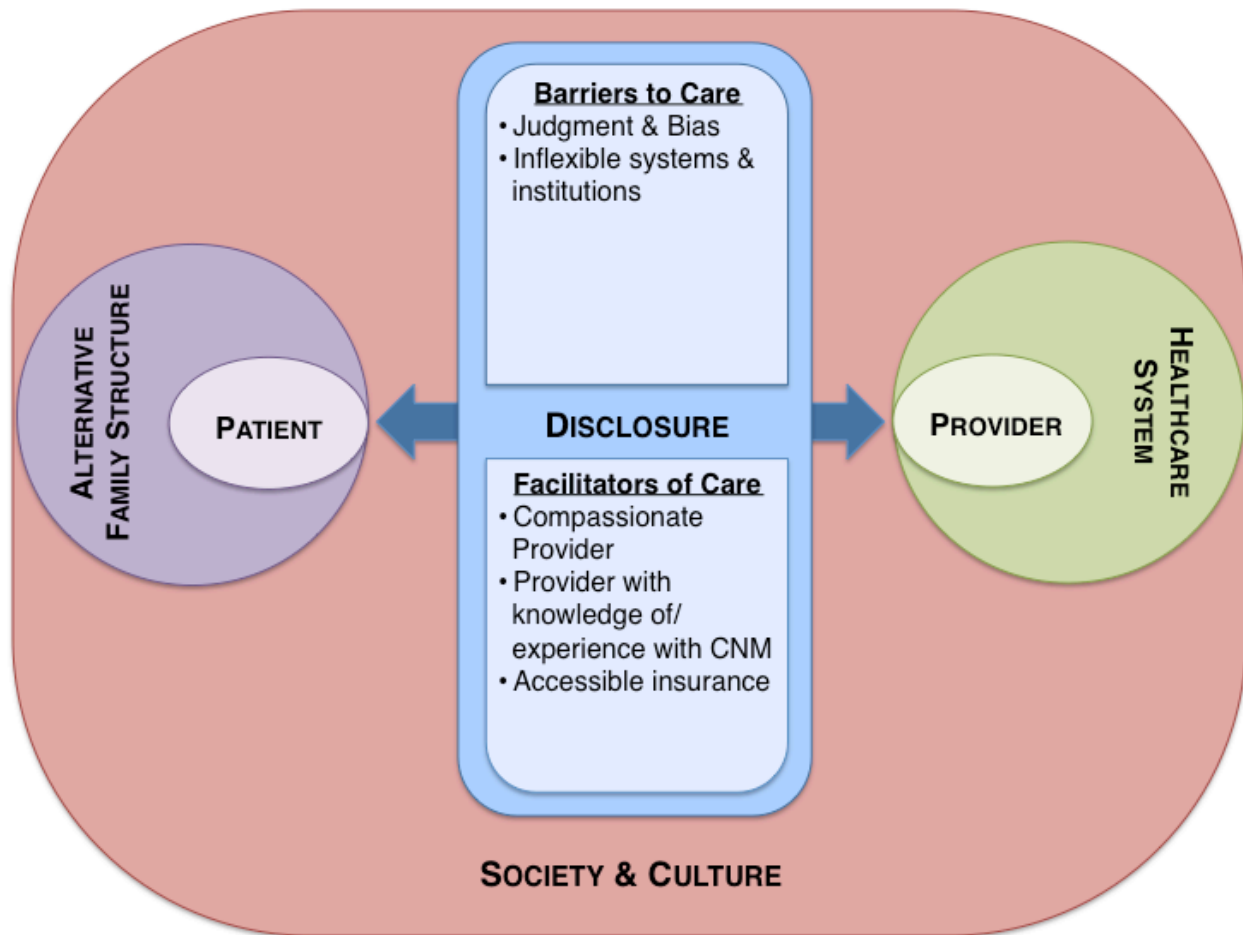


Figure 3. Conceptual model of the barriers to and facilitators of obtaining healthcare for CNM adults.

