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Exploratory Study of Communication as a Psychosocial Factor Influencing Safer Sex Experiences Among Individuals Who Identify as Polyamorous

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EXPLORATORY STUDY OF COMMUNICATION AS A PSYCHOSOCIAL FACTOR INFLUENCING SAFER SEX EXPERIENCES AMONG INDIVIDUALS WHO IDENTIFY AS POLYAMOROUS

by

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ABSTRACT

Even with over three decades of research on and promotion of safer sex, the rates of sexually transmitted infections continue to rise in the United States (CDC, 2017). Although communication about risk and protective factors is key to the promotion of safer sex behaviors, the meaning and impact of such communication is contingent upon culturally grounded understandings of safer sex among individuals of diverse sexual subcultures. This dissertation focuses on individuals who self-identified as polyamorous, a style of non-monogamy, and their understandings and experiences with safer sex. Drawing on the application of the AIDS Risk Reduction Model and narrative inquiry methodology, this research explored sexual risk profiles; safer sex experience narratives; the importance of safer sex communication; and the relationship between safer sex communication and relationship negotiation among polyamorous partners. Based on a survey and thematic analysis of in-depth interviews with 13 polyamorous individuals, the research shows: 1) low rates of self-reported actual and perceived risk among

participants; 2) narrative emphasis on the complexities involved in safer sex decisions; 3) the importance of using safer sex communication strategies to increase safer sex practices; and 4) the significance of relationship negotiation as a particular communication strategy used to sustain relationships and engage in safer sex conversations. The analysis of findings suggests implications for health communication research and intervention. There is an apparent need to look beyond biological factors to include psychosocial and emotional factors in safer sex decisions. Also, the consideration of relational challenges to safer sex behaviors (e.g. phase of the relationship, relationship dynamics, among others) are key to the understanding of contextual factors that ultimately influence individual behavior and decisions about safer sex.

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Chapter 1

Introduction

This introduction establishes the significance of this dissertation project. It starts by highlighting the problem that inspired this research. Next, it outlines relevant literature on protective and risk factors for contracting sexually transmitted infections (STIs), safer sex communication, and polyamory. This chapter ends with the significance of the study, an explanation of key terms, and an outline of the remaining chapters in the dissertation.

Problem Statement

There has been an increase in the rates of STI in the United States (Centers for Disease Control [CDC], 2017). The CDC (2017) reported that in 2016, STI rates showed a 4.7% increase in chlamydia, an 18.5% increase in gonorrhea, and a 17.6% increase in syphilis compared to 2015. The extensive spread of STIs is a concern for public health not only because of the number of people infected with STIs, but also because of the complications that can arise once a person is infected. These infections can lead to long-term health consequences, such as infertility, comorbid STI infection, and mental health issues (CDC, 2017; Machtinger, Wilson, Haberer, & Weiss, 2012).

In addressing this health crisis, it is important to consider risk and protective factors that impact people's health behaviors and decisions. Understanding these factors can advance health communication research and facilitate the design of interventions using safer sex communication campaigns for particular populations. For instance, in the effort to reduce the incidence of STIs, the majority of sexual risk reduction campaigns for adults have focused on three key messages: (a) use a latex condom, (b) reduce the

number of sexual partners, and (c) have sexual intercourse only in monogamous relationships (Swan & Thompson, 2016).

However, Conley, Matsick, Moors, Ziegler, and Rubin (2015) have noted that research findings challenge the effectiveness of promoting monogamy as an STI-prevention strategy for several reasons: the limitations of monogamy on safer sex due to people's inconsistent perceptions of what constitutes a monogamous relation; the tendency among individuals in monogamous relationships to be less likely to practice safer sex with their primary partners; and the fact that soon into relationships, individuals replace condoms with oral contraceptives, often without any STI testing or discussion of monogamy. Furthermore, because monogamy has different meanings to different people - and many individuals choose to live in non-monogamous relationships - safer sex research should also consider non-monogamous relationships as a focus of investigation in the effort to address the STI health crisis.

This dissertation project focuses on individuals who identify as polyamorous and their understandings and experiences with safer sex. Their perceptions and practices may offer new insights on the lived experiences of safer sex that may be used to inform safer sex interventions. Polyamory is defined as "consensual, openly conducted, multiple-partner relationships in which both men and women have negotiated access to additional partners outside of the traditional committed couple" (Sheff, 2010, p. 1). Partners in polyamorous relationships constitute a complex and unique community in which to explore safer sex practices. The understandings and experiences of individuals who identify as polyamorous make them particularly attractive for an investigation on safer sex: on the one hand, they engage in high risk sexual behavior like having sexual

interactions with multiple partners and, on the other hand, they engage in protective behaviors through an emphasis on communication with partners, which is a central value in poly communities.

Informed by the AIDS Risk Reduction Model (ARRM) and through the methodological lens of narrative inquiry, the goals of this dissertation research were to: ascertain the perceptions of risk among individuals who identified as polyamorous; provide insight into their safer sex experiences, and; explore the communication strategies and negotiations for safer sex reported by polyamorous participants. Thirteen participants were asked to engage in in-depth interviews on safer sex meanings and practices.

The findings of this study reveal that participants reported low actual risk as well as low perceived risk and offered a critique of the limitations and biases of standardized surveys on safer sex practices when administered to polyamorous individuals. The thematic analysis of their narratives about safer sex found that participants stressed the complexities involved in safer sex decisions, the importance of setting boundaries to ensure safer sex and the integral nature of trust to safer sex behaviors and decisions. Participants also emphasized the importance of safer sex communication strategies and the content of communication to increase safer sex practices as well as intimacy and trust. Relationship negotiation was a particular communication strategy used in poly relationships to sustain successful relationships as well as to engage in safer sex conversations. These findings indicate a need to expand the standard dimensions regarding safer sex behaviors beyond the biological nature to include the psychosocial and emotional components to safer sex decisions.

Identifying Risk and Protective Factors

It has been well documented that risky sexual behaviors, like sex with multiple partners, contribute to the contraction of STIs. When trying to identify ways to reduce STI rates, it is essential to consider the risk and protective factors that may impact the likelihood of contracting an STI. Risk factors include unprotected sex, having sex with multiple individuals, having a partner who has sex with multiple partners, and sexual contact with someone who has an STI (The American College of Obstetricians and Gynecologists, 2017a; The American College of Obstetricians and Gynecologists, 2017b American Sexual Health Association, 2019; Mayo Clinic Staff, 2016). Additional risk factors include intimate partner violence, lack of knowledge of STIs, substance use, lack of awareness of a partner's status, or reluctance to engage in condom negotiations with a partner (Althoff, Grayson, Witt, Holden, Reid, & Kissinger, 2015; Baral, Poteat, Strömdahl, Wirtz, Guadamuz, & Beyrer, 2013). Cultural norms may disempower some people from having a condom use negotiation with a partner or getting tested (Althoff et al., 2015), as well as influence the number of partners and attitudes toward condom use (Zeglin, 2015).

Protective factors include getting vaccinated, using condoms, getting tested for STIs, being monogamous, limiting the number of sex partners, not abusing alcohol or drugs, and communicating with partners (The American College of Obstetricians and Gynecologists, 2017a; The American College of Obstetricians and Gynecologists, 2017b Mayo Clinic, 2016; Office of Women's Health, 2015). Cultural norms that facilitate protection include family influences (Crosby et al., 2002), mentorship relationships (Tevendale, Lightfoot, & Slocum, 2009), the modality of meeting potential partners

(Sevelius, 2009), and the probability of encountering a potential partner who is HIV positive (Forney, Miller, & The City Project Study Team, 2012). The CDC has included mutual monogamy as an important factor in protecting against STIs (Division of STD Prevention, 2016).

Safer Sex Communication

Safer sex communication is an umbrella term that covers a variety of exchanges between people on the topic of sex, including discussions and information exchanges on condom use, sexual history, STI history, desires, sexual preferences, and others (Cobb, 1997; Noar, Carlyle, & Cole, 2006). Much of the research on safer sex communication focuses on condom use because of the belief that the only protective communication is communication leading to condom use behavior (Troth & Peterson, 2000). Other concepts or variables that have investigated in safer sex communication research include the length of a relationship (Soler et al., 2000), intimacy (Dennis, 2006), and types of relationships (Buysse & Ickes, 1999; Holmberg & Blair, 2009; Troth & Peterson, 2000). This research has consistently demonstrated that engaging in safer sex communication leads to safer sex (Noar et al. 2006).

However, under certain circumstances, safer sex communication can lead to less safer sex (Crepaz & Marks, 2003; Kosenko, 2011; Lucchetti, 1999). When people engage in safer sex communication, there is the potential that one or both people are lying about something risky or are not disclosing all relevant information. In these instances, having had a safer sex talk might make people feel more comfortable engaging in unprotected sex. When the talk may have been incomplete, it potentially leads to risky unprotected

sex. Safer sex communication plays an essential yet complicated role in people having safer sex and therefore is important to research and safer sex interventions and education.

Research on Polyamory

Polyamory, sometimes shortened to poly, is defined most simply as many loves. More specifically, polyamory is defined as "consensual, openly conducted, multiple-partner relationships in which both men and women have negotiated access to additional partners outside of the traditional committed couple" (Sheff, 2010, p. 1). Polyamory is a subgroup of consensual non-monogamy (CNM) (Anapol, 2010). Non-monogamy is not behaving according to or not having monogamous relationships; this would include having multiple partners with or without the partners' knowing about each other. CNM is a form of non-monogamy where all the people involved in the relationships are aware of and consent to being in a relationship model where there are multiple partners (Anapol, 2010). Anderlini-D'Onofrio (2004) offered a historical contextualization of polyamory and explained that modern polyamory also differs from other types of non-monogamy because individuals who practice polyamory tend to be more aware of gender and sexual orientation, specifically with a focus on loving in inclusive, polyamorous ways.

According to Ravenscroft (2004), polyamorous relationships are founded on shared values of openness, honesty, and consent, and place high importance on communication. In effect, one of the core values of poly relationships is communication. Sheff (2016) has argued that communication is vital to set relationship boundaries, express expectations and limitations, discuss feelings, as well as connecting with people. According to Ravenscroft (2004), communicating about relationships is not always easy in poly settings, and there are differences between talking (noise that may or may not

possess meaning), communicating (expressing thoughts and emotions in an honest, loving, and non-attacking manner and having them received in a like manner), and discussion (a conversation that leaves one stimulated, a little tired, but with a sense of accomplishment). One communication strategy in poly relationships is relationship negotiation, where partners establish their wants, needs, and expectations and strive to reach mutual agreement on these (Sheff, 2016). Overall, polyamorous individuals report that communication between partners yields high levels of intimacy that may not be possible in other relationship styles (Sequin et al., 2017).

Significance of the Study

This research focused on polyamorous relationships to explore: the sexual risk profile of individuals who identify as polyamorous (actual and perceived risk); the narratives of safer sex experiences of individuals in polyamorous relationships; the role of safer sex communication in polyamorous relationships; and the relationship between safer sex communication and relationship negotiation among those in polyamorous relationships.

Even with over three decades of research on safer sex, there is an increased rate of STIs across people of various demographics (CDC, 2017). In order to address the health crisis, interventions are needed to reduce the rates of STIs. Research on STI interventions has focused on the risk and protective factors that people face and the safer sex behaviors people can engage in to protect themselves and their partners. The impact of those interventions is limited, however, as STI rates are increasing. Therefore, there is a need to explore ways to expand current safer sex research to inform interventions and education targeting safer sex practices. For example, a *New York Times* article from May 2019

highlighted that a large percentage of HIV-positive patients are women, but much of the research on HIV focuses on gay men (Mandavilli, 2019). Safer sex research may benefit from explorations into groups of people with different demographics, including age, relationship length, ethnicity, gender, identity, and sex subgroups. Examining these groups' attitudes and experiences with safer sex may offer new insights that can be used to build on the successes of previous research and interventions.

Research with individuals in polyamorous relationships offers an opportunity to push the boundaries of safer sex research for several reasons. First, there is limited research on polyamory in general and minimal research on safer sex in polyamory; hence, examining safer sex meanings and practices in people who identify as polyamorous presents a new path for exploring safer sex. Secondly, polyamorous partners present an opportunity to understand the complexities of safer sex in everyday lives because they arguably engage in both risky and protective behaviors that might impact the possibility of contracting STIs. The risk behaviors include engaging in sexual contact with multiple people at the same time (non-monogamy), and one protective factor is the emphasis that individuals in the polyamory subculture place on communication in relationships (including safer sex communication). Exploring their particular understandings and practices of safer sex may help identify areas of expansion for safer sex research in general.

Definition of Key Concepts

There are some key concepts that are discussed throughout this dissertation that have ambiguous meanings, are used inconsistently in the literature, or may overlap with

other concepts. For clarity and consistency, the definitions and explications of these concepts for the purpose of this research are presented in this section.

Sexually transmitted infection (STI) is often used in safer sex literature synonymously with sexually transmitted disease (STD), but they have different meanings. The American Sexual Health Association (2019) explained the difference between infection and disease in these terms: a sexually transmitted virus or bacteria can be described as creating an "infection" (no or few symptoms in the majority of persons infected), which may or may not result in a "disease" (defined as a clear medical problem with obvious symptoms). In this study, the term STI is used to be consistent with the current preferences of researchers and practitioners inclusive of the types of infections people may contract through sexual interactions.

Safer Sex is a term that has evolved from safe sex. Safer sex is conceptualized as protecting oneself and partners from STIs; this definition recognizes that most sexual contact carries some risk of infection (Planned Parenthood, 2019).

Safer sex communication is a concept that encompasses a variety of exchanges between people on the topic of sex, including discussions and information exchanges on condom use, sexual history, STI history, desires, sexual preferences, and others (Cobb, 1997; Noar et al., 2006). A dimension of safer sex communication is condom negotiation, which involves the exchange of information between partners and navigating partner responses to requests (Dako-Gyeke, 2013). Communication and negotiation are closely related concepts and sometimes are used interchangeably in the literature. This research adopts the conceptualization of safer sex communication set forth by Cobb (1997) and Noar et al. (2006) which places communication as an umbrella term for a variety of

communication strategies. Negotiation is under the communication umbrella and refers to communication that features a request and a compromise exchange between partners (Dako-Gyeke, 2013).

Relationship negotiation is a specific communication occurrence in poly relationships where people establish their personal wants, needs, and expectations in their romantic and sexual relationships (Sheff, 2016).

Consensual non-monogamy is defined as non-monogamy where all the people involved in the relationships are aware of, and consent to being in a relationship model where there are multiple partners and often involves three distinct styles: swinging, open relationships, and polyamory (Anapol, 2010).

Polyamory, a sexual subculture (such as a subculture of men who have sex with men, LGBT, non-monogamous, among others), is defined as a set of beliefs, values, and practices that lay outside heterosexual monogamy, which is the dominant relationship style in the US. Specifically, polyamory is defined as "consensual, openly conducted, multiple-partner relationships in which both men and women have negotiated access to additional partners outside of the traditional committed couple" (Sheff, 2010, p. 1). Polyamory is often shortened by insiders to "poly" in phrases such as "poly people" or "poly relationship," and this abbreviation will be used in this dissertation.

Chapter Outline

With the aim to understand potential influences in the increase of STI rates, the next chapter, Chapter 2, provides an overview of the literature on STI risk and protective factors, safer sex and safer sex communication, and polyamory. Chapter 2 will also provide the theoretical groundings for this study, specifically AIDS Risk Reduction

Model, as a framework to understand safer sex understandings and practices in individuals who identify as polyamorous. The second section of Chapter 2 provides an overview of the literature on the geographical and sociocultural conceptualizations of borders, discusses the literature on framing borders in the news, and addresses research on multimodality as an approach to the news research, and participatory journalism. Chapter 3 addresses the methodology applied to frame this study, specifically narrative inquiry, including research design and analytical strategies. Chapter 4 offers a nuanced analysis of the narratives given by participants focused on safer sex understandings and experiences, safer sex communication, and relationship negotiation. Chapter 5 summarizes the findings, situates the narratives from participants into the larger research discourse, and provides suggestions for future research.

Chapter 2

Literature Review

The first section of this chapter discusses the STI health crisis and the prevalence of STIs in the US. The risk and protective factors that influence safer sex are explored for what behaviors individuals should engage in to protect themselves when engaging in sexual activity. Next, safer sex communication, a protective factor, is investigated more in-depth. After reviewing the safer sex literature, then polyamory is contextualized for this research. This section closes with an explanation of the AIDS Risk Reduction Model, the theoretical framework for this research.

STI Health Crisis

In the United States (US), the rates of STIs are increasing at alarming rates (CDC, 2017). In addressing this health crisis, it is important to consider risk and protective factors that impact people's health behaviors and decisions to identify areas that may be useful for interventions. In this dissertation, I posit that perspectives on safer sex may be expanded when considering the safer sex practices and beliefs of people who identify as polyamorous. Individuals in polyamorous relationships constitute a unique population to examine safer sex practices because poly people engage in both risky (e.g., multiple partners) and protective factors (cultural value emphasis on communication) (Ravenscroft, 2004; Sheff, 2016).

Prevalence of the STI health crisis. The CDC produces annual reports that include surveillance information about STIs in the US. The CDC (2017) reported a 4.7% increase in chlamydia, an 18.5% increase in gonorrhea, and a 17.6% increase in syphilis from 2015 to 2016. The number of reported syphilis cases is growing after being largely

on the decline since 1941, and gonorrhea rates are now increasing (Abara, Hess, Fanfair, Bernstein, & Paz-Bailey, 2016; CDC, 2017). From 2010 through 2014, the annual number and the estimated rate of diagnoses of HIV infection, infections classified as stage 3, and death of persons with diagnosed HIV in the United States decreased (from 14.2 to 12.6, 8.9 to 6.1, and 10.1 to 8.6 respectively) (CDC, 2016). From examining different segments of the US population, it is evident that different ethnic groups, genders, and sexual cultures experience STI infections differently.

African Americans were consistently listed as having the highest rates of STIs. In 2016, the rate of all reported cases of gonorrhea was highest among African Americans (1125.9 cases per 100,000) and American Indian/Alaskan Natives (AIAN) (749.8 cases per 100,000) populations which is 5.6 and 3.8 respectively times the rate among whites (199.8 cases per 100,000) (CDC, 2017). The rates of primary and secondary syphilis were highest among African Americans (23.1 cases per 100,000 population) and Native Hawaiian/other Pacific Islanders (12.9 cases per 100,000 population) (CDC, 2017). African American and Latinx[1] heterosexuals are more likely to be HIV infected compared to White heterosexuals (Lansky et al., 2015). In 2015, the highest rate of HIV infection was 44.3 for African Americans, followed by 16.4 for Latinxs, 14.1 for Native Hawaiians/other Pacific Islanders, and 5.3 for Whites (CDC, 2016).

This situation becomes more complex when viewing the intersection of ethnicity and sexual culture. There was a significant increase in syphilis case rates among African

[1] Reflecting contemporary use among scholars, I use Latinx as a non-gendered term for Latinos and Latinas when referring to this ethnic group as a collective. This term challenges the history of colonization and other racial and sociocultural problems associated with the term Hispanic (Garcia, 2017).

American (8 times the increase in White) and White men who have sex with men (MSM), and between Hispanic (2.4 times the increase in White) and White MSM from 2005 to 2008 (Abrar et al., 2016). African American MSM represent the largest portion of people infected with HIV in the US (Herbst, Painter, Tonlinson, & Alvarez, 2014).

The reported chlamydia cases in women were twice as high as men in 2016 and both genders had increased rates (CDC, 2017). Gonorrhea rates had greater increases in men than women, but syphilis rates had greater increases in women than men (CDC, 2017). With regard to HIV infections, males accounted for 81% of all diagnoses with a rate of 24.4 compared to a rate of 5.4 for females in 2015 (CDC, 2016). Again, this situation becomes more complex when examining gender and sexual culture. For example, the increase in gonorrhea rates may be related to increased transmission and/or screening among MSM (CDC, 2017).

MSM are often a focus of STI research because unprotected anal sex is considered a high-risk sexual behavior compared to other sexual behaviors, this is also why MSM are considered to be more likely to engage in risky sexual behaviors. As described above, rates of some STIs increased in men, and these rates were primarily attributable to MSM (CDC, 2017). Additionally, there are comorbidities between some STIs and HIV, particularly among MSM (CDC, 2017), such as the co-occurrence between syphilis and HIV; rates of syphilis increased more in HIV-positive MSM compared to HIV-negative MSM, although both groups reported an increase (Abrar et al., 2016). On a positive note, the number of men, including MSM, diagnosed with HIV decreased from 2010-2014 and the rate of infection from male-to-male sexual contact remained stable (CDC, 2016). In 2015, the diagnosed infections attributed to male-to-

male sexual contact and heterosexual contact accounted for approximately 94% of diagnosed HIV infections in the United States (CDC, 2016).

The complexity that comes with the intersectionality of group membership can become even more complicated when looking at men who have sex with men only (MSM), men who have sex with men and women (MSMW), and men who have sex with women only (MSW). Friedman et al. (2014) conducted a meta-analysis to examine the idea that women in the US become infected by male partners that sleep with men. The reason for this is because MSMW potentially pose secondary HIV transmission risks and increase the breadth and density of socio-sexual networks, potentiating the spread of HIV across communities. The authors found, however, that there were no significant differences in STI rates between MSMW and MSM and MSW (Friedman et al., 2014).