DISCUSSION

Participants in this study reported that they had disclosed, or not disclosed, their CNM to the healthcare providers for a wide variety of reasons. Many were never asked about their relationship structures or simply chose not to disclose because they felt their CNM to be irrelevant during that particular encounter. However, the decisions to disclose, or not disclose, their CNM to healthcare providers was a far more strategic one for many participants, allowing them to avoid bias or discrimination or to control the tone, substance, or consequences of a care encounter. In addition, though few participants recalled extremely negative reactions from their providers to their disclosure of CNM, most recalled more neutral or nuanced reactions and few had

received very positive or affirming results from disclosing during a healthcare experience.

These participant's narratives surrounding disclosure were remarkably similar to those of other sexual minorities, such as lesbian, gay, bisexual, transgender, and queer (LGBTQ) populations [22-24]. A recent study of LGBTQ young adults [25] found many of the same reasons for disclosure or nondisclosure as this study of consensually nonmonogamous individuals, chief among them the failure of the providers to inquire about relationship styles and structures and the desire of the patients to avoid the negative consequences of judgment and bias. However, one notable difference between this study and that with the LGBTQ population is that the CNM participants in this research expressed a greater degree of proactively engaging with the care process, including issues surrounding disclosure, in order to drive their healthcare encounters toward desired outcomes and pick up the slack created by deficits in their providers' attitudes and knowledge about CNM.

Despite this distinct difference, many other aspects surrounding disclosure are similar between the experiences of these two populations. The reactions of providers to disclosure, while not necessarily conspicuously discriminatory, may still have resulted in what Rossman et al. [25] called "nonaffirming care." In the LGBTQ study, this may have manifested as assumptions of heterosexuality or a "tendency of providers to address healthcare from a heteronormative (i.e. assumption that individuals are heterosexual or that heterosexuality is the normative standard) perspective" [25]. With CNM patients, providers may likewise assume monogamy in their patients and tend to address healthcare from a mononormative (i.e. assumption that individuals are monogamous or that monogamy is the normative standard) perspective. Such bias

could create adverse environments for care or even impact a patient's likelihood of disclosing or maintaining care in the future [22].

While the participants' narratives regarding their decisions related to disclosure and the consequences of those decisions were both detailed and nuanced, their exposition with respect to the influence that their medical experiences had on their alternative family structures of CNM, and vice versa, were considerably less direct. A few participants did recall some instances in which they could identify both a clear influence and a direction of that influence in their interactions with providers, as when they reported that their CNM caused them to seek and/or obtain more frequent STI testing or when the inability to obtain STI tests or test frequency impacted their opportunities for relationships.

However, participants' responses to the prompts regarding influence were far more likely to include descriptions of events that tended to be ambiguous with respect to the causal direction of the influence. For example, their discussions about facing the inflexible aspects of the healthcare system often included descriptions of the ways in which their CNM and their associated alternative family structures would complicate their care or force providers to operate outside a preconceived set of guidelines. But participants also related the ways in which these encounters affected their relationships with their partners. As with any complex social interaction, the healthcare encounters between the consensually nonmonogamous participants and their providers was usually both influenced by and had an influence on the participants' CNM. This bidirectional influence between the healthcare encounter and the participants' CNM was additionally mediated by the participant's use of disclosure as a tool obtaining better care.

The final conceptual model was developed from these ideas of (1) disclosure as a tool used by CNM adults within healthcare encounters and (2) the bidirectional nature of influence between providers and CNM patients in order to illustrate the barriers to and facilitators of obtaining care for CNM adults. This model provides new insights into the myriad factors influencing disclosure for CNM adults during healthcare encounters and also pinpoints several areas that could be targeted to improve the quality of care encounters and ease the burden of managing disclosure for CNM adults. Just as CNM participants used disclosure as a tool to either increase the positive aspects of the facilitators of care or decrease the negative aspects of barriers to care in their healthcare interactions, future interventions might focus either on strengthening facilitators or reducing barriers. One example of an intervention that might strengthen a facilitator of care for this population would be increased education for providers about alternative sexual and relationship practices like CNM and the needs of people who engage in these practices. Additionally, a possible intervention that might reduce a barrier of care for CNM adults might be a policy initiative to create a simple and uniform method for any adult to designate their next of kin rather than being forced to rely on the current patchwork system of medical power of attorney, which often has to be filed in advance with each individual hospital or clinic network to be recognized during a health crisis.