Risk factors. Risk factors that people encounter are a critical component to consider when addressing a public health issue. Risk factors can involve individual decisions and behaviors that place a person at risk, which is the anecdotal view of risk factors most people think of when investigating STIs. However, risk factors include cultural/community components as well as health care policies/behaviors. Research on each of these areas that relate to different subgroups that are contracting STIs will be examined.

Among Latinas in the US, individual risk factors can include intimate partner violence, lack of knowledge of STIs, substance use, lack of awareness of a partner's status, or reluctance to engage in condom negotiations with a partner (Althoff et al., 2015). A similar lack of knowledge of STIs, including knowing their status, can be found in other groups like transgender women (Baral et al., 2013) or MSM (Friedman et al.,

2014). An additional individual risk factor is the type of sexual activity that a person chooses to engage in. For example, people that have unprotected receptive anal sex are at a higher risk than protective anal sex or vaginal sex (Baral et al., 2013; Friedman et al., 2014). Other individual-level risks for transgender women include high rates of depression and contraction through illicit hormone and silicone injections (Baral et al., 2013). In MSM, being a "top" (the person who is penetrating the other partner) is a protective factor from contracting HIV (Zeglin, 2015).

Beyond individual factors, different cultural and group norms can increase a person's risk of contracting an STI. Among Latinas, cultural norms may disempower them to engage in condom use negotiation with a male partner or to get tested (Althoff et al., 2015). In communities with a higher prevalence of HIV, network-level risks put members of the network at greater risk (Baral et al., 2013). Transgender women's experiences with targeted physical and social violence might influence their likelihood of contracting HIV (Baral et al., 2013). Additionally, transgender women often engage in substance use behaviors and sex work that results in stigma and discrimination, which places them at higher risk (Baral et al., 2013). Episodic substance use and polysubstance use is common among MSM, due to effects like increasing libido, sexual confidence, among others, but this cultural norm situates people at increased risk of STI infection due to impaired judgment (Knight et al., 2014). Additional masculinity norms impact community level risk factors for MSM, including number of partners, attitudes towards condoms, condom decision-making, attitudes towards testing, and treatment compliance (Zeglin, 2015).

As indicated above, people are placed at increased risk of contracting STIs because of systemic risk factors. These factors can include social exclusion, economic marginalization, limited access to healthcare, stigma, social discrimination, and discrimination in health-care settings (Althoff et al., 2015; Baral et al., 2013; Friedman et al., 2014; Herbst et al., 2014; Zeglin, 2015). For example, few healthcare workers have received training on addressing the needs of transgender women, which leads to limited access to testing and treatment (Baral et al., 2013). Similarly, differential treatment at a clinic may inform why men report lower cases of chlamydia as women are more likely to be tested (CDC, 2017).

Protective factors. In order to develop interventions with the goal of reducing STIs, it is important to consider not only what behaviors people should not engage in, but also what behaviors they should engage in. Behaviors that reduce the risk of contracting an STI are called protective factors. Protective factors include getting vaccinated, using condoms, getting tested for STIs, being monogamous, limiting number of sex partners, not abusing alcohol or drugs, and communication (The American College of Obstetricians and Gynecologists, 2017a; The American College of Obstetricians and Gynecologists, 2017b; Mayo Clinic Staff, 2016; Office of Women's Health, 2015).

In a study of homeless youth and risky sexual behavior, Tevendale et al. (2009) found that positive expectations for the future significantly predicted fewer sex partners for both males and females; that goal setting and decision making skills predicted a higher percentage of condom use in males, and; that global self-esteem is a protective factor for risky sexual behavior for females. In developing a preventative intervention for Mexican youths, Pick, Givaudan, Sirkin, and Ortega (2007) emphasized the importance

of communication as a protective factor and parent-child communication as an effective means of encouraging adolescents to adopt responsible sexual behaviors. Communication is a protective factor that reduces the risk of contracting STIs by increasing condom use, but it also correlates with closer and more intimate sexual relationships (Cobb, 1997; Sevelius, 2009).

Different cultural and group norms need to be considered in determining protective factors. Forney et al. (2012) investigated factors that influence risky sexual behavior in HIV-positive and negative MSM and found that this population had unique needs such as the practical realities of serosorting, the practice of choosing sexual partners based on their HIV status, in a population where there was a mix of HIV-positive and HIV-negative men, as well as the susceptibility of this group to peer social norms. Trans men have been found to have a cultural norm of meeting and negotiating with potential partners online that provides a protective component to their sexual relationships (Sevelius, 2009). Additional cultural and group level protective factors included: family influences and mother-daughter relationships (Crosby et al., 2001), and mentorship relationships (Tevendale et al., 2009).

In sum, almost entirely across the board, there have been increased rates of STIs while increases are occurring across groups, some groups are experiencing greater rate increases than others. Additionally, these subgroups experience different individual, cultural, and systemic risk and protective factors that impact their likelihood of contracting STIs. Consequently, it is important to examine the interventions addressing this public health issue to identify potential ways to intervene in different sexual subgroups.

Interventions. Researchers designing interventions to increase safer sex behaviors approach the issue from many sides. Interventions include activities targeting female sex workers (Abad et al., 2015), partner notification and services (Hogben, Collins, Hoots, & O'Connor, 2016; Meites et al., 2015), post-exposure prophylaxis (CDC, 2016; Seidman et al., 2016), partner communication about safer sex (Luft & Larson, 2017), condom distribution (Malekinejad et al., 2017), linking patients to care (Norton, 2012), theater-based interventions (Taboada et al., 2016), as well as risk reduction and health education interventions (Collins & Sapiano, 2016; Forbes, 2011).

Some of these interventions have targeted high-risk populations. For example, interventions targeting female sex workers included HIV prevention information, access to HIV services, substance abuse prevention information, and skills-building techniques (Abad et al., 2015). Abad et al. (2015) determined in a systematic review that of the interventions analyzed, few rigorously implemented or evaluated the effects of the interventions. Other interventions focus on people infected with STIs, such as the identification, location, and notification of sex partners (and drug-using partners for HIV and some hepatitis infections) of infected persons, and the referral of those partners to evaluation, treatment, and care (Hogben et al., 2016). Through a systematic review, Hogben et al. (2016) found that effectiveness of interventions were mixed, for example, there was support for interactive therapy, but not for purely didactic instruction. Another example is offering post-exposure prophylaxis to people at increased risk of contracting HIV due to exposure like having condomless sex with someone infected with an STI (CDC, 2016; Seidman et al., 2016).

While many interventions have demonstrated some level of success, some researchers have pointed out that many have low-quality evidence to support them (Abad et al., 2015; Hogben et al., 2016). A systematic review of condom distribution found that community-based interventions in the US may reduce risky sexual behaviors such as condomless sex and multiple sexual partnerships, but the quality of evidence was very low (Malekinejad et al., 2017). Similarly, Abad et al. (2015) found that few rigorously implemented or evaluated HIV/STI behavioral prevention interventions exist that address the needs of female sex workers in the US.

In examining partner services to prevent or stop the spread of STIS, Hogben et al. (2016) stated that conclusions are limited because of missing unpublished data, research not using equivalent standards and practices, and that research focused on intervention efficacy with limited information on implementation and translation. Similar issues were discussed in a review of theater interventions to prevent HIV, where evidence supporting the efficacy of this style of interventions is limited and there is a need for interventions to be grounded in a specific theatrical approach as well as research and evaluation approaches to improve replicability and ability to assess whether change is occurring (Taboada et al., 2016). Factors that influence the quality of evidence of safer sex communication practices of Latina women include inadequate reporting of the relationship between the researcher and the participants, data analysis methods, and inadequate description and reporting of psychometrics, particularly the validity, of the exposure and outcome measures (Luft & Larson, 2017). These issues indicate a strong need to improve evaluation techniques for safer sex interventions.

Other than MSM and female sex workers, no other sexual subgroups have been discussed in the intervention literature examined. This indicates a strong need for research that implements and evaluates interventions in other subgroups, as these are unique groups that are likely experiencing increases in STI rates, as discussed above. For practitioners and researchers interested in addressing STI infections in these groups, recommendations for successful interventions like funding, content, implementation, and evaluation issues have been made by previous researchers (Chinman, Acosta, Ebener, Malone, & Slaughter, 2016; Collins & Sapiano, 2016; Forbes, 2011). Drawing on a project implementing an HIV prevention program for US women and girls, Forbes (2011) made several recommendations for intervening in sexual subgroups: develop a clearer understanding of how to shape appropriate interventions for sexual subgroup populations; invest in targeted and culturally competent outreach to build trust and increase uptake of HIV prevention and treatment services among people in minority populations; address related issues like housing, substance use, partner violence, among others. These interventions may also be strengthened through increasing the capacity of interventionists to run programs successfully, such as goal setting, planning, process and outcome evaluation, and using data to improve and sustain programs (Chinman et al., 2016).

Safer Sex Communication

Safer sex is conceptualized as protecting oneself and partners from STIs (Planned Parenthood, 2019). A primary focus of safer sex research and prevention is on using condoms during sexual interactions. Researchers have also conceptualized safer sex to include concepts like “know your partner” where a person asks someone they are considering sleeping with questions about their sexual past (Crosby, et al., 2002;

Lucchetti, 1999). Lucchetti (1999) noted how some people do not know that disclosing sexual histories would be a way to engage in safer sex. Rather than asking about sexual pasts, another way to consider safer sex is to ask a potential partner about STI testing results or HIV status (Kosenko, 2011; Lear, 1995). Researchers are also examining the intention of individuals to engage in safer sex (e.g., wear condoms during sexual acts; Noar et al., 2006) and self-efficacy (both in terms of condom use as well as communication) (French & Holland, 2013).

Safer sex communication is a term that encompasses a variety of exchanges between people on the topic of sex, including discussions and information exchanges on condom use, sexual history, STI history, desires, sexual preferences, and others (Cobb, 1997; Noar et al., 2006). Much of the research on safer sex communication focuses on condom use because of the belief that the only protective communication is communication leading to condom use behavior (Troth & Peterson, 2000). Other concepts or situations that have been used in safer sex communication research include length of relationship (Soler et al., 2000), intimacy (Dennis, 2006), and types of relationships (Buysse, & Ickes, 1999; Holmberg, & Blair, 2009; Troth, & Peterson, 2000). Sprecher, Harris, & Meyers (2008) examined who people communicate about sex with and found that peers are the most common group. Other than peers, mothers, more so than fathers, were also a resource for individuals to communicate to about sex (Sprecher et al., 2008).

Engaging in safer sex communication can be difficult because of the sensitive and potentially self-conscious nature of the communication situation. Dako-Gyeke (2013) studied the strategies that women used to get men to wear condoms, and found that they

ranged from withholding sex, discussing menstruation, fearing unintended pregnancy, and found that these had different levels of effectiveness. Reynolds-Tylus, Rinaldi-Miles, and Quick (2015) and Rinaldi-Miles, Quick, and LaVoie (2014) used the principles of influence and examined how these principles played out in safer sex communication. They discovered that different principles are used in different situations (e.g. casual versus committed relationship) and that some principles were used more than others.

Other researchers have analyzed the styles of communication when people address safer sex with their partners. For example, Lam, Mak, Lindsay, & Russell (2004) classified safer sex communication into direct/verbal communication (telling a partner to wear a condom), indirect/verbal communication (discussing the fear of an unwanted pregnancy), direct/non-verbal communication (putting on a condom) or indirect/non-verbal (having condoms out in a visible place). A similar categorization of communication styles has been developed in research with men who have sex with men (MSM). Crepaz and Marks (2003) examined serostatus (whether a person is HIV positive or negative) disclosure and safer sex communication using the following categories of communication: disclose and communicate, disclose and no communication, no disclose and communicate, and no disclose and no communication. Both Lam et al. (2004) and Crepaz and Marks (2003) found that engaging in safer sex communication was related to more condom use.

A particular area of interest in the study of safer sex communication is safer sex negotiation, which involves the exchange of information between partners and navigating partner responses to requests (Dako-Gyeke, 2013). In a study that explored cultural norms and safer sex talk, researchers found that safer sex negotiations are impacted by

gendered behaviors where men are dominant, and women are passive, and both exert pressure on the negotiation process (Dako-Gyeke, 2013). Safer sex negotiation may also involve persuasion or convincing a partner to wear a condom (Reynolds-Tylus et al., 2015; Rinaldi-Miles et al., 2014). The safer sex negotiations that occur between partners depend on the relationship status, casual or committed, where there is limited planning and opportunity for negotiations in casual relationships and therefore casual relationships may be more likely to be sexually risky (Reynolds-Tylus et al., 2015).

Counterpoint. Several researchers have noted that the conceptualization of safer sex and safer sex communication, as described above, is missing much nuances related to how people actually live sex. The missing concepts are passion (Kyle, 1990), love (Rosenthal, Gifford, & Moore, 1998), and romance (Warr, 2001). In an essay published in the Journal of Sex Research, Kyle (1990) observed that there used to be a place in society for spontaneous emotional sexual interactions, but that the AIDS epidemic and the Reagan administration's culture wars have turned passion into the same type of behavior as smoking, alcohol use, or drug use. He argued that the fact that passion is losing a place in society has negative consequences like passionless relationships, which are a new type of relationship that places work and social status over passion and emotional intimacy.

Concepts of love and romance are similarly at odds the current approaches to safer sex promotion. Warr (2001) highlighted the role of women in relationships and sexual interactions. She explained that women are socialized to be responsible for preserving the relationship and that too many women, sex is a means to intense emotions and intimacy. Along these lines, Rosenthal et al. (1998) discussed how for many

individuals, the meaning of love is associated with stable, monogamous relationships and how the concept of condom use is not consistent with love as monogamy. Suggesting condom use can be perceived as challenging the stable and monogamous status of the relationship.

These variables of the emotional aspects of sexual relationships, like passion, love, and romance, challenge safer sex researchers and practitioners to problematize the "ideal" safer sex conceptualization and explore how these emotions complicate the reality of safer sex interactions and thus impact people's health decisions and safer sex behaviors. Furthermore, the need to consider these affective factors also suggests the value of qualitative, narrative approaches to people's sexual experiences.

Communication leads to condom use. As discussed in the protective factors section, communication is a safer sex practice. Noar et al. (2006) conducted a meta-analysis that specifically examined the relationship between communication and condom use. In the meta-analysis, the authors found a consistent relationship between engaging in safer sex communication leading to safer sex. The relationship between communication and condom use had an effect size of .22. which is a small magnitude relationship. Even though the effect size was relatively small, Noar et al. (2006) referenced two other meta-analyses that found a relationship between communication and condom use, so this is a consistent finding. Direct communication is more effective than indirect when wanting a partner to wear a condom (Lam et al., 2004; Tschann, Flores, de Groat, Deardorff, & Wibbelsman, 2010). Also, any amount of communication is better than no communication when trying to have safer sex with the use of condoms (Reel & Thompson, 2004). The most effective way to communicate safer sex is through

consistent, stable, direct requests (Hall, 2016). While the research supports the idea that having safer sex communication leads to condom use, Noar et al. (2006) discusses that the studies in the meta-analysis all conceptualized and or measured safer sex differently, which means that it is important for future research to define the concepts and measure those concepts consistently and accurately to be able to examine the effects safer sex communication. Lastly, in some instances, safer sex communication can lead to less safer sex (Crepaz, & Marks, 2003; Kosenko, 2011; Lucchetti, 1999). When people engage in safer sex communication, there is the potential that one or both people are lying about something risky or are not disclosing all relevant information. In these instances, having had discussed safer sex might make people feel more comfortable engaging in unprotected sex, but, potentially that discussion was incomplete and therefore can lead to risky unprotected sex.

Differences between groups in safer sex communication. There are differences in how people engage in safer sex communication, depending on the ethnicity of the person, which means that safer sex interventions should be developed in culturally conscious ways. For example, Tschann et al. (2010) found that Latinas are not comfortable discussing sex or condom use, which means that interventionists in those communities need to tailor safer sex trainings to include that cultural norm. Crosby et al. (2002) found that African Americans who did not consistently participate in condom use negotiations were also not consistently having safer sex. Soler et al. (2000) found that African American women were the most comfortable compared to other ethnicities discussing safer sex. Synthesizing these findings mean that interventions for Latinas should consider comfort or other barriers to engaging in these conversations, while in

African American communities, they already have a strong comfort level, but are doing so inconsistently, so interventions should endeavor to increase consistency of safer sex conversations. Lam et al. (2004) found that Asian Americans reported engaging in indirect communication styles in safer sex communications rather than direct as opposed to White Americans who reported more direct styles of communication. Tschann et al. (2010) also found that Latinas tend to communicate about safer sex through indirect styles. Interventions in Asian and Latinx communities should be examining communication styles and ways to increase effectiveness (meaning more condom use) using these indirect styles of communication.

Several researchers examined the way men and women engage in safer sex communication differently and with different outcomes (Allen, 2003; Bowleg, Lucas, & Tschann, 2004; Carter, McNair, Corbin, & Williams, 1999; Dako-Gyeke, 2013; Pulerwitz, Amaro, De Jong, Gortmaker, & Rudd, 2002; Soler et al., 2000; Tschann et al., 2010). Some of the salient points from this research are as follows: women are expected to maintain relationships (Allen, 2003); men are allowed to be unfaithful and to enjoy sex just for the pleasure of it (Bowleg et al., 2004); and while women take a role in negotiating condom use, men have the ultimate control over wearing a condom because they have to do the physical act of wearing it (Tschann et al., 2010). Another important aspect discussed in safer sex communication differences based on gender was issues of power (Allen, 2003; Pulerwitz et al., 2002). These articles explained how in heterosexual relationships, there is an unequal power dynamic that places women lower in the hierarchy. This power status tied with societal expectations - such as the idea that women are the ones that need to maintain the relationship - means that safer sex communications

are inherently different for the man and woman engaging in that conversation. Additionally, Warr (2001) discussed how women view sex as a means to demonstrate and feel intimacy and love and, therefore, experience sex differently than men. Safer sex interventionists should consider societal expectations, power structures, and the potential that men and women ascribe meaning to sex differently. These are key factors when trying to get people to engage in safer sex and in determining whether messaging regarding safer sex communication may be at odds with these gendered realities.

While it is important to understand the unique experiences of various sexual subgroups regarding risk and protective factors (as discussed above), it is also imperative to understand the unique experiences of safer sex communication in sexual subgroups. Konsenko (2011) demonstrated that safer sex communication should not be considered as a stand-alone interaction. He explained that people who are transgender see sex as a way to feel love and intimacy and, as a stigmatized population, there are limited ways for them to feel love and intimacy. Additionally, transgender individuals experience a unique risk related to additional disclosures made outside of safer sex conversations that may out them as transgender to others. As such, the decisions about what is included in safer sex conversations and at what point these conversations happen are more complex because the risks of those conversations are not limited to less safer sex, but could have potential risks ripple through other parts of life, including violence. Konsenko (2011) described how transgender people handle these challenges using three strategies. First, they disclose early to prevent "surprises;" second, they do disclose but instead using non-verbal observations to determine that someone is a safe partner (e.g. how they interact with the

trans community); or third, in the case of transgender sex workers, using condoms at work, but not at home to demonstrate the intimacy of the act with the chosen partner.

MSM also have complexities when it comes to communicating about safer sex. Suarez and Miller (2001) discussed four groups of MSM with different risks. One group involves partners that match regarding serostatus, meaning that either both men are HIV positive or both are negative. With this information, which requires conversations and disclosures, they are able to engage in lower risk unprotected sex because they know that status of their partners. Another group, which Suarez and Miller (2001) considered to be a low risk group, is men who use condoms regardless of whether a partner discloses STI/HIV status or they have disclosed and are positive. The third group, the high-risk group, engages in unprotected sex regardless of whether a partner discloses STI/HIV status or does disclose as being HIV positive. Suarez and Miller (2001) explained that there are instances of misinformation informing this group, meaning they may need more health information; while at the same time, some men report a fatalistic attitude in the belief that if they are going to get infected, then it was meant to be. The fatalistic person may know the activity is risky but may not feel the need or the power to protect himself. Interventionists need to approach both of those perspectives differently to create change effectively. The fourth group that Suarez and Miller (2001) described are young MSM, which includes men that were not around during the worst years of the AIDS epidemic, have seen the recent medical advances regarding HIV and, therefore, think that contracting AIDS is not a big deal. This group also includes young men that are under the perception that having gay sex means that one will eventually become infected with HIV; therefore they are going to be active and have control over being infected and specifically

choose the person that will give them HIV (Suarez & Miller, 2001). In sum, these authors described the variety of complex realities that influence safer sex conversations and behaviors - including misinformation, the societal stereotypes that negatively influence people's health choices, and how any safer sex communication could involve different perspectives that are complicated to navigate.

Safer sex communication and trust. An important consideration in sexual relationships is trust between partners. Goldenberg, Finneran, Andes, and Stephenson (2015) described trust in intimate relationships as a dynamic concept: trust is built over time and trust as simply being there (or not). Additionally, trust can be equated with the belief that partners would never intentionally do anything to harm their partners, such as transmitting an STI or HIV (Goldenberg et al., 2015). Trusting a partner has many meanings, for example: trusting a partner to not have sex outside the relationship (Duncan, Prestage, & Grierson, 2015; Hillier, Harrison, & Warr, 1998), growing intimacy (Bowleg, Heckert, Brown, & Massie, 2015), and defining the meaning of sexual involvements (Flood, 2003). Some people interpret trusting a partner to mean that they are having safer sex (Hillier et al., 1998), which may make them engage in less safe behaviors like stopping condom use (Flood, 2003) or rejecting health messages about the need for safer sex behavior (Bourne & Robson, 2009; Pilkington, Kern, & Indest, 1994). The interplay between safer sex communication and trust is complicated in that when people trust their intimate partner, they report less embarrassment discussing and using condoms (Pilkington et al., 1994), but they also feel that engaging in safer sex communication (like sexual history or asking for condom use) is a breach of trust and

could damage an intimate relationship (Gavin, 2000; Madiba & Ngwenya, 2017; Reddy, 2004).

Polyamory

Individuals in polyamorous relationships constitute a unique population to examine safer sex practices because poly people engage in both risky (e.g., multiple partners) and protective factors (cultural value emphasis on communication) (Ravenscroft, 2004; Sheff, 2016). This section contextualizes polyamory, including the relationship between polyamory and other relationship models.

Monogamy. Polyamory is considered a way to counter monogamy, so before discussing polyamory, it is important to discuss monogamy. Monogamy has been traditionally defined as sexually exclusive, pair-bonding romantic relationships (Ferrer, 2018). Additional variations on the definition of monogamy include mutual monogamy, serial monogamy, and compulsory monogamy. Mutual monogamy means that a person agrees to be sexually active with only one person, who has agreed to be sexually active only with that person as well (Conley et al., 2015; Conley, Matsick, Moors, & Ziegler, 2017). Serial monogamy is when a person goes from one monogamous relationship to the next, meaning "monogamy" that a person will be having sexual contact with only one person at a time not for their lifetime (Conley et al., 2015, Swan & Thompson, 2016). The practice of serial monogamy is a far more common sexual trajectory for an individual than consensual non-monogamy or lifetime mutual monogamy (Conley et al., 2015). Compulsory monogamy is the deeply normalized status of coupling, especially for women (Willey, 2015).

Monogamy places unequal expectations on women and men, often with the purpose of enforcing paternalistic power structures in society (Willey, 2015). Additionally, the concept of a "couple" is a cornerstone of the legal system and contemporary culture in the United States (Willey, 2015). In society, the terms significant, serious, and monogamous are often thought to be synonymous and the importance of a relationship is primarily based on its exclusivity (Kean, 2017). Monogamy and non-monogamy are often considered as binary opposites, but this is a false structure that maintains the social institution of monogamy (Ferrer, 2018) and patriarchy (Willey, 2015). Additionally, these societal norms can become biases that researchers and practitioners subconsciously force others to adhere to (Kean, 2017). Because compulsory monogamy is normalized in US society, it is rarely questioned (Willey, 2015).

The CDC has listed mutual monogamy as an important factor in protecting against STIs (Division of STD Prevention, 2016). The majority of sexual risk reduction campaigns for adults have focused on three facets: (a) use a latex condom, (b) reduce the number of sexual partners, and (c) have sexual intercourse only in monogamous relationships (Swan & Thompson, 2016). Due to unclear definitions of monogamy (Conley et al., 2015), the complication of behavior, emotion, and meaning attached to the concept of monogamy (Kean, 2017), and the interconnectedness of monogamy as a personal behavior as well as a social behavior (Swan & Thompson, 2016), more research is necessary to understand the practical reality of monogamy and broader considerations for the relationship styles on safer sex that purposefully challenge social norms and biases.

Consensual non-monogamy. Polyamory is a subgroup of consensual non-monogamous practices (Anapol, 2010). Non-monogamy is not behaving according to or not having monogamous relationships; this would include multiple partners with or without the partners knowing about each other. Consensual non-monogamy (CNM) is non-monogamy, where all the people involved in the relationships are aware of and consent to being in a relationship model where there are multiple partners (Anapol, 2010). CNM is generally associated with three practices: swinging, open relationships, and polyamory. Swinging typically involves a married heterosexual couple has sex with another person or people and is usually limited to sexual interactions. Open relationships are similar to swinging in that it is usually limited to sexual interactions. However, the difference is that instead of the couple being involved, one partner or the other keeps separate partners outside the marriage or relationship. Polyamory is different from both of these in that multiple people are involved in intimate relationships with each other, and the intimacy is not limited to sex interactions. Poly people engage in and accept a variety of relationship constellations (Klesse, 2006). Polyamorous relationships typically involve foundational values like transparency, communication, consent, sexual intimacy, and emotional intimacy (Anapol, 2010; Klesse, 2006; Pitagora, 2016). In addition to relationship styles, there are other experiences of sexuality that relate to CNM; for example, kink communities or BDSM[2] communities intersect with CNM communities and share cultural values such as transparency, communication, consent (Pitagora, 2016).

[2] BDSM is label for a variety of sexual subcultures including bondage and discipline, dominance and submission, sadism and masochism, as well as cross-dressers, fetishists, and other.

Monogamy vs. polyamory. Several researchers have approached polyamory through the comparison to monogamy. These authors have identified the benefits of both styles of relationship (Moors, Matsick, & Schechinger, 2017), psychological well-being and relationship quality (Rubel & Bogaert, 2015; Seguin et al., 2017), and popular assumptions about both types of relationships (Conley, Ziegler, Moors, Matsick, & Valentine, 2013). When asked about their perceptions regarding the quality of monogamous versus CNM relationships, participants expected that people in monogamous relationships were happier, more satisfied, and better people than people in CNM relationships, but each study found no difference between groups and, in some instances, it even found that CNM reported better outcomes compared to monogamy (Conley et al., 2013; Moors et al., 2017; Rubel & Bogaert, 2015; Seguin et al., 2017). Moors et al. (2017) expected that people in monogamous relationships would report more fulfilled relationships, but the analysis found that people in both types of relationships reported high levels of fulfillment. A similar pattern was found in Rubel's and Bogaert's (2015) project, where participants indicated that they expected people in CNM relationships to be psychologically deviant and CNM relationships to be poorer quality. Rubel and Bogaert (2015) found that people in both types of relationships reported being in the normal range on the Minnesota Multiphasic Personality Inventory, indicating no deviance, and no difference in relationship quality, with people in both styles of relationships reporting high satisfaction. Sequin et al. (2017) found a similar pattern, but, in addition, they found that people in CNM relationships reported more trust, intimacy, and satisfaction with their partners compared to people in monogamous relationships.

Contextualizing polyamory. Polyamory is defined most simply as many loves. Specifically, polyamory is defined as "consensual, openly conducted, multiple-partner relationships in which both men and women have negotiated access to additional partners outside of the traditional committed couple" (Sheff, 2010, p. 1). This term first began to appear in the early 1990s (Sheff, 2010). The choice to emphasize the word "amorous" or love is deliberate as people in polyamorous relationships may or may not have a sexual component; rather, polyamorous relationships are defined as a level of intimacy, and the boundaries of that intimacy are negotiated between those in the relationship (Ravenscroft, 2004).

Anderlini-D'Onofrio (2004) offered a historical contextualization of polyamory and explained that modern polyamory differs from other types of non-monogamy because individuals who practice polyamory tend to be more aware of gender and sexual orientation, specifically with a focus on loving in inclusive, polyamorous ways. Based on a fifteen-year ethnographic study, Sheff (2010) identified another distinct value in polyamory, that women are allowed multiple partners and individuals who identify as polyamorous place emphasis on gender equality (Sheff, 2010).

When people indicate that they are polyamorous, they often work from different definitions or understandings of the term. Klesse (2006; 2014) discussed ways in which the term polyamory is contested. For instance, people who identify as polyamorous may use the word to describe behaviors that they engage in, a sense of identity - even if they do not have multiple partners or a sexual orientation. Many poly people differentiate polyamory from other types of CNM by emphasizing love over sex, however, Klesse (2006) cautioned against that differentiation because it ignores some behaviors (like

spontaneous sexual encounters) and can exclude people who are not in these relations primarily for emotional reasons. Klesse (2014) also warned against considering polyamory as a sexual orientation for several reasons. Although there are potential legal benefits of considering poly a sexual orientation, like protections against discrimination in the workplace, conceptualizing poly as an orientation leaves it vulnerable to essentialist thinking and being coopted by normative beliefs and hegemonic forces (Klesse, 2014).

Poly relationships. Polyamorous relationships take on a myriad of combinations and connections between people. For example, a committed couple may have one or both partners involved with other people outside of the couple. These other people may or may not be involved with the other half of the couple. It may not be a couple at all but may be a group of three or more people that are committed to the group only and are not involved with people outside of the group. Someone may be involved in a group but also involved with people outside of the group. Someone may be currently in a monogamous relationship and wanting to engage in a poly relationship or someone may be in poly relationships and wanting to become monogamous. Someone may currently be single and still identify as poly. Thus, there are infinite combinations and connections that fit under the umbrella of poly relationships. Polyamorous relationships are distinctly separate from other non-monogamous relationships that people might be familiar with, like polygamy or polygyny, because central to polyamory is the idea of flexibility to have the types and combinations of relationships that people need/want (Ravenscroft, 2004).

Within this subculture, there are common terms for some of the various relationship combinations that are seen in poly relationships. For instance, a dyad is a

relationship unit that consists of two people, a triad consists of three people, a quad has four people, often two couples, and a moresome consists of five or more people. A vee is a relationship where there is a core couple and one of them has a lover, but the lover and the other member of the core couple aren't intimate themselves.

Terminology and word choice are important because words have meaning and when navigating the unique contexts of polyamory, the words that are used convey important ideas. Similarly, choosing not to use certain words is also important. Ravenscroft (2004), for example, recommended that people who are considering polyamory cut the words *faithful*, *loyal*, *fidelity*, and *fooling around* from their vocabularies. While these words are often used when discussing relationships, in poly contexts, they enforce binary and hegemonic perspectives of relationship. However, Ritchie and Barker (2006) argued the reality that language does not exist that accurately expresses the experience, identity, relationships, and emotions experienced in polyamory. Because of this, poly communities have developed some of their own language, like *metamour*, *wibble*, *compersion*, and *frubbly*. Metamour is a married partner's partner. Wibble is an emotion word indicating insecurity, it is similar to the concept of jealous, but is more accurate for the poly community. Compersion and frubbly are also emotion words that mean the pleasure that someone feels when someone they love is loved by other people.

A few researchers have examined the differences between primary and secondary relationships within polyamory. Balzarini et al. (2017) examined relationship and sexual satisfaction in primary and secondary relationships and found that people reported higher levels of satisfaction in primary relationships in all areas, except for sex. Sexual

satisfaction was higher in the secondary relationship compared to primary relationship. The authors noted that this could indicate that primary relationships can benefit from secondary relationships, and that people aren't necessarily looking for a secondary relationship because the primary relationship is lacking.

Mitchell, Bartholomew, and Cobb (2014) investigated primary and secondary relationships through the idea of need fulfillment. They used three potential models: an additive model (having more partners just adds to existing experience), a contrast model (one partner is compared to the other, with one being selected as better), and a compensation model (the things lacking in one partner are made-up for by another partner). Mitchell et al. (2014) found that there was no support for the additive or compensation models and that there was some small evidence for a contrast model, which lead to more reported dissatisfaction with relationships. Overall, the authors found that primary and secondary partners were rated highly on the need fulfillment scales, which they interpret to mean that primary and secondary relationships tend to function independently from each other. These studies support the notion that relationships and sexuality with multiple people can be healthy and normal experiences. They challenge the idea that non-monogamous relations are inherently the result of individuals trying to find an alternative to a detrimental relationship.

Communication and polyamory. Communication is a central value to poly individuals and in poly relations, especially in establishing relationship boundaries, expressing expectations and limitations, discussing feelings, and connecting with people (Sheff, 2016). Polyamory is a unique community without established norms, people decide for themselves what poly means and how they will participate in polyamorous

relationships; consequently, communication is key. Communicating about relationships is not always easy in poly settings. Ravenscroft (2004) discussed some of the nuances of communication in poly relationships, specifically that there are differences between talking, communicating, and discussing:

> You can't get anywhere unless you start out by having both the ability and the willingness to talk – and I mean talk freely and constantly and spontaneously and with great emotion and no fear of being made to look or feel stupid. (p. 243)

In this passage, Ravenscroft (2004) articulated the ultimate goal in communicating when in poly relationships. While communicating in this way may seem more difficult, it can also yield high levels of intimacy that may not be possible in other relationships, as Block (2009) stated:

> we communicate in ways I never dreamed of, staying up late at night talking about the nature of monogamy, of sexuality, of marriage, and of life in general. I suppose open marriage works for us for precisely that reason: because we talk about it, because it has opened us up to each other. (p. 7)

Block (2009) explained that after she and her husband decided to become polyamorous, they began to communicate in ways that had not happened in their marriage prior to polyamory. Taking the time to communicate at this level can yield benefits such as increase intimacy with partners.

Safer sex and polyamory. Safer sex literature often situates monogamy as the safest relationship style when it comes to STI transmission. Munson (1999) challenged this by giving some examples and explaining that if a person has sex with one other person, but that person is HIV positive, they were at risk of contracting HIV 100 times,

even though it is only one partner that they had sex with. Munson compared that someone sleeping once with each of 100 people, and even though it would be risky, statistically they were at risk of contracting HIV a few times. Additionally, Munson (1999) challenged the assumption of monogamy as being overly focused on penis-vaginal and penis-anal sex, making it very male-centered, even though there are many ways beyond that to engage in sexual activity.

Focusing specifically on safer sex behaviors, Lehmiller (2015) examined behaviors like condom use, STI testing, and cheating behaviors and found that people who considered themselves as CNM reported safer behaviors than people that considered themselves monogamous, and found that there was no difference in self-reported instances of STI infections, even though people conceptualize CNM as riskier. Southern (2017) contextualized CNM and sexual health more broadly than just the transmission of STIs. He explained that CNM styles of relationships and sex are often pathologized by clinical psychologists/psychiatrists and the DSM specifically because they don't adhere to the normative socially preferred relationship style of monogamy. Southern (2017) argued that definitions and considerations for sexual health should be expanded to include considerations for autonomy, respect, and choice; ultimately, sexuality should be viewed as a human right.

AIDS Risk Reduction Model

The AIDS Risk Reduction Model (ARRM) is a theory that identifies important areas that influence behavior that will ultimately lead to a reduction is high-risk sexual behaviors with the goal to prevent the transmission of HIV (Catania, Kegeles, & Coates, 1990; Catania, Coates, & Kegeles, 1994). It was designed to provide a framework to

explain and predict decision-making for safer sex behavior. The ARRM integrates components from other health behaviors change models, like the Health Belief Model, to conceptualize this decision making process (Catania et al., 1990). The ARRM identifies three stages: Labeling, Commitment to Change, and Taking Action (See Table 1). Each stage features psychosocial components that influence an individual's ability to achieve the goal of each stage. Catania et al. (1990) clarified that the label *stage* does not mean that progression through the stages is invariant, unidirectional, and irreversible. Instead, Catania et al. (1990) recognized that people may be at different levels within each stage simultaneously and that the level of one stage may not directly impact another stage or actual behavior decisions. From an intervention development perspective, ARRM explores why people fail to practice safer sex behaviors in order to identify and tailor strategies to increase the efficacy of interventions to increase safer sex behaviors (Catania et al., 1990; Catania et al., 1994).

Stage one is *Labeling* and three factors influence how individuals label their sexual behaviors as problematic: (1) knowledge of sexual activities associated with HIV transmission, (2) belief that one is personally susceptible to contracting HIV, and (3) belief that having AIDS is undesirable (Catania et al., 1990). Knowledge of the health outcomes of AIDS and the behaviors that transmit HIV are important for determining personal risk. Additionally, perceived susceptibility is needed because knowledge alone does not necessarily indicate that people understand that they are personally at risk. A lack of perceived susceptibility means that people are not likely to reduce risky sexual behaviors. A person's social networks and social norms influence the lack of desirability of having AIDS so it is important to consider how other people impact an individual's

Table 1

The AIDS Risk Reduction Model

Component	Stage 1	Stage 2	Stage 3
Description	Labeling (awareness, recognition of sexual risk behavior)	Commitment (intention to change, decision to alter sexual risk behavior)	Action (overcoming barriers to implementing decision to engage in safer sex practices)
Psychosocial Factors	Knowledge Perceived Susceptibility Concern of Risk Social Norms	Cost-benefit Self-efficacy Sexual communication abilities Perceived Susceptibility Labeling	Labeling High/Strong Intention Sexual communication abilities Social Support
Potential Outcome	Recognizing safer sex practices as a positive solution	Committed to engaging in safer sex practices	Uses safer sex practices

problem perceptions in larger social networks and more intimate personal interactions. These constructs are not directly related to behavioral change, so being more knowledgeable about the risk of HIV/AIDS does not necessarily mean that a person is always practicing safer sex (Catania et al., 1990; Catania et al., 1994). However, these constructs are important influences on people's behavior decisions (Catania et al., 1990; Catania et al., 1994). This means that if a person lacks knowledge about the disease or its

implications, they are less able to make decisions to engage in healthy behaviors. Additionally, these constructions and behaviors have a reciprocal relationship in that perceptions influence behavior and behaviors also influence perceptions (Catania et al., 1990; Catania et al., 1994).

Stage two is *Commitment to Change*, which is committing to making healthier behavior changes. Several factors influence how an individual commits to improving their behavior: (1) cost-benefit assessment, which includes components of response efficacy and enjoyment, (2) self-efficacy, and (3) knowledge and social influences on commitment (Catania et al., 1990). People weigh the costs and benefits of engaging in a behavior to determine whether it is worth doing and consider how effective the behavior is to getting the desired result (response efficacy) and how enjoyable the behavior is. It would be easier for a person to commit to a behavior if it was effective and pleasurable, rather than ineffective or unpleasant. Self-efficacy is how people perceive their capability to perform a behavior, the more one feels able to perform a behavior, the more likely they would be to perform that behavior. Knowledge and social norms influence behavior decisions because the more knowledgeable a person is about a behavior and the more socially acceptable that behavior is, the better they can make the cost-benefit assessment. Similar to Problem Perception, Commitment to Change is one influence in behavior decisions, but an individual with a high commitment to change does not necessarily translate to always engaging in safer sex behaviors (Catania et al., 1990; Catania et al., 1994).

Stage three is *Taking Action*, which involves taking steps to change behavior. Three factors contribute to taking action: (1) information-seeking, (2) obtaining remedies,

and (3) enacting solutions (Catania et al., 1990). Information-seeking has an individual component of a person gathering information, and a social component of seeking help from others and being aware of partner expectations. Obtaining remedies is influenced by self-esteem and experience with proposed remedies; additionally, the support of social networks increases the likelihood that an individual would use the remedy. People face a variety of challenges when enacting solutions and the primary tool for successful enactment is communication (Catania et al., 1990; Catania et al., 1994).

ARRM applications in research. The components of ARRM have been tested by Catania et al. (1994) as well as Lanier and Gates (1996). Catania et al. (1994) tested the ARRM in a sample of unmarried heterosexual adults and found support for several aspects of the ARRM. First, personal susceptibility was particularly important for Problem Perception (stage one). Second, partner types caused variation in Commitment to Change (stage two). Third, perceived norms were situationally impactful for Taking Action (stage three; Catania et al., 1994). While overall, there was support for the ARRM, Catania and authors (1994) found important differences when the model was applied to new partners versus existing/primary partners. The model was consistent in predicting condom use in new/secondary partners, but was less consistent in predicting condom use in existing/primary partners (Catania et al., 1994). Lanier and Gates (1996) also tested the ARRM using a sample of high-risk youths. Overall, each stage of the ARRM was effective for understanding AIDS risk avoidance behaviors for high-risk youths, but Lanier and Gates (1996) recommended that previous life experiences be formally integrated into the model.

Using a systematic review of experimental studies predicting sexual behavior, Huebner and Perry (2015) found little support for most theoretical predictors of sexual behavior (one of the theoretical predictors included the ARRM). Huebner and Gates promoted the need for more rigorous research designs to test theoretical assumptions presented in health behavior theories.

The ARRM has been empirically examined in a variety of contexts, including in the development of interventions (Harper, Dolcini, Benhorin, Watson, & Boyer, 2014; Suarnianti, Martiana, & Haskas, 2019), different ethnic groups (Champion, & Collins, 2012; Salud, Marshak, Natto, & Montgomery, 2014), gay and bisexual men (Gillis, Meyer-Bahlburg, Exner, & Ehrhardt, 1998; Moeller, Halkitis, Pollock, Siconolfi, & Barton, 2013), and with intravenous drug users (Brecht, Stein, Evans, Murphy, & Longshore, 2009; Longshore, Anglin, & Hsieh, 1997). Suarnianti et al. (2019) utilized the ARRM to identify areas of influence on nurses' actions to reduce the transmission of diseases. Nurses face a high risk of contracting the disease as part of their jobs, so the authors explored organizational factors on reducing the risk of contracting various diseases in hospitals. Results indicated that organizational factors directly impact the actions of nurses and the commitment of nurses to take action to reduce the risk of transmission (Suarnianti et al., 2019). Salud et al. (2014) applied aspects of the ARRM to explore the HIV-testing intention among Asian/Pacific Islander female college students. Aspects of the ARRM that influenced the participants' intentions included sexually active individuals who had low risk perception, lacked knowledge, and feared HIV testing (Salud et al., 2014). The authors recommended that any outreach to Asian/Pacific Islander female college students should attend to a context of the strong cultural taboos

around sexual issues, while addressing ARRM aspects like correcting knowledge about HIV/AIDS and encouraging self-protection strategies.