This study had several strengths. My position as an insider researcher allowed me to directly access the CNM population for recruitment. This was particularly helpful because of the potentially sensitive nature of the study topic and the nature of the target population, which is “small and so well integrated with the mainstream community that it is difficult to identify individual group members” [13]. Additionally, given the small sample size, this study was quite diverse in terms of sex/gender and sexual

orientation. A great deal of the literature on the consensually nonmonogamous has previously focused on heterosexual men and bisexual women [1]. The inclusion in this study of other sex/genders and other combinations of sex/gender and sexual orientation represents a solid step forward in research with this population.

Limitations

This study had several limitations, most of which relate to constraints placed on the study population by the design of the study itself. As a small, exploratory study, this research only included 20 participants. All participants were local to the Puget Sound area near Seattle, WA, an area of both the state and the country that tends to be more socially liberal. Several participants actively voiced the idea that living in the liberal, urban “Seattle bubble” might be significantly influencing their responses; therefore, I consider the results of this study to have no generalizability to more conservative or rural areas.

In addition, participants were all in their early to mid adulthood, with no CNM youth or older adults contributing to the research, and results of this study are not necessarily generalizable to other age groups. While I had made a deliberate decision to exclude youth from the project, the maximum participant age of 50 in the study population may have resulted in part due to my recruitment methods. My main source of recruitment was a public Facebook post. After I put this call for participants on my own page, the post was share by my friends and acquaintances and eventually made its way into at least two private Facebook groups for CNM, one of which is specifically for younger polyamorous adults in Seattle. Although I did not track the specific place where each participant found out about the study, based on the timing of the recruitment after my post was shared to the young, poly, professional Facebook group, as many as nine of the participants came directly from this group or from the

subsequent snowball sampling. In addition, two of the three physical meet-up groups that I attended for recruitment purposes organize their meetings via Facebook, Meetup.com, or both. In this way, I may have unintentionally influenced the age, education, and racial/ethnic characteristics of the subsequent sample by biasing participation to those who most resemble me: late 20s-early 30s, highly educated, and white [12]. In addition, I may have encountered similar problems with my recruitment process as the National Transgender Discrimination Survey and National Trans Survey, wherein a lack of internet access in up to a third of the general population and lower rates of access in certain demographic groups, particularly non-whites and people over age 65, led to an Internet-recruited study population with potential bias along certain demographic lines [26, 27]. Future studies may avoid some of this demographic bias by starting the snowball sample with several initial seeds, rather than just one, of more diverse demographic characteristics.

Another recognized limitation of this project came from the eligibility criteria: participants were required to speak English. This constraint, imposed by my limited funding, introduced a bias into my study population. Relatedly, eighteen out of the twenty study participants (90%) self-identified as white or Caucasian and one additional participant identified as Native American and Caucasian. Like previous research on consensual nonmonogamy, this study overwhelmingly documented the experiences of white CNM people. Sheff [1] provided a detailed discussion of this phenomenon in her own research, including her thoughts about the effects of racism and cultural traditions on class and individual relationship practices. To this, I would add the historically racist and exploitative relationship that medical research has had with people of color [28]. Given this history, my own positionality as a white, educated

healthcare researcher certainly impacted my ability to recruit non-white participants, resulting in a highly racially skewed study population.