Moeller et al. (2013) interviewed 10 young gay and bisexual men about sexual behavior decision-making. Themes that arose from the interviews aligned with aspects of the ARRM, like knowledge and perceptions (Moeller et al., 2013). The authors (2013) detailed the disconnect between knowledge of the risks of HIV and intentions to remain HIV-negative when it comes to actual behaviors and recommended that the frameworks guiding HIV prevention include greater emphasis on the role of emotion and gender dynamics in the sexual decision making of young gay and bisexual men. In injection drug users, Longshore et al. (1997) studied how aspects of ARRM, particularly at stages one and two, related to a sample of HIV-negative injection drug users who reported having sex with more than one partner and their intentions to reduce HIV transmission risk behaviors. The authors reported that perceived self-efficacy for sexual risk reduction may be a crucial factor leading to the formation of intentions to change sex-related HIV risk behavior.

In this dissertation, the ARRM is a theoretical framework applied to the exploration of the importance of communication about sex in the process of decision making about safer sex behaviors. As discussed earlier, according to the ARRM, sex communication is one of several psychosocial factors that influence the stages of decision making about safer sex behaviors. Communicative practices, whether in the form of perceptions, interpretations, labeling, and communication abilities are salient for the understanding of how people negotiate and practice safer sex. The ARRM recognizes the importance of communication in influencing safer sex behaviors (Catania et al., 1990).

Communication is conceptualized in the ARRM as discussions of sexual matters between partners to increase safer sex practices, mindful that people have varying degrees of ability and comfort in participating in these discussions (Catania et al., 1990).

For instance, in stage one of the decision-making process - involving labeling and awareness of risk behavior - the ARRM proposes that perceptions and recognition of an individual's risky behaviors are an important component. Perceived susceptibility is described in the ARRM as the degree to which an individual believes they are vulnerable to contracting HIV (Catania et al., 1990). This study explores perceptions through survey and interview questions about whether participants perceive themselves to be risky and how participants rationalize their perceptions of their own risk level in their narratives.

The second stage of the ARRM is the commitment to change, and this commitment is influenced by factors such as sex communication abilities, cost-benefit analysis of engaging in safer sex behaviors, perceived susceptibility, labeling, and self efficacy. Self-efficacy is conceptualized in the ARRM as people's perceptions of their ability to perform safer sex behaviors (Catania et al., 1990). This study explores notions of communication abilities and self-efficacy through interview questions that elicit narratives about how easy and difficult the participants find it to communicate about and practice safer sex.

In the third stage of the ARRM, taking action, the importance of communication in recognized as influencing safer sex behaviors (Catania et al., 1990). Communication is conceptualized in the ARRM as discussions of sexual matters between partners to increase safer sex practices, mindful that people have varying degrees of ability and comfort in participating in these discussions (Catania et al., 1990). This study applies this

concept of communication in the interview questions about how participants talk about safer sex and how safer sex is part of relationship negotiations.

Chapter 3

Methodology

This chapter focuses on the methodological framework used in this research project. I describe the data collection tools and procedures, participants, and interview design, and data collection tools. The chapter ends with a discussion of the approach to data analysis and considerations about trustworthiness in qualitative research.

Informed by narrative inquiry methodology, this study aims to explore individual narratives of safer sex practices and safer sex communication among polyamorous individuals. Exploring poly people's safer sex practices may help to identify areas of expansion for safer sex research and health interventions. In order to accomplish these goals, this project explored four research questions:

RQ1: What is the sexual risk profile of individuals who identify as polyamorous?

RQ2: What are the most salient themes in the participants' narratives about safer sex experiences among polyamorous partners?

RQ3: How do participants describe the importance of safer sex communication in polyamorous relationships?

RQ4: How do participants understand the relationship between safer sex communication and relationship negotiation in polyamorous relationships?

Narrative Inquiry

This project was guided by narrative inquiry, an approach to research that is used across multiple disciplines, including education, anthropology, psychology, and health-related fields (Lal, Suto, & Ungar, 2012; Webster & Mertova, 2007). Narrative is pervasive in everyday life and is the closest we can come to understanding experience

(Atkinson & Delamont, 2006; Clandinin & Connelly, 2000). Narrative inquiry emerged in the 1960s as some researchers' ontological and epistemological positions shifted from a positivist perspective to the view of reality as socially constructed. This raised the value of the use of narratives in social science research (Lal et al., 2012). The development of narrative inquiry thus came from a critique of some of the dominant assumptions that guide research: a change in the relationship between the researcher and the participant, a move from numbers to words and stories as data, a change from a focus on general patterns to a focus on the specific experience, and a growing acceptance of alternative epistemologies (Pinnegar & Daynes, 2012).

Lal et al. (2012) identified several researchers and the ideas that advanced narrative inquiry further in the 1980s: Ricoeur explored narrative as a form of human consciousness; Bruner depicted narrative as a way of knowing; and Polkinghorne framed narrative as the way people give meaning to their experiences. These conceptualizations contributed to this current study because approaching narratives as a way to access people's consciousness and experiences potentially allows for identifying important aspects of sexual behaviors that health practitioners might be able to use to promote safer sex behaviors.

Narrative inquiry considers the temporality, sociality, and place of experiences (Clandinin & Rosiek, 2012; Riessman, 1995). Temporality is informed by Dewey's understanding of continuity in experience, where experience is informed by the past, crafted in the present, and colors the future (Clandinn & Connelly, 2000; Clandinin & Rosiek, 2012). Temporality is important in health behavior research because people's behaviors also occur on this past, present, and future timeline; thus, communication and

other interventions for health education can influence positive reflection and change in decision making processes over time. Sociality includes the personal (feelings, desires, morals) and social (environment, forces, other people) conditions of experiences—part of this is the relationship between the participant and the researcher (Clandinin & Rosiek, 2012; Pinnegar & Daynes 2012). In safer sex research, sociality is an important consideration because sexual acts are personal and relational social acts influenced by human interactions. Place incorporates the specific concrete and physical boundaries where the inquiry and events take place (Clandinin & Rosiek, 2012). Additionally, place is important in understanding potential influences in people's safer sex behavior decisions. In research using narrative inquiry, questions include the how, for whom, and why stories are told, as well as how interviewers influence what stories are told and how they are told (Lal et al., 2012). This project considered these aspects during the analysis of the narratives by considering potential reasoning behind the stories shared by the participants.

Critics of narrative inquiry have argued that the blurred distinctions between the researcher and the participant can decrease the possibility for objectivity in data collection; they have also argued that the analysis process in narrative inquiry is weak, describing rather than analyzing (Riley & Hawe 2005). Riley and Hawe (2005), proponents of narrative inquiry, acknowledged that researchers using narrative inquiry can fuel these criticisms when their interpretive frameworks lack definition and are inappropriately applied to the data. To address these concerns, Riley and Hawe (2005) recommended that researchers follow a guiding set of analytical principles and employ reflexivity in order to interrogate the dynamic between the researcher and the

participants. In addition, to ensure the rigor of narrative inquiry, it is important to justify the research personally, practically, and socially (Clandinin & Huber, 2010).

Reflexivity was exercised throughout the design of this research via discussions of researcher bias with mentors as well as the checking of assumptions throughout the interviews with participants. The dynamic between the researcher and the participants is best described as the authoritative voice, which involves reporting long stretches from narrators' stories or long excerpts of naturally occurring conversation followed by the researcher's interpretations (Chase, 2005). During analysis, I ensured that participant voices are centered in the findings through the use of longer quotes, and then my voice appears in the synthesis of stories across participants. Chase (2005) highlighted that a benefit of the authoritative voice is that analytical interpretation can make visible taken-for-granted practices and structural forces of social experiences. The use of the authoritative voice means that the researcher speaks differently from, but not disrespectfully of, the participants' voices (Chase, 2005).

The justifications for narrative research operate at different levels here. The research is personally justified because exploring safer sex practices that may challenge the focus on condom usage aligns with my personal commitment to health communication research and the experiences and the experiences of my friends and family, for whom safer sex decisions are more nuanced than just using condoms. The research is justified practically because identifying interesting aspects of safer sex might inform communication strategies and campaigns for safer sex promotion. This research is also socially justified socially because it is important to address the STI health epidemic in the contemporary social context.

In this dissertation, narrative inquiry is approached through the larger philosophical lens of constructivism. Constructivism was first formally discussed in the early 20th century by Vygotsky and Dewey (Lohmeier, 2018). Both constructivism and narrative inquiry are grounded in the philosophy of Dewey (Lohmeier, 2018). The epistemological perspective of constructivists holds that knowledge is constructed socially by linking new information to experience, rather than by people being passive recipients of knowledge (Creswell, 2014; Lohmeier, 2018). The ontological position of this paradigm is relativist, meaning that realities are socially and experientially based, and dependent on the individuals and groups holding the constructions (Guba & Lincoln,1994; Labonte & Robertson, 1996). Even though these realities are localized, they are also often shared across individuals and groups (Guba & Lincoln, 1994).

The aim of inquiry under constructivism is to understand and reconstruct the constructions that people hold, exploring consensus while still being open to new interpretations as information evolves (Guba & Lincoln,1994; Labonte & Robertson, 1996). Thus, constructivist methodology is interpretive and dialectic and involves a constant comparison of differing interpretations through a process of iteration, analysis, critique, reiteration, reanalysis, and synthesis (Guba & Lincoln,1994; Labonte & Robertson, 1996). Advocacy and activism are also key concepts in constructivism (Guba & Lincoln, 1994). In constructivist methodology, the investigator is an integral part of the inquiry (Creswell, 2014; Labonte & Robertson, 1996). The researcher is part of the reality that is being researched, such that the investigator and the participants are assumed to be interactively linked, and where the "findings" are a creation of the inquiry process

itself rather than a collection of external facts (Guba & Lincoln,1994; Labonte & Robertson, 1996).

Constructivism is a philosophical lens suitable for health promotion research because health promotion is often framed in socio-environmental terms and quality of life concerns. Quality of life is a concept that refers to personal experiences and, therefore, often involves people's multiple interpretations rooted in diverse cultural understandings that are also dependent on the influence of communities. (Labonte & Roberston, 1996).

Some critiques of constructivism point out that the role of the researcher is expanded beyond reasonable expectations of expertise and competence (Guba & Lincoln, 1994); and that constructivism leads to radical relativism because reality is simply people's constructs (Labonte & Robertson 1996). However, Labonte and Roberston (1996) argued that regardless of whether one true reality exists, any individual's personal understanding of reality is a social construct, and whether these personal understandings are considered scientific is a hegemonic determination.

From this paradigmatic focus on personal and social constructions of experience, the AIDS Risk Reduction Model (ARRM) was used as a theoretical framework for this project. It was used to explore the diverse understandings and constructions of safer sex behaviors among individuals who identify as poly, and how these constructions may influence the decision-making process to engage in safer sex behaviors.

Data Collection

Participants. The participants in this study are individuals 18 years old or older who identify as polyamorous. To select participants, I used snowball sampling - a nonprobability sampling technique where existing participants recruit or refer additional

participants from among their acquaintances. Given the personal and sensitive topic of research, snowball sampling facilitated the identification of participants via individuals who were familiar and had a level of trust with the new participants recruited. This technique was used, however, mindful of the goal to include individuals with diverse demographic characteristics and from different polyamorous relationships and communities.

Recruiting from different relationships and multiple communities allowed for the opportunity to explore social group dynamics and norms that may be unique to specific poly communities and differ from other poly communities. Individuals were invited to participate in interviews via online communications, including email and social media posts. Recruitment materials included a statement of the purpose of the research and invited people to participate in an individual interview. The rights and welfare of participants in this project were protected following all University of New Mexico Institutional Review Board (IRB) policies. IRB approval was obtained prior to beginning any recruitment or data collection. Participants consented prior to participating in the interview, including consent to be audio recorded. I interviewed 13 participants who were predominantly white and female with an average age of 34 - see demographic information in Table 2 below and for detailed demographic information, see Appendix A.

Interviews. Individual interviews offer the opportunity for an in-depth understanding of a social phenomenon (Mason, 2002). In-depth interviewing can be used for achieving a deep level of knowledge and to learn the meanings of participants' actions (Johnson, 2001). Interviews are a particularly useful tool for exploring conceptualizations and experiences of safe sex and relationship negotiation in polyamory because this is an

Table 2

Participant Demographics

Category		Frequency
Gender		
	Female	8
	Woman	1
	Male	4
Ethnicity		
	White	10
	Asian	2
	Latino	1

unexplored phenomenon and the fluid and flexible structure of interviews allows for the participant to drive the narratives. Additionally, interviewing allows for learning about situations that cannot be observed (Lindlof & Taylor, 2002), which is particularly salient in this research on safer sex practices. Utilizing methods that privilege the subjective experience is important particularly when examining experiences that are outside of the normative standard. Interviews also enable the construction of situated knowledge by focusing on the contexts of lived experiences (Mason, 2002). Interviews create an environment that facilitates the gathering of information about social experiences that is contextualized and offers the opportunity to examine the complexity and nuance of social interactions (Mason, 2002). Interviews also allow the researcher to explain phenomena in a way that highlights an understanding of complexity in peoples' situated experiences (Mason, 2002).

An in-depth interview protocol guided the discussion with participants about their safer sex practices and communication practices (Appendix B). Charmaz (2014) emphasized the importance of learning about the situation before beginning to develop questions, which includes reviewing literature as well as understanding the situation from a non-academic perspective. I read literature on the risk and protective factors to prevent STIs. I have become familiar with polyamory over approximately 10 years through conversations with people that participate in the lifestyle as well as reading books written for and by the poly community. Additionally, in preparation for the research I discussed interview topics and questions with poly people whom I know personally to ensure that the interview protocol was culturally appropriate. The interview guide was developed to be a flexible tool that allows for both focusing on safer sex practices and communication about safer sex as informed by previous research as well as pursuing new areas that are important to the participants that arise during the interview session (Charmaz, 2014; Johnson, 2001).

Practice interviews are recommended for emotionally sensitive topics (Charmaz, 2014). In this case, I have extensive experience conducting emotionally sensitive interviews with my training in clinical psychology, and this background gave me the skills needed to participate in an interview about safer sex. The interviews were conducted over the telephone or via the online video conferencing service Zoom; all were recorded. Recording the interviews allowed me to capture all information while building rapport with interviewees during conversation and focusing on the discussion. This also helped to put the participants at ease and create a safe space for the conversation to take place. I built rapport through actively listening to participants and engaging in the

conversation is such a way that I encouraged the participant to delve deeper into the topic (Johnson, 2001). I endeavored to be sensitive to the participants, making sure that I was conscious of their needs and rights.

Data Collection Tools. As part of the interview, participants were asked to complete a survey. The survey was used to help describe the participant population and enable participants to articulate their position within the larger quantitative conceptualization of safe sex and condom use in the literature, but not used for any statistical hypothesis testing. Rather, and more important for the purpose of this qualitative study, having participants complete this scale provided the opportunity to discuss specific behaviors and communication practices. It also helped expand the conversation about safer sex to explore potential areas of critique on how researchers and practitioners conceptualize safer sex as understood through the questionnaires. The primary objective for data collection was to explore the subjective viewpoint of poly people who shared their experiences and perceptions of safer sex. The survey consisted of a demographic questionnaire, the Klein Sexual Orientation Grid, and the Sexual Risk subscale of the HIV Risk-Taking Behavioral Scale (See Appendix C).

A demographic questionnaire was used to collect personal information about age, sex/gender, level of education, marital status, ethnicity, living arrangements, relationship status and history, and past sexual experiences.

The Klein Sexual Orientation Grid was modified and used to assess a participant's sexual orientation and sexual identity (Weinrich & Klein, 2002). Participants were asked to whom they are sexually attracted and how they think of themselves and responded on a 1 (other sex/heterosexual only) to 7 (same sex/gay-lesbian only) scale. Responses helped

categorize participants into one of five categories: Heterosexual, Bi-Heterosexual, Bi-Bisexual, Bi-Homosexual, and Homosexual. Participants consistently reported that this scale did not reflect their orientation, therefore, it was not used in the analysis for this study.

The Sexual Risk subscale of the HIV Risk-Taking Behavior Scale was used to assess behaviors that have been linked to contraction of the HIV virus (Darke, Hall, Heather, Ward, & Wodak, 1991). This is a standardized survey that is often used in general populations as well as substance users. Frequencies of behaviors are reported for the past month. Participants responded to nine items on a scale from 0 - safest sexual behavior to 5 - most risky sexual behavior. Item scores are summed, and total scores can range from 0 to 45, with higher scores indicating more sexual risk. Internal reliability for this scale has been reported at .70. Sample items include: "How many people have you had sex with during the month?" "How often have you used condoms when having sex with your regular partner over the past month?" and "How many times have you had anal sex in the past month?"

Data Analysis

Participants' stories were analyzed using a combination of coding procedures drawn from grounded theory methodology and thematic analysis. This was important for this research because it integrates systematic and rigorous coding that is sensitive to emerging concepts and to the understanding of participants' experiences as they expressed them in their own voices (Charmaz, 2014). Thematic analysis is a search for clusters of meaningful ideas that emerge as being important to the description of a phenomenon, and it involves the identification of themes through reading and re-reading

of the data (Fereday & Muir-Cochrane, 2006). The identification of emerging codes provide the basis for the identification of salient themes. Thematic analysis is important for this research because it provides a flexible approach that can be modified for the needs the research, providing a rich and detailed account of data (Nowell, Norris, White, & Moules, 2017). Thematic analysis is an iterative and reflexive process (Fereday & Muir-Cochrane, 2006). Because of this iterative process, I believe that combining coding techniques associated with grounded theory with thematic analysis from a narrative inquiry lens creates possibilities for developing a richer understanding of the phenomenon under study (Lal et al., 2012).

Recorded interviews were transcribed and generated 146 single-spaced pages of transcripts. The transcription process utilized Rev.com, an online transcription service, followed by transcript verification to ensure accuracy and to ensure no participant identities were unintentionally recorded during the interview. This verification process was an important initial step, as I did not do the transcribing of the interviews myself. It gave me the opportunity to absorb the data through listening as well as reading as I began to engage in the analytical process. After verification, the transcripts were imported to the open source TAMS Analyzer for the coding process.

Coding was a multiphasic process that started with line-by-line coding that identified several in vivo codes. At this phase of the coding process, I remained open to direction that data dictated as well as the scenes and sentiments from the participants' perspective (Charmaz, 2014). Line-by-line coding allowed for seeing otherwise undetected patterns in the data (Charmaz, 2014). Using in vivo codes allowed me to preserve participants' meanings and perspectives (Charmaz, 2014). The next phase in the

coding process involved focused coding. This iterative process is an important part of thematic analysis (Fereday & Muir-Cochrane, 2006). The focused coding was used to sift, sort, synthesize, and analyze the codes building toward larger categories (Charmaz, 2014). I compared the initial codes to organize them into patterns. The third step in the coding process was axial coding to relate the categories in order to identify the themes in the data. Axial coding makes the coding process more systematic with the goal of bringing the data back together after breaking it apart in the initial coding phase (Charmaz, 2014). At this step, the previous phases of the analysis process were scrutinized to ensure that the clustered themes were representative of the initial data analysis and assigned codes. Throughout the analysis, I accounted for similarities as well as differences between the narratives of the participants (Willig, 2013).

During the interviewing, after each interview, while verifying transcripts, and throughout the coding process, I wrote memos. These memos included my reflections on the key aspects of the data, the concepts that appear to have the deepest meaning and that have the most importance as expressed by the participant (Charmaz, 2014). The memos were referenced and revised throughout the coding process. These memos were used to start the code list, and those codes were further refined throughout the remainder of the analysis process. Additionally, in the final stages of analysis, the memos included clustering to organize the data. Clustering was a visible, flexible way to organize the stories shared by the participants (Charmaz, 2014).

In addition to the transcripts, responses to surveys were used to answer the research questions. Table 3 lists the sources of the data for each research question. To determine the actual risk profile of participants, a risk score was calculated from adding

Table 3

Sources of Data

Research Question	Source of Data
RQ1: What is the sexual risk profile of individuals who identify as polyamorous?	Actual Risk: Survey Question 8, 12, 13, and HIV Questionnaire composite score Perceived Risk: Survey Question 9 and Interview question 3e
RQ2: What are the most salient themes in the participants' narratives about safer sex experiences among polyamorous partners?	Survey Question 13 Interview guide questions 3a and 4
RQ3: How do participants describe the importance of safer sex communication in polyamorous relationships?	Interview guide questions 3b, 4, 5, 6
RQ4: How do participants understand the relationship between safer sex communication and relationship negotiation in polyamorous relationships?	Interview guide questions 6, 7, 8

the risk related questions together. These questions were scored with a zero for low risk or 1 for high risk (e.g. are you currently sexually active? Yes = 1, No = 0). These scores were added to the score from the HIV Risk-Taking Behavior Scale (Darke et al., 1991). Risk scores range from zero to 48, with 48 being the most risky.