Added to this backdrop of historical tensions between health researchers and POC (person of color) was the unintended consequences of limiting study participation to only one member of a family group. While adding this limitation did serve to ensure that this research represented the experiences of people beyond a single, small social circle, it may have inadvertently skewed the demographics of the sample. In any case where a family group had multiple people interested in participation, I allowed the potential participants to discuss the issue among themselves and decide which person would ultimately participate. In at least two cases, this resulted in participation of a White family member rather than a POC. It is possible that POC people actively chose to avoid participation in order to evade engaging in an activity that could be looked upon as the performance of emotional labor to further the education of a white woman. However, I do not know the exact reasons why these POC potential participants chose not to engage in this research, and specific issues related to racism and emotional labor [29] may not have led to the skewed racial characteristics of this sample. It is also possible that if I had actively asked the POC family members to participate rather than allowing the family group to decide which member to include in the study, the sample might have been 80% White/Caucasian, possibly less, which is closer to the 70% White demographics of the Seattle population [21].

CONCLUSION

This study provided an exploratory look at the healthcare experiences of consensually nonmonogamous individuals. The experiences recounted by participants showed that the healthcare experiences of CNM populations might be qualitatively

similar to those of other sexual minorities, such as LGBTQ populations. This insight allowed for the creation of a new conceptual model of the barriers and facilitators of obtaining healthcare for CNM individuals. Hopefully, this model will highlight possible target areas for interventions to improve the healthcare experiences of CNM adults. In addition, this model can serve as a starting point for future research on the healthcare experiences of the consensually nonmonogamous. Such future research should additionally expand the study populations to include the perspectives of CNM elders and youth as well as non-white CNM individuals.

Finally, I will end with the quotation of one study participant to serve as a cautionary note as we move forward in conducting research with and providing care for sexual minority patients:

[...] because if you think about the whole thing — idea of the Hippocratic Oath, of "Do no harm," if you're attacking somebody's family unit, what they define as family, that's one of the most fundamental aspects of being a human being, is who is your family, your group, tribe, whatever you want to call it. And to have that be misunderstood, miscategorized, or negated or invalidated is some of the greatest harm that you could do a patient right off the bat.

-ID#6L5, Genderqueer Female

APPENDIXES

Appendix A: Glossary of Terms

NOTE: Whenever possible, references are given to support community or academically accepted definitions; however, most terms herein are defined for the purposes of this study.

Term	Definition
Alternative family structure	A family structure that does not fit the traditional model of a husband, a wife, and children. An alternative family structure may not be based around legal or blood relations. In this study, the alternative family structure was based within or around a CNM relationship network, but may have also included legal or blood relations (such as children of adults in the CNM relationships).
Consensual nonmonogamous, Consensual nonmonogamy (CNM)	<p>Consensual nonmonogamy (CNM) reflects the view that people can freely choose to engage in intimate romantic, sexual, and/or emotional relations with multiple other people at the same time. The practice of CNM is vastly different than those colloquially referred to as “cheating” or adultery; instead, CNM requires the full knowledge and consent of everyone involved. In contrast to polygamy, most forms of CNM require equitable power dynamics and the relationships do not necessarily require legal or religious recognition [1, 2]. CNM is sometimes referred to as ethical nonmonogamy or responsible nonmonogamy; however this terminology has potential judgmental connotations that I wished to avoid. In the context of this study, any person who had the <i>experience</i> of engaging in a CNM relationship was referred to as CNM, regardless of how they <i>identified</i>.</p> <p>*Note: Cheating is considered possible in CNM relationships, but it is generally recognized as a betrayal of trust or the breaking of a previously established relationship agreement rather than the engagement in intimate contact with someone outside of a dyadic relationship.</p>
Healthcare experiences	Any interaction with the healthcare system that is related to a person’s health. This includes interactions with doctors, nurses, medical technicians, laboratory personnel, medical receptionists, insurance company representatives, hospital and clinic administrators, patient advocates and navigators, social workers, psychiatrists, psychologists, other mental health workers, pharmacists, pharmacy technician, other hospital/clinic/pharmacy employees, etc. I specifically excluded interactions with religious/spiritual leaders unless they also fall into one of the other healthcare categories above (e.g., counseling from a priest would be excluded unless the priest were specifically employed by a hospital or medical facility).