Trustworthiness in Qualitative Research

Trustworthiness in qualitative research ensures rigor as well as research findings that are worthy of attention (Nowell et al., 2017; Shenton, 2004). Trustworthiness is achieved through the criteria of credibility, transferability, dependability, and confirmability—values that are parallel to the conventional quantitative criteria of validity and reliability (Nowell et al., 2017). Credibility refers to how accurately the researcher recorded or represented the phenomena under scrutiny (Nowell et al., 2017;

Shenton, 2004). Shenton (2004) recommended several techniques to ensure credibility, including using a rigorous methodology, researcher familiarity with the culture for participants, and examination of previous research findings. This study followed a rigorous methodology in developing the interviews as well as throughout the analysis as discussed in this chapter. Additionally, this project was grounded in my familiarity with the poly culture, as I have had familiarity with polyamory for over 10 years, including discussions with poly people and reading books regarding engaging in poly relationships. Lastly, the research questions and interview protocol were developed after examining the previous research on both safer sex and poly topics.

Transferability addresses how generalizable the inquiry is to other situations. To support transferability, findings are presented with thick descriptions (Creswell, 2014; Nowell et al., 2017). However, as this research covers a nearly unexplored topic, the goal of transferability is limited. Dependability includes ensuring that the research process is logical and clearly documented (Nowell et al., 2017). Shenton (2004) noted that in qualitative research, replicability of research procedures are limited due to interviews occurring in a specific moment and that interviews conducted in a different will inherently consist of a different subjective reality. To address dependability, the research process was presented in a detailed manner in this chapter. Confirmability focuses on presenting findings that are the result of the participants' experiences and not the characteristics and preferences of the researcher (Shenton, 2004). To achieve confirmability, research must include the beliefs that influence the data collection (Nowell et al., 2017; Shenton, 2004).

Chapter 4

Findings

This chapter presents the findings of this investigation and addresses the answers to each of the research questions. As it will be discussed below, participants in this study shared narratives about their safer sex experiences and practices that offer insights into the complexities of safer sex communication. Their narratives also enable the identification of potential new ways in which researches and practitioners might promote decision making about safer sex.

Narrative Profiles of Participants

The following section presents short narrative profiles of the participants in this study to highlight the diversity of experiences that constitute polyamorous relationships and how individuals described their experiences with this style of relationship. The names have been changed to protect the confidentiality and privacy of the 13 interviewees who generated data for this project. These profiles were created from information that emerged from the interviews as well as information from the demographic survey. Words and phrases in quotations are the participant's own words.

Emma is a 42-year-old white woman from Texas. She currently has two boyfriends, one of which lives with her. She said she has always been poly, but never really knew it. She attributed the delay in her self-identification as poly to her Catholic upbringing.

Olivia is a 33-year-old white woman from Georgia. She has relationships with three individuals: she has a husband, one "serious" partner, and a "causal" boyfriend. She is also part of a "polycule," a group of poly individuals who are linked together through

their relationships. For Olivia, poly is different from other relationship types because of the ability to love more than one person, rather than just having sex with more than one person.

Liam is a 43-year-old Latino male from Texas. He is currently single but has participated in a poly relationship in the past and wants that style of relationship. He said he unintentionally fell into a poly relationship, but that feeling so much love from two people was one of the happiest and most fulfilling relationships in his life. He said that after having poly relationships, monogamous relationships feel incomplete.

Noah is a 41-year-old white male from Georgia. He has relationships with three individuals: he has a wife, one "serious" partner, and a "casual" partner. For Noah, his marriage comes first, but poly relationships help him get all of his emotional needs met. He said he and his wife have had experiences with cheating in the past and hated the dishonesty. For them, polyamory helps all of the partners get their needs met with honesty.

Ava is a 26-year-old white female from New Mexico. She is in a relationship with two people. While she identifies as poly and is currently in poly relationships, she said she feels that most of the important things that make poly relationships successful are needed for any relationship, including monogamous relationships, to be successful.

Logan is a 37-year-old white male who travels the world. He is currently single. His said poly identity is not contingent on being in poly relationships; it is a constant regardless of his relationship status. He has been poly since a young age. He said he never understood why humans started "pair bonding" and questioned why would people want to limit themselves.

Isabelle is a 29-year-old Asian woman from Arizona. She currently has several partners in relationships with various levels of emotional intensity. She said she had been living poly, but never had a label to use to understand the relationships. Then, a partner said: "I think you are poly," and that was enough to make her affirm her identity position.

Charlotte is a 26-year-old white female from Ohio. She is married and has one other "serious" partner. She said she grew into polyamory, having started in a monogamous relationship with her husband that turned into an open relationship, and then developed into polyamory after she found a partner that she grew to love in addition to her husband.

Amelia is a 36-year-old white woman from California. She is married to a woman and has a "casual" girlfriend and an "on-and-off" boyfriend. She has experience with open relationships, but they never worked because of the lack of communication and hiding. To Amelia, polyamory is better because it comes with the expectation of full communication and knowledge for all partners and partners' partners.

Evelyn is a 36-year-old Asian woman from California. She is married to a woman and has a girlfriend. She prefers polyamory because all partners are protected and everyone is consenting. She likes having multiple relationships in a safe way.

Silas is a 34-year-old white male from Texas. He has a "primary" partner and several "one-time sexual partners." He described a tension between polyamory, with an emphasis on all aspects of love, and other types of open relationships where it is just about sexual relations.

Abigail is a 27-year-old white woman from Georgia. She has a "primary" girlfriend and a "secondary" girlfriend. She said she had a friendship that developed into

a poly relationship when they began to develop romantic feelings for each other, and her friend was already married. Through lots of discussion, they worked out a poly relationship.

Avery is a 27-year-old white woman from Virginia. She has a “primary” partner, with various “casual" partners. She said she only recently became poly after the end of a long-term monogamous relationship. After the end of that relationship and “dating around,” she began dating someone who brought her into “the world of polyamory.”

These profiles of the participants in this study offer the opportunity to explore similarities and differences between their unique positions and provide some context to the following sections. The remaining sections of the chapter will address the research questions.

RQ1: What is the sexual risk profile of individuals who identify as polyamorous?

There are two dimensions when considering the risk profile of the participants. First, is actual risk, or how much people engage in risky sexual behaviors, which was based on self-reported behaviors. Second is the perceived risk, or how much people perceive themselves to be at risk. In this research, the discussion of these dimensions is based on self-reported behaviors in the survey as well as on reactions to the survey shared in interviews. Each of these dimensions will be discussed below separately.

Actual Risk. The actual risk profile was a composite score of participants’ self-reported behaviors (the composite score is explained in Chapter 3). Table 4 shows the risk score for each participant. Among the participants interviewed, seven were in the lowest risk quartile, five in the second quartile, and one person in the just above the 50% mark in the third quartile. This suggests that participants are protecting themselves while

Table 4

Risk Profile

Pseudonym	Composite Risk Score (Possible range 0 – 48)
Emma	20
Olivia	1
Liam	23
Noah	17
Ava	26
Logan	22
Isabelle	9
Charlotte	13
Amelia	2
Evelyn	3
Silas	12
Abigail	7
Avery	2

engaging in sexual activity. However, the questionnaire asks participants to report based amount of sexual activity in the past month may have a different risk profile if they were to reflect on a wider time period.

After completing the survey, participants were asked to reflect on whether the survey questions accurately represented the range of safer sex practices they engaged in, and if anything was missing. The majority of the participants indicated that the survey met their expectations of what they thought would be asked in a safer sex survey. However, participants reported some concerns with the questionnaires. They mentioned limitations and considerations that seemed to be ignored in the design of the survey,

including: time frame to determine sexual activity, the limited scope of the safer sex practices mentioned in the survey and the omission of practices like testing or use of other forms of contraception, the male-centered bias by focusing on male condoms, and, particularly relevant to poly relationships, the weak conceptualization of a partner. The questionnaire asks participants to report based on their sexual activity in the most recent month. Therefore, respondents with a limited amount of sexual activity in the past month noted that they may have a different risk profile if they were to report on a longer wider time period.

When evaluating the safer sex practices represented in the survey, some participants offered the following assessments. Olivia said: "So I guess it is for the nilla [non-kink] side of the house, yeah, that's what I expect… The kink side of the house would also include things…that can be … unsafe situations." Thus, while she found the survey representative, she also highlighted sexual situations that are missing in a broader safer sex context. The further that sexual actions deviate from the stereotypical penile-vaginal sex, the more complicated the safer sex concepts become. Olivia highlighted the distinction between kink and non-kink; however, the safer sex questionnaires used by researchers and practitioners do not address sexual acts that include kink and, therefore, are inaccurate for individuals who engage in kinky sex. Similarly, Ava added mutual consent as a practice not included in the survey: "Yeah. I would say that I would want more questions about the idea of consent in sexual situations, because I consider that a part of safe sex; but in terms of disease prevention, yeah."

In her assessment of the survey, Charlotte felt it had a male and penis centered focus and thus reported that:

> I think it was good. I think it should've specifically mentioned dental dams as well in the oral sex section, because…it's the same basic principle, but it is a different thing to think about, because the whole thing felt very male oriented.

Participants also reported that the survey was limited in terms of the measurement over time and frequency of sexual activity. In addition, they noted that the conceptualization of partners implied in the survey was weak from the perspective of the polyamorous experience. Logan explained:

> I guess to me, it sounds like something that researchers would come up with that doesn't really seem to relate much to my personal life. I think mainly because … there are times when, maybe one to two years, when I'm not in any relationship at all, and this happens to be one of those times; so answering these questions for this time, there would be one answer. If I was in a relationship, a lot of the answers would be different. I'm not continuously in a relationship of some kind or another, and it changes a lot based on that. It would take more dimensions to answer on that level, I guess. Because the average frequency, it's totally different than the frequency in a situation. If you average the frequency now versus the frequency in a relationship. It would come out over the past 12 years I've had sex once a month. But it's not really representative of what's going on and some of the questions, since I'm not currently having sex, I can't answer them accurately…There's those kinda dynamics that I think are overlooked a lot of the times.

Amelia also described the limitations of the survey:

> Do I feel like it aligns with my views of safe sex? To just say, "Here's a safe sex survey," it was not comprehensive enough, by any means. Depending on what kind of information you were trying to get, that is. It was very surface stuff. I know that the most recent activity would be most relatable and most...relevant, but for someone like me, I just said, "No, no, no, no, no, no, no, never, never, never, never," because everything was in the last month. Nope, nothing in the last month, so you don't get any data on what my actual practices would be if I had been active in the last month because I haven't been active in the last month.

The temporality of the questions in the survey, with a focus on activities in the past month, was deemed problematic because the limited timeframe may not accurately reflect participants' safer sex practices at other times. Framing the survey offered a concrete period of life to reference, but resulted in an incomplete picture of risk.

Emma felt that while she accurately answered the questions, the information was lacking because she felt that survey assumed a focus on new partners. She stated:

> I answered them all correctly, but it wasn't very enlightening of my situation. 'Cause we don't practice safe sex anymore. I mean, if you're going by with that terms, we don't. But we did. We did through the first, probably the first six months of our relationship. We had safe sex… I can tell you that if there was a new partner, we would use protection every time. But part of that is that I have an established relationship with, and it wouldn't matter which partner had a new partner, as soon as a new partner would be introduced, we would be back to using safe sex. As a group.

Noah also thought that it lacked the layers in relationships. He explained his difficulty responding to the questionnaire:

> Like in my case, my primary partner, we just do what we've always done. She had her hysterectomy, so we have no issues about pregnancy. I trust her. She's only had one partner other than me in years, so. She only recently had a partner. And from what I know, they were safe, so I'm not too worried about that. So yeah, I guess, maybe it'd be easier to explain if it was more towards are you doing this with your primary partner as opposed to your secondary partner. Other than that, I think that's about it, I guess.

Isabelle had the same experience with not knowing how to respond when there were multiple sex partners in the same timeframe and different safer sex practices with each partner:

> I got tripped up on it because I'm like, well, I did with one and I didn't with another. Is that rarely? Is that mostly? Is that never? I don't know. It's easier to answer if it's just with one person. But because I'm with several, and the degrees of safe sex vary amongst all of them, I don't know. So, I was kind of like. When it comes to, like, the frequency of usage of things, it gets very dicey if you have a lot of different people. But that's just a product of our situation.

In sum, participants seemed to evaluate the survey based on the assumption that it intends to target a specific interpretation of sexual activity. The assumed sexual activity is male centered, vanilla sex. Their comments suggest that they recognize the conceptualizations of safer sex that are conventional while calling attention the fact that their lived experiences of safer sex can encompass a broader range of practices. In their

view, the survey offered a glimpse into the risk behaviors of the participants but was limiting because it was an incomplete snapshot of practices. Participants identified a variety of risk behaviors that they engaged in (e.g. kinky sex, different sexual behaviors with different people, safer sex practices other than condom use) but that were not captured in the survey and, therefore, found that the survey offer an incomplete risk assessment.

Perceived Risk. Perceived risk is how risky the participants consider themselves to be. In response to the survey question regarding how risky they are sexually, seven participants reported that they considered themselves to be not at all risky, four said a little risky, and two said somewhat risky. However, in the interview, all participants responded that they did not consider themselves to be risky sexually. To justify this perception, two themes were repeated: 1) they were not sexually risky because they follow a safer sex plan and 2) they don't consider themselves to be risky - even when their narratives reveal contradictory statements - but think that external entities think they are risky.

Throughout the interviews, participants discussed various safer sex practices and plans, and these plans were referenced when justifying their statements that they are not risky. For instance, Olivia based her assessment of her risk level on the safer sex standard that her partner circle adheres to:

> No…[a safer sex] standard is the only thing that [was required for having multiple relationships]... when my husband said, "Fine, I'm cool with open but we're always going to be safe," and … that's like the core of it. … I don't think myself at risk. We had a mild scare because of a partner of a partner situation and the whole

> crew got tested like it went from once every six months to well, let's just do it now and suddenly like all 12 people in my circle who weren't even related to this [got tested] … Let's just make sure. But we haven't had any scares since or any concerns since.

It is worth noting that even with the group following this safety standard, they still had a STI scare. This suggests that the relationship between following the standard and actual safety outcomes is unclear.

Noah shared a similar justification, "No, no, because I don't like sleeping with just random people or anything. I am keeping my circle fairly closed." Rather than looking holistically at the various safer sex practices that impact their sexual risk, the primary consideration he used to determine his sexual risk was that he is part of a closed circle. Evelyn also mentioned having a safety plan as a justification for her risk determination. In this case, it's about the commitment to communicate amongst the partners about sexual boundaries:

> I do not consider myself to be risky, sexually. Because again, my two established relationships, we discuss it, we talk about it, and we also have rules. If we are going to get involved outside of our current relationship, obviously communication should happen before, because we've learned the hard way that communication after is not … good. We are lucky that no one came out with anything. We kind of learned a hard way, but not the harder way. Yes, we do have rules. We do have rules, basic rules that we talk about those constantly.

Evelyn had a similar pattern in the justification as Olivia where, even with the safety plan in place, there were historic examples of failures that led to them revise their safety plans. Even with those past breaches, they consider themselves not to be sexually risky.

In some instances, participants gave their personal view of not being risky and then commented on how they might be risky. Silas admitted to having risky oral sex, but still stated with confidence that they are not sexually risky:

> No. I guess largely for the reasons that I'm stating. Always condom use, for the most part. I mean, I guess the riskiest activity would be oral sex, which ... [I] don't use dental dams and that sort of things. So, that would be the riskiest behavior.

Avery also offered a contradictory justification for determining herself to not be risky:

> I don't in particular. I think I have sex with people that I would consider are sexually risky, but I wouldn't say myself. It's something that I've considered, in terms of the more I get involved in the poly community and the kink communities that I'm involved in, where it's like, "Oh, I could see myself having riskier sex down the road, or having more and more sexual partners." But I'm also somebody who was a serial monogamist up until a year ago or so, where I didn't have a lot of sexual partners. And that's part of what I like about polyamory, there's a lot more freedom, but it also means there's a lot more sexual freedom and a lot more sexual partners. So I think my practices, for the most part, stay pretty safe, but I do have concerns about the people I'm having sex with and how risky their sexual behaviors are.

So while she doesn’t view herself as risky, she does state that she has sexual interactions with people who are risky. Similarly, Amelia stated that she is not risky, but contextualized that in the framework of not being sexually active at the moment:

> Generally speaking? No. Have I had risky sex? Yes. But overall, no, because I'm not really having sex that way. I'm not really sexually active. I haven't had sex, like when we defined it earlier, I haven't done any of those things in quite some time.

In the moment, she considered herself to be not risky because she is not active, but also states that she has been risky in the past and does not address what might happen if she were active in the future.

In addition to personal contradictions, there was some recognition that society would consider them too risky even when they don’t view themselves as risky. Liam recognized that a medical doctor would consider him and his partners to be risky, even when they don’t consider themselves to be:

> I feel like all three of us would consider ourselves not risky, which is, I guess, hard to explain to a doctor who just sees three sexually active partners, with one of them having a husband who's sexually active with them. But still.

Liam expressed the tension between his personal view and the view of a doctor about having sex with multiple people who also have sex with others people. Isabelle highlighted this tension between personal view and society at large:

> I personally don't. I don't think I'm risky at all. Society would say I am. But I am not. Society would think I am because I have multiple sexual partners. And, when it comes to risky sexual behaviors, it's people who stick around with a whole lot

> of different people. And they're not committed to just one person. Because that's what our fucking society tells us. So, by their standards, I am risky because I have sex with a lot of different people. But I don't think I am because I'm tested regularly, I'm very openly communicative to my partners. Like, we've had times where there were STI scares. There's been a couple of times in my life where there were STI scares, and it was handled like, it was handled like adults. We talked where it's like, okay, thank you for letting me know. We should probably refrain from having sex until I get tested to make sure I didn't get anything and then we go from there. So, I don't think I am. Society thinks I am.

She stated the conflict between the personal and the social, while also highlighting the complexity of safer sex protections and how those behaviors are overshadowed by the simple fact that she sleeps with multiple people and this society determines her to be sexually risky.

The ARRM proposes that perceived susceptibility to contracting an STI is an important factor in labeling their sexual behaviors as problematic. The participants' narratives demonstrated that participants were able to recognize that there is risk associated with poly relationships, particularly related to the number of people involved in sexual relationships and the spiderweb of connections between partners. Because of this recognition, participants explained that they implemented safer sex plans. However, because participants implemented safer sex plans, they perceived themselves to be at low risk of contracting a STI. The effectiveness of some of the safer sex plans described by participants is unclear, therefore the participants' perceptions of their risk level may not be accurate.

Participants reported low actual risk as well as low perceived risk. The result from the scales used to determine actual may not fully encompass all of the sexual situations where risky behaviors might occur, so the low risk determination should be examined further. Additionally, while participants did not consider themselves to be risky sexually, there were some contradictions in the narratives as well as contractions between personal views and societal views.

RQ2: What are the most salient themes in the participants' narratives about safer sex experiences among polyamorous partners?

Safer sex practices appeared in the participants' narratives of their experiences in polyamorous relationships. Three dominant themes appeared in the safer sex narratives: 1) the complexities of safer sex practices, 2) setting boundaries as a way to implement safer sex practices, and 3) the importance of trust as the litmus test for what safer sex practices to use. While this section presents these three themes separately, they intersect in various ways in the narratives to reflect the multilayered realities of actual safer sex experiences, starting with condom use and then branching into other important aspects of protecting themselves.

The complexities of practicing safer sex. When asked about how they practice safer sex, participants shared many examples of the complexities of safer sex practices. These practices included: physical safety, knowledge of safer sex issues, consent, and communication and transparency. Safer sex practices are complex because of the interrelation between physical, emotional, and communicative aspects to safer sex that cannot be isolated from each other. Participants referenced basic practices of safer sex,

such as using condoms and testing, but then expanded beyond that to include physical and emotional safety as well as the challenges of safer sex.

For instance, Isabelle connected safer sex to communication to ensure consent and physical safety and described that safer sex is influenced by what each person unique circumstances:

> You know, if there was any colloquial, if there was any other random person off the street, they'd probably just say, using condoms. But there's more to just using condoms. Oh gosh. Thinking about anything that's safe sex. I guess any sort of either communication or physical method to make sure that each other's bodies are safe, that they're fully consenting to what is going to be going on, and what is going to be, you know, I guess inserted or brought into their bodies.

She explained that in order to practice safer sex, individuals have to understand that different people have different levels of knowledge about safer sex and that while people may think it is limited to condoms, it involves ensuring bodies are safe.