Influence	For the purpose of this study, influence was defined as any action or process that produces an effect on the actions or behavior of another. Influence on unexpressed thoughts and opinions will be excluded from this study.
Monogamous, Monogamy	The CDC defines “mutual monogamy” as an agreement to be sexually active with only one person, who has agreed to be sexually active only with you [30]. While this definition of monogamy may seem straightforward, Conley et al. [7] point out that monogamy is not understood or practiced by everyone in the same way and may vary based on individual relationship agreements, differences between identity and experience, and differing understanding regarding the relevance of sexual vs. emotional intimacy in relationship fidelity.
Nonmonogamous, Nonmonogamy	Nonmonogamy occurs when a person engages in intimate romantic, sexual, and/or emotional relations with multiple other people at the same time, regardless of the knowledge or consent of the others involved. This may include both CNM as well as “cheating” in a monogamous relationship. In research, it is important to distinguish between CNM and nonconsensual nonmonogamy (“cheating”) because the experiences and motivations of people engaging in these behaviors may differ.
Polyamory	Polyamory is a type of consensual nonmonogamy. Depending on the source, definitions of the term ‘polyamory’ vary and may refer to simultaneous sexual and/or emotional relationships with two or more people at the same time. Nevertheless, full knowledge and consent of all parties involved is foundational for this type of relationship. The mixed Greek (<i>poly</i> = many) and Latin (<i>amory</i> = love) roots show that love is central to polyamory, wherein love is allowed to “evolve without expectations or demands that it look a particular way than it does with the number of partners involved.”[31] The term “polyamory” is sometime shortened to “poly.”
Thruple	A thruple is a three-way relationship, also known as a triad or triangle, in which each member is involved with both other members of the relationship. The word “thruple” is a play on words to indicate a relationship that is like a couple, only with three members instead of two.

Appendix B: Facebook Post for Participant Recruitment



Lauren Smith

June 29, 2016 · 🌐 ▼

Internet Hive Mind I need your help!

For my thesis, I'm doing a qualitative study on the healthcare experiences of the consensually nonmonogamous. I need to interview local (Puget Sound area) nonmonogamous folks. I have a couple of inclusion/exclusion criteria:

- Age 18+.
- Speaks conversational English. (I don't like requiring this, but I honestly have no budget for translations.)
- Has been involved in a nonmonogamous relationship, including 3 or more people, which has lasted at least one year.
 - The relationship does not have to be current, as long as it occurred after turning 18 years of age.
 - No specific relationship configuration (triangle, vee, etc.) is required.
 - A person does not have to identify as nonmonogamous. To qualify for participation, they need only to have a nonmonogamous relationship experience.
- Is NOT someone that I know or have met prior to starting this study.

Because of that last requirement, I know that none of my AMAZING friends who read this qualify. But I'm willing to bet that some of you know people who qualify and might be interested. I've made this post public, so feel free to share it. If you know someone who is interested in participating who doesn't Facebook, I can be reached via email at ljsmith0 at uw dot edu. (That is the number zero in that email address, not the letter "O".)



SCHOOL OF PUBLIC HEALTH

UNIVERSITY of WASHINGTON

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This informed consent form is for people with consensually nonmonogamous experience who we are inviting to participate in research about the healthcare experiences of the consensually nonmonogamous.

Principle Investigator: Lauren Smith
University of Washington
School of Public Health

This Informed Consent Form has two parts:

- **Information Sheet (to share information about the study with you)**
- **Certificate of Consent (for signatures if you choose to participate)**

You will be given a copy of the full Informed Consent Form

Part I: Information Sheet

Introduction

I am a graduate student at the University of Washington. I am doing research on the healthcare experiences of people who have consensually nonmonogamous relationship experience. I am going to give you information and invite you to be part of this research. You do not have to decide today whether or not you will participate in this research. Before you decide, you can talk to anyone you feel comfortable with about the research. This consent form may contain words you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask them of me or of another researcher.