Ava also connected consent, physical safety, and safer sex:

> Condoms first, obviously. And then I think about regular testing, and I think about consent, and checking in during to make sure that everything is feeling okay. Especially if there's any pain or not, and talking about how we want things to happen before we do them. Well, it's important for safe sex because you want to make sure that everybody involved is okay with that's happening, otherwise that makes it into an unsafe situation.

Ensuring physical safety is particularly important in her sexual experiences because those sexual experiences include physical pain. For her, safer sex that involved pain required the use of condoms, but also protecting other people's bodies.

Evelyn expands safety to include not only physical safety but also emotional safety:

> For me safer sex … in the most general term would be preventing the spread or transmission of sexually transmitted infections, preventing any unwanted side effects of sexual activity (e.g., pregnancy from penile and vaginal intercourse), safety also just the physical and emotional safety... like rape is not safer sex to me because someone has not consented and there is no negotiation of that... For me, if someone doesn't feel safe in an emotional and physical sense then sex should not be happening. [Safer sex also includes] the prevention of transmitting other diseases using barrier methods like condoms, contraceptives, [and] birth control... [Safer sex also involves] just a clear communication amongst people to say "hey I have been exposed to this or may have or am HIV positive." … I don't think they should have it tattooed on their forehead, but say before they engage in sexual activity "hey disclaimer, I have syphilis or … I am HIV positive; we can still engage in sex but how can I not spread this disease to your body?"

Embedded in her explanation of physical and emotional safety around sex was the need for partners to understand the specific context of that sexual encounter. Noah also articulated the connection between emotional safety and safer sex, explaining that safer sex includes choosing partners that are safe:

> Not just health-wise but emotionally, as well. It's all a package to me. This may sound crude, but there's a saying, "Don't stick your dick in crazy." I don't want to, particularly, get involved with somebody who's unstable…I don't want to include anybody that will cause drama. We've done that, and that didn't work out well for us.

Logan listed and ranked practices that he associates with safer sex:

> I would say in order of relevance. Number one, communication, transparency. Number two, testing. Number three ... Well, I'll say number two would be testing and behavior. Number three would be barrier protection and it's a very far-off number three. I'd probably say 90% communication, maybe 9% testing and behavior, and maybe 1% barrier protection.

He placed significant emphasis on communication and transparency and almost no significance on using condoms. His conceptualization of safer sex is difficult to understand because using condoms is a rather straight forward behavior that a variety of people can understand and implement, but communication is a more vague idea that can mean different things to different people and therefore is likely more difficult to implement.

Similarly, Liam discussed the basics of safer sex and expanded it to emphasize the importance of communication:

> I think that a larger view of that would include being tested regularly, and having some communication and trust between the partners, where if some of those traditional methods aren't used, it's because there's defined boundaries that have been created among that dynamic in the relationship.

He includes defining boundaries and trust as important aspects of safer sex in addition to communication, condoms, and testing. He gave a personal example to explain what safer sex looked like in a specific relationship:

> I have had a vasectomy, so I do not need condoms for birth prevention. My two female partners have, for their own reasons, their own birth control prevention methods, primarily not for sexual activity, but for other health reasons, like migraines … because it helps reduce that severely… So for our relationship, birth control wasn't an issue…What remained was any kind of STI concerns. And entering that relationship, we had established that all three of us were free of any kind of STI or STD. And so, from the beginning, we did not use condoms, or anything . . . I guess, in my experience, it escalated pretty quickly, in terms of from just meeting to a relationship. But it was at some point where just we all decided on our own to … get tested and share our results. I think that was an underlying concern for everybody, and we just addressed it on our own, and one person shared their results, and then, "You know what? That's a good idea. Let me get tested, I'll share mine."

His narrative illustrated how safer sex behaviors are complex because women may be using birth control for medical reasons and communication about birth control and testing status ultimately lead to the decision to not use condoms. Even though he was not using condoms, he still considered it to be safer sex.

In addition to the actual safer sex practices used during sexual activity, Isabelle also shared about the emotional safety that is involved:

> I have two rules in my polyamorous relationships in terms of what I want to know. Everything else, you don't have to tell me shit. If you don't want to tell me anything else about your relationships, I'm happy. That's fine. There's two things I need to know. One of them is if the relationship is going to go something more than casual. If it's going to go into like, a partnership or like a romantic relationship. And the reason I want to know that is because of time. Like, if, like resources…there will be some emotional and sometimes resources that will be taken from one relationship to another one… And the second thing is I need to know if you're going to be fluid bonded with somebody else. Because that's a safety thing. Cause, I'm consenting to this person, to this person in front of me, my partner. I am consenting to them entering my body. I'm not consenting to other person entering my body. So, I need to know who else is going to be involved in, you know, coming, no pun intended, coming into my body… Not everyone has the same expectations.

Her rules included the more traditional sense of safer sex of what infection risks might be involved in sexual interactions, but she also discussed it from the perspective of consent. Her other rule really centered on emotional and relationship expectations more broadly and on the need for disclosure about the investment of people in the relationship.

In addition to explaining a broader understanding of safer sex beyond what they considered the traditional safer sex behavior of using condoms, participants also identified challenges of safer sex that were specific to their lifestyles. Some of the challenges mentioned by participants included specific types of sexual acts as well as safer sex practices limiting the pleasure of sexual acts.

For example, Olivia described that safer sex included practicing safer kinky sex:

> Bodily fluids in general ... We don't do blood play. We keep things extremely clean. It's pretty easy… So, yeah, there's definitely a lot of negotiations because of the kink level side of it too. Like, well, how do you want to be represented, how do you want to represent, do you want to, do you want to keep this in the bedroom, do you want to go public, do you want to go with me to the conventions, like how far do you want to go?

She felt that safer sex included specific acts involved in sexual activity and then extended beyond the bedroom to how they would represent their relationship to other people. Charlotte also explained that conceptualizations of safer sex tend toward emphasizing penises and therefore leave out sex that does not involve penises:

> I mean, it's the same basic principle, but it is a different thing to think about, because the whole thing felt very male oriented, like penis oriented; and .. what about when I'm having sex with someone without a penis? We're using different techniques and stuff.

As Avery discussed safer sex, she commented on how safer sex practices can reduce the pleasure of sex almost to the point of not making it worth doing:

> The disadvantage, though, is kind of the organic nature of it. Like it is a pain in the fucking ass to unwrap a dental dam and put it in place correctly; and they don't stay in place, and you usually need at least a decent quality one, it's usually really hard to get off… So it's like it's absolutely less pleasurable, which is a kind of shitty thing to say, where ... We got in a big fight like two months ago, where Luke was like, "I don't know why it's so hard for you to use oral sex barriers with

other people." And I was like, "Because it's just not as fun. It's literally not as pleasurable." And they were like, "Well, that's kind of shitty." And I was like, "Well, what's the point in having sex with other people if it's not enjoyable?" like that's also kind of what I'm feeling there.

Avery explained the disconnect between using safer sex tools like condoms, dental dams, and gloves being used for safety and how those tools can interfere with having a pleasurable experience. The lack of pleasure put her in the position to decide between safer sex that is less pleasurable or sex considered less safe by some but more pleasurable. When engaging in safer sex, participants navigated a variety of sexual situations and safer sex preferences that demonstrate the complex nature of safer sex behaviors.

Setting boundaries to ensure safer sex. When participants discussed practicing safer sex, several of them emphasized having a set of safer sex boundaries. These boundaries appeared in two primary ways: personal boundaries that they wanted a partner to adhere to and boundaries that a partner had that they had to adhere to. Participants also discussed the need to navigate the conflicts that emerged when their personal boundaries and the partner's boundaries did not align.

For example, Olivia explained the personal boundaries that she has for engaging in safer sex, "Condoms, regular testing, and 100% honesty with all your partners." Those were her boundaries, but she then went on to describe the safer sex boundaries that other partners have:

Well, not during oral, but I do have one partner that requires [condoms and dental dams] during oral, he's just like that... [at] minimum, my husband and I get tested

every six months, and we have a couple of our partners that test at every three months. They're OCD, which I'm totally onboard for the amount of times the chlamydia's traveled around Georgia, we are totally cool with just…And obviously those who are willing to be on birth control totally do it in our circle. I just can't. So everybody else has to be extra cautious because of me… I mean except for the real nasty diseases, most of them are pretty curable these days; but children…That's not curable. That's not so curable. That's not a curable situation.

Olivia alluded to partners having to navigate each other's boundaries; she had to use condoms during oral sex to meet one partner's rules, while other partners had to adhere to certain rules because she is unable to use birth control.

In her narrative, Charlotte discussed very strict safer sex boundaries:

For me that is asking partners to provide some sort of proof that they've been tested, especially because when you're in a relationship that's open, I mean, my other partners can see other people as well, who may not be as careful, so we all have to make sure to be careful with each other… So just asking for those results, and then refusing to continue the encounter if they're not willing to put on a condom or whatever, or I've had people who we had a pretty good thing going… they started [out] being totally cool with wearing a condom, and then they started asking over and over like, "Hey, can we do it without?" And were not listening to me when I was like, "No, I'm not willing to do this without protection." And that pressure was what ended things.

She was willing to stop sexual activity if a partner was not adhering to her strict safer sex boundaries. She felt that it was her responsibility to be this strict because of the expectations that she and her husband established:

> We'd been dating for a while, we'd been married for a bit, and then we decided to open things up. So, now all of a sudden we're having to negotiate safer sex both with each other, but also what I do with other people. So, we were having discussions around that, because he's like, "Oh yeah, I'm totally fine with you going out. That doesn't bother me at all, but I need to know that you're doing these things to protect both of us." So we had talks around that, which was interesting, because I'd never [talked] about … safer sex practices, but not with you, like with other people, so that's kind of an interesting conversation.

Her husband had expectations for how she behaved with other partners and those expectations informed the boundaries that she employed before engaging in sexual activity with the other partners.

While several participants discussed maintaining and enforcing boundaries, one participant, however, described the process he went through when he reconsidered his boundaries from being hard “rules” to being “principles”:

> One progression over time is from rules to principles, and this is a big part of my personal philosophy in general with everything I teach in the realm of martial arts, and tai chi, and mind-body mastery, and everything that I do. It's not about rules, it's about principles. Understand these principles and how things work. It's not about these rules that you have to follow or break. These are the principles by which things operate and by having consciousness or the principles by which

> things operate, one can make conscious decisions and choices and take conscious inspired action. That would be a part of it to whatever degree it was evident that it needed to be a part of it, and if it's not spoken of, it's not because it's taboo to be spoken of. It's because it just doesn't need to be spoken of, but if there was a need to speak of it, it would be spoken of.

For Logan, it was more ideal for his boundaries to be set by principles that would emerge in the moment with a specific person rather than have a set of rules that apply across most or all sexual interactions, and having these principles constituted sufficient considerations for engaging in safer sex.

Participants said that once they know their own boundaries, they need to establish these boundaries with partners. Avery, for instance, lamented the difficulty of negotiating boundaries with partners that did not have their own boundaries or had only minimal boundaries:

> But for example, in the past months, I started seeing another side partner ... Rob identifies as a cisgender, bisexual man, super uncomfortable using any of the safe sex practices except for condoms, because they're male-identified, so they're like, "Condoms are fine." But I was like, "If you're going to give me oral sex, that means you use a dental dam," and they were super weird about it…And so it's so much harder for me to set up those boundaries with other people that aren't setting them up for themselves. And so anytime that I have sex at kink parties or with people who are in the kink community, it's super easy, because we're all on the same page and we all have that same value system that's informing why we're using safer sex practices. But when I have sex with people who are not, and

> maybe they're just poly or they don't have a problem with the fact that I'm poly, it is much more difficult because of the stigma, or just feeling uncomfortable using those kinds of barriers.

She said that when she had partners from communities where the cultural expectation was to have personal safer sex boundaries, it was easier for her to enforce her safer sex boundaries. When a partner had limited boundaries, it was harder for her to enforce her personal safer sex boundaries. Noah, however, did not experience the same level of difficulty:

> I guess, it's just ground rules. When you're in this kind of situation of poly or non-monogamous, you include that information. "Hey, this is what I'm doing. I don't wanna bring anything home. Don't bring anything home to me." So it's pretty straightforward... I don't think it's a complex process. I think, if you're just open with your partner about what's going on, that kind of stuff just works its way in, and you deal with it.

For him, the boundaries were just established and adhered to without much complexity to the situation.

In several instances, rules were presented as understandings that are already established and that stayed constant. Evelyn agreed with that, but also mentioned the need to check-in with partners over time to determine whether the boundaries needed to change:

> We do have rules, basic rules that we talk about … constantly . . . When there is someone else that my girlfriend has been having her eye on, and funny enough, so have I. But we, the two of us, we talk, and I say "oh if you're going to have sex

> with this other person, it's okay because I know you've been wanting to have sex with another person, and hell so would I." But my girlfriend says: "okay, yeah, that's great." But we would still need to sit down and actually talk about it, if I was going to have sex with her for real. I appreciate that, that even though we have some understanding of the rules, we really should be sitting down and talking about it. We always make sure to at least verbally renegotiate or we talk about verbally renegotiating, should we cross these certain bridges.

Participants described baseline boundaries and then boundaries that were situationally considered. The relevancy of boundaries to different moments were dependent to situations and the individuals impacted. Also, when new partners might be introduced, boundaries needed to be reviewed to ensure all partners are satisfied with the relationships.

Trust influences engagement in safer sex practices. Trust emerged as a theme in every participant's narrative when asked about safer sex. Participants indicated that trust is an important part in deciding what safer sex practices they engage in with partners during sexual interactions. Trust was understood to build over time and is an important consideration in relationships as well as sexual activity. For polyamorous participants, trusting is complex because it involves dealing with multiple partners with their own history, experience, and trust expectations.

Trust was discussed as something that builds over time. For example, Liam explained that it can be difficult for him to establish trust:

> Well, that's a great question. The trust, for me, doesn't come easily, and ... I don't know if I have a good answer for that. I think, like most things that are safety-

based, there's an element of an understanding that there's a risk that you could be wrong, but it moves forward in a hope that you're not, and a willingness, I guess, to accept the consequences if you are wrong. But I believe that trust is earned through a building of a relationship, then that can be successful.

Charlotte agreed that trust builds over time: "A lot of it's just time together, and the trust that builds up with that." Additionally, Logan also explained how trust builds over time:

> It could very well be that the level of trust in a relationship increases over time. I think that's a natural and healthy progression, and it's probably something like a sharp increase towards the beginning and then it somewhat leveling off over time like a logistic curve kind of a thing, so that's in terms of relationships.

When asked how trust builds over time, Avery gave some indicators:

> Just self-disclosing, and sharing, and having clear understandings of what we want from each other, because to some extent you just got to trust people; because if you need every single check mark, you need to know where they are all the time, and what's happening all the time, then it almost becomes like paranoia, and it's so fixated on rules. And there has to be blind trust at some point, like people need to prove themselves, but you also just need to trust that when people are saying something they mean it. And it's really hard to do that, because there's always going to be [untrustworthy people] in the world, but you can't guarantee everything with human behavior.

She considered sharing and disclosing as the way to build trust, but she also indicated that at some point, you have to make a leap of faith. She recognized that the leap of faith can be risky because a partner may be lying.

As Abigail explained, trust is also built through regular communication:

> It looks like talking about potentially having sex with someone before you have sex with them. So through my girlfriend and I, like our relationship and how we talked about it. It was that … if we were going to have sex with somebody else, [we] needed to talk to the other person first and then make sure that it was okay, that the other person was comfortable and then you could have sex with that person. And then we talk about it afterwards... this also counts for emotional intimacy too, like if you have feelings for someone, let's talk about it instead of a person being worried that the other people are going to be upset, which hasn't happened yet, but yeah, lots of communication.

For Abigail, in her relationships trust was built through frequent communication around emotional and sexual interest in new partners; not only did that build trust, it also built emotional intimacy.

Olivia discussed some ways to identify whether people were trustworthy:

> I have my minimum requirements for safety. Other people may have additional requirements for safety. If they during the negotiation process try to bypass my minimum requirements and try to say, "But what if we were in this situation," at that point I know there's a possibility that they could betray my trust and I won't go further.

She makes a judgment call regarding her feelings of trust and safety based on interactions she has with a potential partner. If a partner passes the initial trust test, Olivia explained that trust is something that must be maintained throughout the relationship:

> That's part of the trust factor. If you trust them enough to engage in anything that might expose you, then you trust them to be honest with you. And so, yeah, the honesty factor is, you know, once that's breached it's really hard to get that back. But, yeah, you know, if the condoms are involved then safe practices are there even if they're not honest you at least are still, you know, protected yourself. But, yeah, with us it's ... primarily it's about being completely honest.

For Olivia, even though trust was important when considering even engaging in sexual activity with someone, she felt that safer sex practices like condom usage was still important in case a partner is dishonest. That way, you protect yourself in that case that the trust is broken. Amelia shared that not practicing safer sex can also damage trust:

> But, actually, there's also the emotional and trust component. Even if you feel confident [that the other person does not have an STI], like I did, and even though it wasn't intentional, it hurts the trust in our relationship to not be practicing safer sex when we're supposed to have been. It hurt my relationship with my wife, and it affected her relationship and my relationship with her girlfriend and my metamour.

From this view, not behaving the expected way in sexual activity with other partners damaged trust between partners.

The explanations of trust primarily shared by participants were generally between two people. Avery, however, gave an elaborate explanation of the complicated ways trust looks when multiple people are involved. She shared a long story involving multiple people that illustrated the complexities of trust in safer sex as well as in polyamory. First,

she talked about asking partners whether they have an STI or not, and then taking them at their word:

> I do usually try to have conversations with people about their sexual health status, usually in the sense that I'll say, "Hey, I got tested last month and I don't have any STIs currently," so that way it's less of asking in this kind of presumptive way, of like, "Oh, are you good?", because I really hate using that clean dichotomy of like, "Are you clean?" versus dirty. But at least I try to assert it, so then the other person can. But granted, it's not like I've ever had anybody be like, "Oh yeah. No. I do have an STI." I think a lot of people are just like, "Oh yeah. No. I'm good," even if it's been like two years since they've been tested, just because they're in the moment and they want to have sex, and so they're just going to say things. So even that is not the most foolproof system.

The interaction is initiated with her disclosing her STI status as a way to build trust and to low stakes initiate what can be a difficult conversation. Then, she reflected that everyone just said that they don't have an STI, and so she even recognizes that trusting people at their word is somewhat problematic because it is not a "foolproof" system.

Avery went on to discuss what happened when trust is broken:

> Like we had a huge relationship negotiation, and safe sex negotiation, conversation a month or two ago, when I had unprotected sex with somebody, and I had to be honest about it. And I very easily could not have told the truth and just kind of kept it to myself, but that's not really what this relationship is for, and there has to be the trust that I have to own up to doing something that falls outside

> of the boundaries that we've set up and negotiated, in order to trust that Luke would do the same, or my other partners would do the same.

She explained the importance of disclosure as a way to maintain or repair trust. So, even though she did not follow the agreed upon rules for having sexual activity with other partners, she told her partner so that they would know about it and work to renegotiate their relationship; in this case, the act of disclosure was a place to repair trust. To further contrast the importance of disclosure and the consequences of broken trust, Avery gave an example of when someone was having unprotected sex with multiple people but did not disclose and how that deepened the sense of betrayal:

> But it's funny, because I even asked Luke at one point, where I was like, "Would you have felt differently if Jacob had been honest about it?" Because I guess they had been told by a friend, like Jacob did not admit it, they had to confront him. And it was interesting, Luke was like, "Oh yeah. I think I could've forgiven Jacob at that point," which I was really surprised by. Because I was like, "Oh, I'm surprised you would forgive them." And they were like, "Well, it's not about safer sex. I mean, it is about safer sex, but it's about trust. Like if I can trust that you'll at least come clean, then we can work with that. If it continues to happen, that's going to question my general boundaries and safety around you, but at least I can work with you owning up to a mistake you made. If you don't own up to it, I can't do anything to navigate our romantic relationship."… Luke was like, "You had unprotected sex and then immediately told me. You weren't doing it to be dishonest. You broke rules in our negotiation and the boundaries we set, but you're not doing it to be dishonest."

In this example of someone who was not having safer sex, it was an additional strike against them because they did not disclose it and that lack of disclosure made the trust system fall apart and ultimately damaged the relationship beyond repair. Because Avery did disclose the lapse in safer sex, they were able to continue to be together in the romantic relationship because of the honesty involved in that disclosure.

That history of broken trust for one partner given in that example was used as justification for very strict safer sex standards in other relationships. Even though Avery did not act egregiously, her partner expected that she behave very strictly because a previous partner acted carelessly and lied about it:

> Like I remember Luke was telling me about… Jacob, who was having unprotected sex with several people…for like six months and didn't tell…I mean, I think it was really interesting, because I've seen the way it trickles down into the relationship, because kind of when Luke and I got in the argument a month or two ago, I was just like, "I don't know why you're so intense about this," and they were just like, "Because Jacob really fucked things up, and it really messed with our trust dynamic, and I haven't had someone in a poly dynamic with us that has actively done something in a dishonest way," And I've noticed it influences the way in which they navigate safer sex. I think that's why they're so intense about it.

The expectations that Avery had to perform to were set not because of anything that she did or did not do, but those expectations were set because of the history that her partner had with someone who broke trust. The trust was not just between the two partners but was complicated because of past partners as well as the knowledge that there are current and future other partners.

Avery went on to describe the broader impact of that dishonesty and how the damage went beyond just the sexual relationship:

> And it's interesting to think, too, within the poly context, how much of that holds weight, because I know Luke doesn't speak to Jacob anymore ... because it was kind of a triad situation with Luke, Jacob, and Becca a little bit, and Luke does not speak to Jacob at all anymore, but Becca still does. And even the other weekend, we were texting, and Luke was like, "I'm just so bothered that Becca is still texting Jacob, and friendly with them, when they fucked us over." And I was like, "Yeah. I mean, but you can't tell her who she can and cannot be friends with." And Luke's like, "Well, yeah, but I just don't understand why she would want to even be friends with them to begin with." So even that, like the trust in how people navigate the non-sexual parts of kind of a breakup within that poly dynamic is really odd. But I think there has to be some level of trust that I ... I mean, it is on trust, and if someone breaks that, it really makes you question the kind of larger system, where it's like, "Well, if I trusted this person, then how do I know that everyone else is doing as they say they are?"

Here, Avery reflected on how her poly community functions based on a reliance on this trust system and that even one person breaking that trust can have ramifications into the whole community.

Avery continued reflecting on trust and safer sex and compared it to trust issues in past monogamous relationships:

> But I think just because we talk about it in this way, that it feels supernatural, and it's not taboo, and it's not secretive, makes me trust them. I mean, there's always

> some level of concern in the back of my mind, because I've dated people who were dishonest and cheated, in monogamous relationships, but there is some level of that kind of freaked me out. I think I've talked a lot about my concerns with that, with Luke, over time. And I think because I've been vulnerable and honest with them about the ways in which other people were unfaithful to me, it makes me feel more likely that they're not going to be unfaithful.

She explained that she still experienced cheating and lying when in monogamous relationships, but that in the poly relationship, the trust built through communication and disclosure created a stronger sense that a partner would not be unfaithful.

In addition to the complexities of trust involved in past experiences with multiple partners, Amelia shared an example of how current partners have different levels of trust amongst each other:

> With a new partner, especially if they're unknown, yeah. There was unprotected, although brief, penetration with him not too long ago. We knew better, and we didn't intend to. We were supposed to use condoms and all that good stuff. But because I know him intimately, not just like sexually, but I know him very well, I know his sexual history and trust it. But because my wife doesn't really trust him ... there's issues with him ... and because my metamour doesn't know him from anyone else in the world, after that I got a full panel of testing before I would do anything with my wife and, therefore, my wife wouldn't be passing anything onto her girlfriend. So before any sexual activity could happen, for their sake, even though I was confident ... the only worry I had is risk of pregnancy, but I did get a full panel.

In this example, there are several people involved in sexual activity separately, and because there were varying levels of trust amongst all of the individuals, Amelia had to get tested so as to maintain trust in the other relationships.

The ARRM highlights self-efficacy and a cost-benefit analysis as important influences for people to commit to engaging is safer sex. Several participants described practicing safer sex and discussing safer sex as easy to accomplish, indicating that they have higher levels of self-efficacy and thereby a commitment to engage in safer sex. Participants also described a cost-benefit analysis process that they conduct to assist them with engaging in safer sex. Participants clearly explained the benefits of safer sex were related to protection of themselves and their partners. The costs were related to various sex acts that are not easily conceptualized with the standard safer sex practices or the loss of pleasure in various sexual activities cause by dental dams or other protective behaviors.

RQ3: How do participants describe the importance of safer sex communication in polyamorous relationships?

Participants described communication as an important component of polyamorous relationships generally and of safer sex specifically. When they discussed safer sex communication to maximize safety, two themes arose: 1) communication strategies and 2) communication content.

Communication strategies that maximize safety. The participants discussed three main effective communication strategies for safer sex discussions to maximize safety: (1) early and frequent safer sex communication, both at the beginning of a relationship and throughout the relationship, (2) safer sex communication when changes

occur or issues arise to check-in with partners, (3) direct communication as the best approach to safer sex communication, and (4) communicating "like and adult" with honestly and with emotional maturity. All participants comments referred to these categories of communication strategies.

Avery discussed the need to be sensitive to the timing of safer sex communications, noting that the best time is before engaging in sexual activity, especially when engaging in kinky sex:

> I try to do it before we're having sex, because I find it so uncomfortable when I'm having sex with somebody. I really started to model this after my DC partner [who is involved the kink scene]. I remember we were making out and whatnot, we were in a hotel room, and I was like, "Do you want to just not go to the bar and just stay here?", and they were like, "Well, I still want to go to the bar and then we can have a boundaries conversation," and I was like, "Ooh, okay," and had really good boundary conversations…So having that conversation in a non-sexual context is so much more freeing, because there's no sense of anticipation, or, "Let's just rush through it, so we can do this thing." And it feels more of a shared conversation of interest, and trust, and boundary setting, than any conversations that I've had previously with people, as you're starting to make out, and foreplay, and all of that. And usually those conversations just get kind of limited to, "Oh, do you have protection or barriers, and have you been tested recently?", and those are not really conversations as much as answering questions. So I like trying to have a conversation about it. I think a lot of that is influenced by the fact that a lot of my poly community intersects heavily with the kink

> community, and there's a lot more negotiation that comes into play there. So I try to have safe sex conversations outside of the sexual realm, and try to navigate where people are comfortable and what works for them.

In the story Avery offered as an example of effective safer sex communication strategies with a partner, she highlighted not only the need for these conversations to happen before sexual activity, but also outside of sexual interaction. For her, these conversations built trust and safety in the relationship.

Silas also discussed how safer sex conversations happened at the beginning of the relationship with her primary partner, but also before sexual interactions with new partners:

> For my primary partner, we were just very open about it when we first met. For the other partners, since most of them are developing through existing relationships, it's very, for the most part, no strings attached. And/or because we're meeting primarily for the explicit purpose of it, I really don't have a problem with being like, drug disease free? Even though I know that that's ... little questionable as an implication, but it's just very point blank. Again, it's very transactional… It's like, this is what's gonna happen, or this isn't what's going to happen. Even … in the rare occasions that something develops into a sexual relationship, I've just always been like, pause, depending on whatever is going on, and just been like, this is the situation, and take it from there.

Early conversations allowed Silas to establish expectations and ensure all people are on the same page. It also allowed them to set the groundwork on which to move forward in the sexual interactions.

The fluid and organic nature of safer sex communication is important to ensuring that people know what to expect during sexual interactions throughout a relationship. Evelyn offered some examples in her description of safer sex communication strategies:

> I just talk about safe sex with a partner when it comes up. For example, talking about, "hey if you talk about sexual activity, you know what to do together." "Hey this sounds really great!" Oh what will it look like? What do you think of that flavored lube? Whenever it comes to mind, just talk about it because it's more conversational, and the conversation becomes more organic by then. Hopefully you can say to your partners, "hey this is important, let's talk about it." "Okay let's talk about it."

For this participant, the recurrent and organic nature of the safer sex communication worked to ensure an ongoing sense of safety and pleasure throughout the relationship.

Participants also described the importance of initiating safer sex conversations when changes occur or when issues arise that partners need to be aware of. For Isabelle, these conversations occurred at the beginning and throughout the relationship:

> It usually happens at the very beginning. And it's a very easy conversation. You know? … My most recent partner that I would have to had that conversation with, my most recent partner is a woman. And, I don't know if we've really talked about safe sex. We talked about it throughout our relationship. So, I'll just come up with the other story of the one previous to her. It was very simple. It was very much, and it happened with a lot. I wouldn't necessarily say it's with partners. I think it's actually just who I am as a person when it comes to talking about sex, and like safe sex.

Isabelle shared that she had a personal preference for communication in relationships in general and that safer sex communication is one type of communication that is important to her.

Liam reflected on the need to have safer sex communications when incidents arose that may impact the relationship because there can be repercussions from such incidents that may have happened that a partner should know about:

> I've always been in a relationship where if that type of activity is going to be considered, I would exchange background information; "By the way, I have a vasectomy, so unless you use condoms for some other reason, there might not be a need," kind of discussion. But if that has been established, and the decisions are mutually agreed, I think that is the baseline and continues forward to the rest of the relationship, unless something changes, "hey, by the way, this happened," and whether it's something that might break trust or just a side event, I think then the discussion can be brought up again. But I think that kind of goes along with the trust idea, where if you've established a structure of a sexual relationship, I'd go by that established structure, and would expect that if that changes, that would be disclosed to me, as much as if that changed on my side, I would disclose that as well.

He had the expectation that partners would initiate a safer sex conversation when something might affect his safety and stated that he would initiate the conversation if he needed to as well.

As is true in life, people learn from making mistakes, and Abigail explained that she learned about the importance of ongoing safer sex communication through sharing a story about a time when she and her partners had a lapse in this type of conversation:

> Well we talk about it, but we also don't really talk about it I guess because we talked about it a little bit at the beginning of my girlfriend and I's relationship because we were new and having to figure out boundaries and stuff like that. But as time's gone on and I haven't had any other partners and she's only had her wife as another partner, we haven't talked about it as much, and we didn't talk about it again until her wife slept with someone else. And then we have a serious discussion again about it, but I mean if the topic ever comes up, we just kind of talk about.

As highlighted in several of the narratives, early and frequent safer sex communication is important to ensuring comfort and safety.

A third strategy for effective communication that was repeated throughout the narratives is engaging in direct, plain communication. Participants stated that these conversations were easy to have and that they generally took a direct approach to engaging in them. When asked about having safe sex conversation, Charlotte stated that she prefers they occur early and that they are easy to have:

> I personally find it pretty easy. I talk about sex a lot. I'm pretty open about it, so I'm pretty comfortable advocating for what I want… So, for me, it's fairly easy, and once you get more practiced at asking those questions and stuff, it's not been a super big deal. Just straightforward ... I don't have time to waste beating around the bush here. Like, hey, if we're going to do this, here are the ground rules. You

> have to get tested, you have to use a condom. I just lay it all out there. That is before anything even happens, because it's not like I'm waiting until the moment. I think sooner is better. Like, hey, these are going to be my requirements. If you're interested in getting physical, I'm going to need these things from you.

She explained that having direct conversations early in the relationship allowed for her to advocate for herself and to make sure that the partner is able and willing to meet her safe sex requirements.

Emma also discussed the need in poly relationships for early and direct communication:

> Everything in this type of relationship is said head on… Okay, if you're going to have sex with more than person, you're talking about having sex with more than one person. So… [the] first conversation you really have to say is if you're gonna have sex with two guys, you're gonna be having sex with another guy, how do you feel about that? It's much better than springing it on them. You know? The easiest way is direct. "I'm not gonna have sex until we all go, as a date, to get our blood work and we will see if we are compatible to have sex that way." … You just do it at the front. It's easier to start that way and back off than it is not to even start that conversation … and I've never had a guy say no. Ever.

She explained that direct and early conversations are better and easier in order to avoid negative consequences. Moreover, she added that these conversations were positive experiences.

For participants, direct safer sex conversations are important in building a sense of safety because they are used to check-in with partners and ensure that everyone feels

comfortable, especially when multiple partners are involved. Ava offered examples of how these conversations occur:

> For the conversation before things are started, usually "Hey are you up for this right now? Or do you want to do this later this evening?" And then we'll say, "Yeah sure." Or, "No maybe not tonight." Checking in during is, "Is this feeling okay? Do you want me to do something different, do you want to try this, do you want to try that?" Et cetera. And then also talking afterwards is important as well … just saying, "How was [everything]? Is there anything we can do differently next time?" Because it's always confusing and complicated especially if I'm with both partners… I'm very into verbal feedback at all times. So, if my partner's getting quiet, I'll stop, and I'll say, "How are things?" I want feedback. I want to know how I'm doing, if I'm doing anything right or wrong. And I have no problems stopping things in the middle.

The participants emphasized the importance of direct communication for safe sex throughout relationships, from establishing relationships to setting expectation for sexual activity and even when engaging in a sexual act.

Lastly, participants expected their partners to “act like adults” and engage in open communication with honesty and emotional maturity. Amelia paired the importance of direct communication and acting like “an adult” with ensuring the safety of the partners:

> So, for me, I'll just say whatever. I don't have to keep anything hidden. So if it was someone that was gonna be new, I would just be really ... everything would be up front, if it's new or old. I'd say, "Look, this is an issue that we have to address. We're adults and we need to be safe. So, okay, when was your last STI

> panel? Have you ever had one? If you haven't had a panel within the last six months, you need to go in again before I can have sex with you. This is the agreement I have with my wife," or whatever.

Abigail also emphasized the expectation that all partners would act with maturity:

> We just kind of talk about it I guess…I'm almost 30 and both of [my partners] are almost 40 ... She would probably kill me if she heard me say that. They are in their mid-thirties, on the higher end of mid-thirties and so ... We're too old to just kind of not talk about things I guess ... I mean people avoid talking about things at any age, but we're kind of just like, we don't have time to just not talk about something if it's an issue or if it's a topic where we need to discuss.

As Amelia and Abigail described, all of the strategies of effective safer sex communication ultimately stem from the need to be honest and have emotional maturity. Engaging in honest, direct communication that occurs at the beginning of relationships as well as throughout relationships works to establish and maintain a sense of safety when engaging in sexual activities.

Content of safer sex communication to maximize safety. By sharing stories and examples of how they engaged in safer sex discussions, participants stressed the importance of the content of the communication. In discussing the content of safer sex communications, three themes emerged: 1) safety ground rules, 2) disclosure of details that impact safety, and 3) addressing the effects of miscommunication.

A primary purpose of engaging in safer sex communication was to clearly establish safety ground rules. Isabelle shared her typical safer sex rule setting conversation:

> If we're starting to talk and it's like, hey, let's meet up and … if there is the intention to have sex, and if it's the first time, then the conversation happens of like … "when was the last time you were tested? A year ago? … How would you feel … if you went to get tested and then … let me know what's going on?" And then I tell them when the last time I was tested, and if they felt uncomfortable about my timeline, same thing for me. I tell them, there has to be condoms, we have to use condoms even if you get tested. And then I also say, I have an IUD… so I have birth control... And from there, some are like … they have .. questions … they [want] to know my sexual history… But, it's a very simple question. And it usually happens before our first sexual experience. And it kind of just, assuming there's no change to the relationship, it stays the same until there's a change to the relationship, and then we have another conversation.

In her safer sex conversations, she and her partners discuss their various expectations regarding safer sex, however, these discussions are question driven, so there is likely some variation in these discussions. The effectiveness of this question driven conversation may need further investigation.

Avery shared her typical safer sex conversations:

> "What is a boundary for you?" So, like I know Luke would say, "Unprotected oral sex is a boundary for me. That's not going to happen." So I would say boundaries would be, "You need to use certain kinds of barriers," "Certain kinds of sex are off limits, because maybe I find them too risky," or things like that…And I think a lot of boundary setting and safe sex kind of go hand in hand.

In addition to ground rules related to the specifics of safer sex, Avery presented the unique complexity of ground rules that apply to sexually engaging with partners who are trans or gender queer:

> And a lot of that had to do with, a fair number of my partners are trans or gender queer, and so there's just different boundaries and discussions of "What is off limits for you? What do you like? What do you not like? What type of words do you like to use?" Even thinking about the fact that I have sex with lots of trans men and there are certain terms that are uncomfortable, like both Luke and my DC partner do not like using the word vagina at all; they only refer to it as their cunt. So, it's those types of things, where it's like that is very particular and it's going to change that sexual dynamic.

Safer sex conversations included terms and labels that make the partner feel comfortable and safe in the sexual experience.

Beyond sexual safety expectations, there are other practical concerns that can impact safer sex. Noah shared an example of a very practical concern:

> We had to actually discuss what she was comfortable with using. It's like, "Hey, do I need to do anything special?" She said, "I have a latex allergy." "Okay." Well, at the beginning of the date we determined that because I said, "I need to pick some up." She said, "Okay, well, I have this allergy, so." So yeah, that's basically how the conversation went.

Through the process of discussing ground rules, the opportunity to address non-sexual, yet very important concerns like allergies were able to arise. In addition to sexual safety, setting ground rules also involved broader concerns, like relationship requirements.

Olivia explained how relationship expectations were included as part of safer sex expectations:

> It comes up in the first date. The partners I have now are ones that I spent time with talking online for a week or two before we actually met in person, so conversations like that came up but essentially it would be ... It would come up in the ground rules of let's talk about you being poly. What are the requirements of you being poly? And that's when it would come up. Because that's usually something when looking for poly partners as well, what are requirements like. Like I don't want to sleep with your wife, is that part of the deal? You know, that kind of thing.

Safer sex communication is an important opportunity to establish safety rules and learn a partner's expectations. Through these conversations, trust and comfort are built as partners start bonding and this helps create a foundation of safety.

Another important component of the content of safer sex communication is disclosure of health status and other incidents and situations that may be risks to the safety of partners. Isabelle very bluntly stated her expectations regarding disclosure of partners' engagement in unprotected sex:

> I just need to know what is going to [happen], what am I being exposed to? Because, if there is a STI scare, I want to know where it came from… I'm not going to pass a judgment on anybody that is like, oh, you caught chlamydia or whatever. How dare you not practice safe sex? I just want to know if it was me fucking up or if it was somebody else fucking up, and then deal with it there. Not everyone has the same expectations.

Her expectations for disclosure of STI risks are communicated directly, but she recognized that people may have different expectations. Logan demonstrated those different expectations. For Logan, disclosure of STI risk was a complex discussion:

> Well, I suppose my first concern would be knowing if they are fully aware and read up and know the relevant information [about STIs]... and I've had relationships, where that's the case or it's not the case and I have to explain, “This is what HPV is and this is what HSV is and this is how it works.” If it happened to be as a partner, a potential partner who's not informed on the subject to say, “This is what you need to know about it and here's where you can read more about it.” I just wanted to be sure that they have the factual information and the awareness to make whatever judgments and decisions they want to make for themselves. Provided that's in place, I would want to know, “Do you have any cause for concern?” If so, “What is it? What's your cause for concern? What the history or what's the situation?” If I have any cause for concern, I'll share it regardless. [They’re] welcomed to ask me whatever they'd like to know about, I'm an open book. I guess there's a certain principle involved, which is it's not a taboo subject, it's okay to have these concerns, it's okay to talk about these concerns…Rather than reacting in any way that thwarts their need or their desire for clarity, or certainty, or safety and doesn't take it as an assault or affront in any kind of a way but that is a genuine concern to raise and to discuss.

Logan’s example of a STI disclosure conversation included preparing for having to deal with STI misconceptions as well as creating a safe space for concerns to be brought up,

validated, and resolved. This style of conversation would mirror aspects of safe sex discussed above that include the emotional wellbeing of partners in addition to health.

Safer sex discussions in poly relationships involve all the individuals with whom a partner might have sexual interactions. Isabelle was aware that she was at risk when her partners slept with other people and it was important for her to know about that activity:

> That is my expectation [that my partners would be open and communicate about their feelings and experiences and things with safe sex]. I have found in recent experiences that's not everyone's expectations. I have two rules in my polyamorous relationships in terms of what I want to know. Everything else, you don't have to tell me shit. If you don't want to tell me anything else about your relationships, I'm happy. That's fine. There's two things I need to know. One of them is if the relationship is going to go something more than casual. If it's going to go into like, a partnership or like a romantic relationship. And the reason I want to know that is because of time. Like, if, like resources. So, it's like, oh hey, there's going to be another person involved in our lives more often. Like, this is a more, this is an important person. This is somebody who, you know, there will be some emotional and some time resources that will be taken from one relationship to another one…And the second thing is I need to know if you're going to be fluid bonded with somebody else. Because that's a safety thing. Cause, I'm consenting to this person, to this person in front of me, my partner. I am consenting to them entering my body. I'm not consenting to other person entering my body. So, I need to know who else is going to be involved in, you know, coming, no pun intended, coming into my body.

Isabelle described the repercussions of having partners that sleep with multiple people in two significant ways. First, there are emotional and relationship consequences to adding a new partner to an existing relationship. The second concern is the additional risk of contracting and STI if the other individuals engage in risky sex. Thus, disclosure in safer sex communication is key because the decisions and behaviors of one individual have a ripple impact on all other individuals directly and indirectly involved with that individual.

Addressing the effects of miscommunication is another important part of the content of conversations about safer sex. This was exemplified through the stories of what happens when there is miscommunication. Emma explained the importance of effective, accurate communication in poly relationships:

> Sometimes we work on what I need, and sometimes we work on what Boyfriend A needs, and sometimes we work on what Boyfriend B needs. But there is some kind of negotiations going on at all times because we want everybody happy, healthy, and communicating. Because the biggest thing is the communication, right? We need to communicate… I'll give you an example… We have date night on Tuesday… And there was a lack of communication, okay? A lot of lack of communication. And I got hurt in the process. Boyfriend B was expecting me to scream at him and I didn't scream. I talked to him normally, and he didn't know what to do. 'Cause I spoke to him normally and I didn't hit him. I'm like, "Why would I hit you?" I mean, that doesn't make any sense. So there's a lot of talking things out and relearning behavior that is considered normal. Which isn't normal. It's not healthy… so we talk a lot. And there's negotiations that happen all the time. And no, I didn't get sex on Tuesday, which I was pissed off at. They both

> work long hours. Both work very physical jobs. And so, that's where the porn movie does not come into play. You have this notion, even I have this notion that I have two boyfriends so I'm gonna get sex more, right? Doesn't that make sense. Twice the dick, I get twice the dick. But no, it doesn't work that way. I get twice that "I'm tired, honey. I just wanna sit down and watch TV."