Purpose of the research

Consensual nonmonogamy is the idea that people can freely choose to engage in intimate romantic, sexual, and/or emotional relations with multiple other people at the same time. Unlike “cheating”, consensual nonmonogamy requires the full knowledge and consent of everyone involved. I want to hear about your experience with consensual nonmonogamy, especially the ways your family structure may not fit a traditional model. I specifically want to know about your healthcare experiences during times you have engaged in consensually nonmonogamous relationships. I will ask about your disclosure of your consensual nonmonogamy during your healthcare experiences. I will also ask about the interaction between healthcare experiences and your experience of family structure within consensual nonmonogamy. I want to know more about these things in order to improve the healthcare experiences of consensually nonmonogamous patients.

Type of Research Intervention

This research will involve your participation in a single one-on-one interview that will take about one hour.

Participant Selection

You are being invited to take part in this research because your experience with consensual nonmonogamy can contribute much to our understanding and knowledge of healthcare experience among the consensually nonmonogamous.

Voluntary Participation

Your participation in this research is entirely voluntary. It is your choice whether to participate or not. You can change your mind any time and stop participating even if you agreed earlier.

Procedures

I am asking you to help me learn more about the healthcare experiences of people who have consensually nonmonogamous relationship experience. I am inviting you to take part in this research project. If you accept you will be asked to talk about your personal experiences with consensual nonmonogamy in a single one-on-one interview.

As we begin the interview, I will sit down with you in a quiet, comfortable place that we have both agreed upon. If it is better for you, the interview can take place in your home or a friend's home. If you do not wish to answer any of the questions during the interview, you may say so and the interviewer will move on to the next question. No one else but the interviewer will be present unless you would like someone else to be there. During the interview, I will ask you questions about consensual nonmonogamy and your healthcare experiences and then you will share your knowledge. The questions will be about your healthcare experiences as a consensually nonmonogamous person, the factors surrounding your disclosure of consensual nonmonogamy during your healthcare experiences, and the interaction between your healthcare experiences and your experience of family structure within consensual nonmonogamy. You do not have to share any personal stories, beliefs, or practices that you are not comfortable sharing.

The entire discussion will be audio-recorded. You may speak freely during the discussion and any names or potentially identifiable information you say will be deleted from the interview transcripts. The interview recording will be kept on password protected, encrypted devices and will be destroyed as soon as it has been transcribed. No one except Lauren Smith will ever have access to the interview recordings. A transcript of the interview will also be accessible to other researchers on the project. The transcript will be destroyed along with any other remaining study materials in December 2020.

Duration

This is a one-time interview that will take about an hour.

Risks

I am asking you to share personal information and you may feel uncomfortable talking about some of the topics. You do not have to answer any question or take part in the discussion/ interview if you do not wish to do so. You do not have to give us any reason for not responding to any question or for refusing to take part in the interview.

Benefits

There may be no direct benefit to you, but your participation may help to uncover information about the shared healthcare experiences of the consensually nonmonogamous and improve healthcare experiences for this population.

Reimbursements

You will not be provided any incentive to take part in this research. However, you will be given a \$10 gift card for your time and travel expense.

Confidentiality

I will not be sharing any information about you to anyone outside the research team. The information that I collect from this research project will be kept private. Any information about you will have a number on it instead of your name. This number identifier on the data will not be linked to your name in any way. Audio recordings of the interviews will be destroyed as soon as they have been transcribed. All other study data will be destroyed in December 2020.

Sharing the Results

Nothing that you tell me today will be shared with anybody outside the research team, and nothing will be attributed to you by name. The final results of the study will be publicly available at the following website: www.laurensmith.com.

Right to Refuse or Withdraw

You do not have to take part in this research if you do not wish to do so. You may stop participating in the discussion/interview at any time that you wish. I will give you an opportunity at the end of the

interview/discussion to review your remarks, and you can ask to modify or remove portions of those, if you do not agree with my notes or if I did not understand you correctly.

Who to Contact

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact me my phone or email:

Lauren Smith
575-418-1032
lsmith0@uw.edu

This proposal has been reviewed and approved by the Human Subjects Division at the University of Washington, whose task it is to make sure that research participants are protected from harm. If you wish to find out more about the IRB, contact Lauren Smith at 575-418-1032.

You can ask me any more questions about any part of the research study, if you wish to. Do you have any questions?

Part II: Certificate of Consent

I understand that I have been asked to participate in research about the healthcare experiences of people who have consensually nonmonogamous relationship experience. I understand that I do not have to participate in this research or answer any questions that I do not want to answer. I understand that some questions may make me feel uncomfortable, and that I do not have to answer them. I understand that this interview/ discussion will take about one hour. I understand that I can review any notes taken during the interview and that I can tell the interviewer not to use them. I understand that no one outside of the research team will have access to the notes or audio-recorded interview.

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

Print Name of Participant: _____ **Date:** _____
Day/Month/Year

Signature of Participant: _____

If illiterate

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.



Thumb print of participant

Print Name of Witness: _____ **Date:** _____
Day/Month/Year

Signature of Witness: _____

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following:

1. Participation in this study is completely voluntary. Participants may stop the interview at any time or refuse to answer any question without giving reason and without penalty.
2. The study consists of a single one-on-one interview that will last about one hour.
3. All information collected in this interview will remain strictly confidential. No personally identifiable information will be collected or linked in any way with the participant's interview responses.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this ICF has been provided to the participant.

Print Name of Researcher taking the consent: _____ **Date:** _____
Day/Month/Year

Signature of Researcher taking the consent: _____

Appendix D: Demographic Information Collection Form

Form ID: ##

All of the questions on this form are **completely optional**. If you do not want to answer one or more of the questions, please feel free to leave blanks.

Age:
Sex/Gender:
Race/Ethnicity:
Occupation (Do not include the name of your employer.):
Income (An approximation is okay.):
Education:
Is there anything else you want us to know about you? (e.g., other health conditions you think are relevant, topics you do not want to discuss during the interview, etc.)

Appendix E: Interview Guide

Form ID: ##

Interview Guide: A Qualitative Study of the Healthcare Experiences of the Consensually Nonmonogamous

Time of Interview:

Date:

Place:

Interviewer:

Thank you for agreeing to do this interview. This project will examine your healthcare experiences as a consensually nonmonogamous person.

Questions:

1. Describe your experience with consensual nonmonogamy (CNM). (Prompts: Current or past? Preferred terminology? Relationship structure? Length of CNM experience?)
2. Tell me about the most memorable healthcare experiences you have had, if any, where your CNM became relevant. (Possible prompts: Healthcare context- acute or chronic/ emergency or routine/ established or new provider?)
3. Have you had any healthcare experiences where you **did not disclose** your CNM? (If NO, go directly to the next question.) Explain the factors that went into your decision **to not disclose** your CNM.
4. Have you had any healthcare experiences where you **disclosed** your CNM? (If NO, go directly to the next question.) Explain the factors that went into your decision **to disclose** your CNM.
5. Have you had any healthcare experiences where you think your decision **to not disclose** your CMN immediately affected your healthcare experience? (If NO, go directly to the next question.) Describe the most memorable healthcare experiences you have had where this occurred.
6. Have you had any healthcare experiences where you think your decision **to disclose** your CMN immediately affected your healthcare experience? (If NO, go directly to the next question.) Describe the most memorable healthcare experiences you have had where this occurred.

7. Tell me about the most memorable healthcare experiences you have had that you think influenced your experience of an alternative family structure of CNM. (Note: This is NOT CNM influencing healthcare experience.)
8. Explain the most memorable occasions when your experience of an alternative family structure of CNM influenced your healthcare experiences.
9. Is there anything you would like to add that you think is important to know about your healthcare experiences as a CNM person?

Thank you again for helping with this interview process. Your participation here will remain strictly confidential. If you have any additional questions about your participation, please feel free to contact me at the phone number or email address listed on your copy of the consent form.

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