This example illustrates how the repercussions of a single miscommunication were multi-layered. Feelings were hurt, they did not have sexual intercourse and that upset Emma, and assumptions were made by partners about communication expectations and navigating past influences. Additionally, miscommunication can have a negative impact on a relationship, even if there is no physical damage. Isabelle shared an example of when a partner did not disclose an instance of engaging in unprotected sex:

> It happened where one of my partners didn't disclose to me that they were having unprotected sex with somebody. I had to ask them, “are you doing this?” And they said “yes,” and I'm just like, you were supposed to tell me beforehand… [this time] nothing happened. I didn't get any STIs or anything like that. But it was just the whole like, I wasn't consenting to this. You didn't tell me this. I needed to know this. And I told them… I literally only have two things that I need to know. That's it. And you literally didn't tell me one of them. What the fuck? … So that was a huge issue.

Amelia also shared an instance of miscommunication:

> Well, [our safer sex expectations] really evolved, over time. We didn't have anything in writing when we first started and when she got a girlfriend, which was our bad. But after the fiasco that I referenced with the guy that I'm involved with

> on and off, we then sat down and made it clear, because there was miscommunication, in general, about that. The last communication we had had, it's been a little while, so we both remembered things differently. So, I'm like, "No, we need to have this in writing. We should have, already." So not too long ago… we finally put it in writing in a shared Google doc of all our agreements and said, "Okay, we need to really be clear and specific." Yeah, so that's when we actually had specific agreements, is in that document.

In this instance, there were hurt feelings, but it also led to them creating a written document to clearly state the safer sex and other relationship expectations. This miscommunication incident ultimately helped the partners develop a stronger understanding of relationship expectations and strengthen the relationships between the partners.

According to the ARRM, a key component that influences an individual's safer sex practices is high levels of communication skill. Participants' narratives demonstrated that they had high levels of comfort and ability in engaging in safer sex conversations. Several participants linked their communication preferences to their polyamorous identities and cultural expectations. Group norms, as explained in the ARRM, influence individuals' intentions to practice safer sex, and through the participants' narratives, poly group norms of open and direct communication contributed to participants' safer sex decisions.

In sum, in safer sex communication, the content of the conversations is an important aspect to make people feel and be safe in their relationships and sexual interactions. In these discussions, participants explained the importance of setting ground

rules with their expectations for the partners, the role that disclosure of risky sexual and STI status plays, and the importance of addressing miscommunication.

RQ4: How do participants understand the relationship between safer sex communication and relationship negotiation in polyamorous relationships?

Relationship negotiation is inherently a part of poly relationships, as communication with multiple partners entails ongoing making and re-making of expectations through communication and consent. Participating in difficult relationship negotiation conversations about all or any aspect of the polyamorous relationship creates an interpersonal dynamic that facilitates conversation about safer sex practices in particular. All but two of the participants described relationship negotiation as an important cornerstone of poly relationships that serves to help negotiate relationships to increase overall relationship satisfaction.

When asked to describe the process of relationship negotiations, participants referred to conversations that participants had with partners that covered a variety of topics in an effort to ensure successful relationships. Their understanding of the function of the negotiation process centered on three themes: 1) to define relationships, 2) to manage multiple partnerships while maintaining relationship satisfaction, and 3) to negotiate issues that included safer sex conversations.

Relationship negotiation to define relationships. First, several participants explained that the negotiation process was important in defining relationship expectations so all partners were in agreement on the terms of the relationships. For Evelyn, relationship negotiation offered a path forward for relationships:

> For me the relationship negotiation process is really just deciding where you see the relationship with this person, and where you see it, where you would like to see it, and what it would look like and the kind of work it would take. Including sex, including emotional. I love to bring up the story that when my wife decided that we decided to go from friends to dating. What she said was, "I don't want to be platonic anymore." I crack up because it makes sense and it's such a genuine question, but it sounds silly when she asked me basically instead of "will you be my girlfriend?" She says "I don't want to be platonic anymore." It's like hey what do you see us as, where do you see us going? How do you think that will work? And just being able to talk and having an understanding amongst you, your partner, and or your metamours.

Emma described open conversation between partners as integral to poly relationships for ensuring that all partners shared a common understanding:

> Usually it starts, you negotiate with each relationship. So what boyfriend A is willing to do, you negotiate that. Then you talk to boyfriend B and then you kinda do it all together and decide if that's what you want to do. I, for me, part of poly, I mean, I know that there's all sorts of people that have their relationships separate, like they're polyamorous but relationship A has nothing to do with relationship B which has nothing to with relationship C. I'm not that clever. I'm not that willing to be that close mouthed. So, I would rather them all know about each other.

These conversations started in pairs separately and then built up to a group conversation that was important for smoothing interactions between all partners.

Ava mirrored what Emma said, but added that these open conversations were key to ensuring that all partners were happy in the relationship:

> Primary for me, is making sure that my partner and my metamour are emotionally good in the relationship, and making sure that we are not having any underlying issues with jealousy, or feeling neglected… it's easier to misconstrue something, and it's easier to feel like the odd one out, and I want to make sure that she doesn't ever feel that way... Just as a way to reassure her because I don't want her to feel like she's the secondary person in the relationship at all. When she moves in… We're probably going to end up negotiating some things a little bit differently, but it's been working out so far… I want to make sure everybody's still on the same page, and that everything's still fine. Or if something changes, then I definitely want to have a conversation with both of them.

Relationship negotiations were important to Ava to make sure that her partners were emotionally good in the relationship. When aspects of the relationship changed, Ava indicated that relationship negotiation conversations would reoccur to navigate the changes in the relationship.

Avery explained that even though these discussions can be difficult, they ultimately work to make her happy in relationships:

> I find it really tedious, but I think that honestly is the best forms of communication, because whenever there's some form of relationship negotiation, it needs to be a space where I feel like I can say everything, they feel like they can say everything, we're both feeling like we're being heard, and we're both getting something within some level of that compromise. So I feel like it takes a long

time, sometimes, which can be a little agitating. But it's something that I've enjoyed so much more than my monogamous relationships, because you have to talk through a lot of relationship negotiations, like poly is inherently built on those conversations. In monogamous relationships, you can avoid and deflect from things for a long time. I mean, I've dated partners, monogamously, who would stop using condoms, and I remember it would take me weeks or months to be like, "Hey, could you not do that?", versus I feel so much more empowered to kind of call people out on that stuff, or even call them in and be like, "These rules don't work for me. The way this is set up doesn't work for me. Can we renegotiate what that looks like?" So, I don't know, I just feel like it's a lot of long tedious conversations with lots of like, "I hear what you're saying, and what I think you're saying is this."

Relationship negotiation seems to be crucial for the maintenance and success of polyamorous relations. Avery placed this in contrast to monogamous relationships. Because relationship negotiations were missing from her monogamous relationships, she felt more empowered to ensure her happiness in poly relationships. Participating in difficult relationship negotiation conversations was important for facilitating successful relationships.

The importance of negotiation to define the relationship was learned by Liam, who reflected on the lack of those conversations in his past poly relationship:

> I think that the relationship negotiation, in retrospect, probably could've been handled better and been more clarified, for sure. What I discovered is an interest from two friends ... They were friends, they were like best friends, and I felt an

> interest coming from them. And in my previous experience, in that situation, one person would indicate an interest and the other one would not, because they were friends. So it's one or the other, usually. But they both continued to express interest, and not individually… And so I started feeling romantic feelings for them both simultaneously, which was unexpected and new… One thing that was [part of the relationship negotiation was] expressed to me by one individual was that it was very important for her to be seen as their own individual, and that was expressed to me very clearly and very adamantly, and so I began to create very specific language and communications for one versus the other, and maintain that separateness.

As the relationship grew organically, there was not an obvious time to engage in relationship negotiation, which meant that Liam navigated the relationships through trial and error. He worked to take partner concerns into consideration and addressed them, but discussing concerns after they became issues made them more difficult to handle. Through that experience, he learned that having relationship negotiation conversations was an important thing to do to improve that chance that the relationships would be successful.

Manage multiple partnerships while maintaining relationship satisfaction. In poly relationships, relationship negotiation is important in order to manage the perspectives of the various partners because they bring their own needs and expectations to the relationship, and the decisions made between people further impact the web of relationships that includes additional partners. Abigail described this complexity:

Well, especially with a polyamorous relationship, if you are in a relationship with somebody and then they are potentially in a relationship with another person… things can spider web out depending on how many partners each of you has and then how many partners that person has and so on and so forth…So for my relationship it's in two sections. So there's negotiation that my girlfriend and I have with each other that doesn't involve her wife and then there's negotiation that happens with all three of us. So with my girlfriend and I, we kind of just casually talking about things… She doesn't put things off but it's more relaxed, like okay, we'll talk about it when we need to talk about it. Her wife on the other hand is very Type A, very anxious all the time and so if something needs to be discussed, it's discussed at that moment. And I think when the three of us talk it's a lot more detail oriented because that's how her wife is and so she wants to know how things are going to work, exactly how they're going to work, which I value. I do like having a very clear idea of where things are going to go. It's just that things that concern her wife aren't necessarily things that my girlfriend and I would've thought about, which I think is helpful because it does help bring another dimension into the discussion… So yeah, it's kind of a two-step process. There are things that my girlfriend and I just talk about and there are things that all three of us need to talk about and I know that it works the same with her and her wife. There are things that she and her wife talk about that I am not a part of because that's their relationship and then there are things that one of them might say, okay well she needs to be brought in on this.

The layers and complexity of communication in poly relationship was presented well in this example. Relationship negotiations happened between each person and the group as a whole. In addition to the combination of people involved, personality and personal communication styles also played a role in the overall communications. Abigail appreciated that having multiple perspectives ultimately improved communication in the relationships because each individual brought their own perspective to the conversations.

Additionally, there was a hierarchy in negotiations regarding whose concerns were addressed when multiple partners were involved. Primary partners and spouses tended to get priority in negotiations. Amelia clearly stated that the primary relationship comes before all other relationships:

> For us and our dynamics, we're primary, and that's the priority. Our relationship is above anyone else. If something's negatively affecting our relationship it has to be addressed, and maybe that relationship needs to be stopped. There needs to be much discussion, because we're the priority, our relationship is, for us, at least… And so, if that's already established, then you have to with the new person, make sure that they're on board, because they have to not only see whatever agreements, know whatever agreements you have with your primary, like with my wife and I, but they have to agree to uphold those. Now, they not may not be specifically a part of that agreement with all those details. It's not applying to them, per se, but by being in a relationship with me, including the safe sex part, they're agreeing to uphold whatever it is, directly or indirectly, that I have agreed with my wife, because we are the primary relationship.

Noah shared the relationship negotiation process from the perspective of his wife's and his primary relationship unit:

> Yeah, [my wife and I] had that talk a long time ago about what was a good idea and what wasn't [when adding new partners]. It has, usually, in the past been, "Hey, I'm interested in someone. Do you mind if we go out?" Because we, originally, had a thing of we had to give each other approval of the partners, so there wasn't a whole lot of, like, I meet somebody and then decide to do that. It's more, "I'm interested in this person, can I ask them out?" kind of thing, so… we just basically put that on the table… It's just, basically, "Hey, this is what I have in mind. Are you cool with this, or what?" We try to be pretty laid back about it. I try to make it a point to make sure she's okay with who I'm seeing and how that progresses every so often, just to make sure she's still the in the same place. I want her to be comfortable about it... We have veto status. I've only ever said once to her that I didn't want her sleeping with a certain person, and she respected that. And she told me the same about somebody.

In this structure, Noah and his wife do not share partners, but even though the relationships are separate from the primary couple, they have veto power over each other's relationships outside the marriage. Additionally, they checked-in with each other about the extramarital relationships to ensure that the primary relationship was still strong.

Charlotte and her wife had parallel expectations of the primary relationship and extramarital partners:

> We'd been dating for a while, we'd been married for a bit, and then we decided to open things up, so now all of a sudden we're having to negotiate safe sex both with each other, but also what I do with other people, so we were having discussions around that, because he's like, "Oh yeah, I'm totally fine with you going out. That doesn't bother me at all, but I need to know that you're doing these things to protect both of us." So we had talks around that, which was interesting, because I'd never had talk about like, oh, safe sex practices, but not with you, like with other people, so that's kind of an interesting conversation… and we're like, "Okay, this is very important. We gotta do this the right way if we're going to do this."

Charlotte and her wife were comfortable with dating aspects of additional relationships, which meant that their expectations in relationship negotiations were less strict. They were more concerned with the safer sex aspects of additional relationships, so they wanted more negotiations regarding that topic in particular.

Negotiate relationship issues and safer sex conversations. Safer sex communication was considered by participants a part of relationship negotiations. Poly people negotiated relationship expectations as well as safe sex practices, and these negotiations often occurred together. These negotiations are important for ensuring satisfaction with the relationships, because as Avery described, negotiations cultivate a sense of trust:

> I think within the poly community, definitely, because there's so many people at play, kind of like what I was talking about earlier, like knowing that there's a larger web of people. Like I know some of Becca's partners, just because they're

> more serious, and we just talk about those things, but I don't know a lot of them, so there has to be some kind of relationship negotiation, where poly, for me, is based on trust and communication. If we can't trust you, and we can't openly communicate about something, this is not a healthy multiple person relationship. So if there's no sense of feeling comfortable to talk about safe sex, and feeling like there is space to do that, then it doesn't really meet my relationship negotiation needs.

Charlotte had similar expectations. She gave an example of the interplay between safer sex communication and relationship negotiation:

> Some people would get really weird about it. They're like, "Oh, how could you ..." Like I thought they were gross or something. I think that's a big problem with stigma around STIs, because by asking people like, "Hey, so I'll get tested, and I expect you to get tested or whatever before anything happens." And they would get defensive. Like, "Oh, do I look like someone who would have an STI" It's like, well anyone can. It's nothing against you personally... they're like, "Oh, how could you think I'm not clean?" I'm like, "I don't know. I don't know you. I literally matched with you like 20 minutes ago." But that was part of the if this is going to be a thing, then these things need to happen. It was a huge part of the relationship negotiation.

Safer sex decisions were an integral of relationship negotiation because those decisions impacted the type of relationship that Charlotte would have with potential partners, or whether there would even be a relationship. Olivia also shared a description of the integration of relationship negotiation and safer sex communication:

> So during the negotiation… I have my minimum requirements for safety. Other people may have additional requirements for safety. If they during the negotiation process try to bypass my minimum requirements and try to say, "But what if we were in this situation," at that point I know there's a possibility that they could betray my trust and I won't go further. If they go, "Well, you know, if things happen, stuff falls off," no, if you're going to start discussing it like that I already know you're somebody I'm not going to trust. But if they're like, "No, I totally meet your minimum requirements. I'm totally cool with that. That makes sense," great. But, yeah, that's definitely part of it. If we don't get down to the brass tacks of it during that initial conversation it will come up before we actually do anything.

Through the communication about safer sex expectations with partners, Olivia made relationship decisions. In these examples, safer sex communication is integrated with relationship negotiation. There may be instances when relationship negotiations are separate from safer sex communication, but these two types of discussions appeared to occur together over the course of relationships with the purpose of maximizing the chances for successful relationships.

Two participants, however, did not think that relationship negotiation was important. For Logan, the establishment and evolvement of relationships follows intangible philosophical principles. Silas also explained that negotiations are not important, but offered a different understanding of the establishment and evolvement of relationships:

> I didn't quite realize I was so rigid about this, but… there's not much of a negotiation. It's sort of [we do it or we don't]… I mean, we do it, meaning we have safe sex with condoms, or we don't have sex… So, there's not like, oh, well maybe we'll do XY. No. It's not gonna be.

In sum, conversations about safer sex and relationship negotiation were intertwined as both are communicative acts that serve as tools that participants used to try to make their relationships as safe and successful as possible. To conclude, in this chapter I presented the main findings of this research. In the following chapter, I discuss the implications of these findings and how they relate to relevant theory and literature on this topic.

Chapter 5

Discussion and Conclusions

In this chapter, I summarize the findings of this study to discuss their significance for research on safer sex communication and polyamory and the implications for practical interventions in public health education. The chapter ends with the identification of the limitations of the project and recommendations for future research.

Summary of the Findings

In response to the first research question regarding participants' sexual risk profiles, the data analyses reveal that participants reported low actual risk as well as low perceived risk. The actual risk profile was consistent with participants' perceptions that they were not very risky sexually. These findings may suggest that participants are protecting themselves while engaging in sexual activity. However, risk scores and self-assessments were complicated by the participants' perceptions of the limitations of the safer sex questionnaire and the contradictions participants reported between engaging in risky behaviors but not considering themselves to be risky. There may be some selection bias because the type of individual that is willing to participate in a research project about safer sex practices is likely someone who feels comfortable and confident in discussing and practicing safer sex.

In effect, participants offered critiques of the limitations of the standardized survey used to assess their sexual risk. First, they noted the timeframe that the HIV questionnaire used, the most recent month, to assess risk was potentially problematic because it measures a limited amount of time and participants may have a different risk profile if they were to reflect on a longer time period. Second, participants noted that the

focus on condoms seemed to be cis male focused and participants who did not have sex that involved penises noted that the framing of the questionnaire did not fit their sexual experiences. However, when the participants were asked whether the questionnaires fit their understanding of safer sex, all participants reported that they did think it fit. Third, participants criticized the questionnaire because of the limited scope of sexual practices They noted that the discussions among polyamorous partner have a considerably larger scope to include more practices than was included in the questionnaire. When asked what the questionnaire was missing, participants listed additional aspects that they thought would improve the accuracy of the safer sex questions. These aspects included the use of dental dams, latex gloves, and issues of communication and consent.

Participants generally reported that they considered themselves to be not at all risky or only a little risky. They reported that the reason why they were not risky was because they followed a safer sex plan. These plans included a variety of safer sex practices that were seen to have different goals and levels of success in protecting against STIs. Some participants discussed vasectomy being an important part of safer sex because it prevents pregnancy and therefore condoms are not needed. In this case, there was not a focus on the risks of contracting a STI. Other plans included trust and other emotions involved in relationships where once they reach an emotional threshold, then condoms were no longer needed. These plans show that while participants might have safety in mind, the effectiveness of their plans might be less than ideal. The meanings attached to the safer sex plans may indicate that there is a need for more education regarding the effectiveness and nuances of various safer sex practices.

Furthermore, several participants stated that their perceptions that non-polyamorous individuals and external entities assume they are risky. This was expressed with a tone of defensiveness in the discussions of external perceptions. The defensiveness seemed to be directed against judgments or bias that participants faced because of their choice to have polyamorous relationships and once that judgement was presented, participants seem to end any further considerations about safer sex practices or risks.

In response to the second research question regarding the salient themes in participants' narratives about safer sex experience, the analysis of narratives about safer sex identified three salient themes in the participants stories: the complexities of safer sex practices, setting boundaries as a way to implement safer sex practices, and the importance of trust as the litmus test for what safer sex practices to use.

First, participants described using a variety of safer sex practices, starting with condom use and then branching into other areas like birth control, vasectomy, and emotional safety. However, these physical tools were part of a range of practices that included emotional safety, communication, and trust as interrelated safety practices. For participants, communication, transparency, and trust were important components of safer sex; with some participants describing these as almost more important than using condoms or getting tested.

Second, when addressing safer sex practices, interviewees discussed the practice of setting boundaries for what types of safer sex practices were important for different types of sexual activity and partners. These boundaries included personal boundaries that they wanted a partner to adhere to and then boundaries that a partner had that they had to adhere to. There was an interplay between boundaries set by the participants and the

boundaries set by their partners, as well as the potential for misalignment between each individual's boundaries. Participants discussed the need to navigate when their personal boundaries and the partner's boundaries did not align.

This involved negotiations about what safer sex practices were reasonable and included aspects of pleasure. If a safer sex act is not pleasurable, then it seemed not worth doing that particular sexual act at all. This process of negotiation was easier to accomplish and it was easier to enforce personal safer sex boundaries when there was a cultural expectation to engage in this process, a cultural expectation that other people who identified as poly held. Conversely, when a partner lacked their own personal boundaries or did not expect to have a discussion about safer sex boundaries, it was harder to enforce personal safer sex boundaries. Self efficacy may play an important role in ensuring that people feel comfortable enough to have this safer sex boundary conversation regardless of the expectations of a partner as this conversation seemed crucial to participants' safer sex behaviors.

Third, trust was key to safer sex decisions. Participants discussed the importance of trust in determining whether a relationship progressed to include any sexual activity as well as what safer sex practices were used. Trust, according to the interviewees, is something that builds over time as partners get to know each other through building the relationship and spending time together. Even though trust was used as a primary consideration when making safer sex decisions, participants seemed to recognize the inherent flaw that comes with putting so much weight on trust in these decisions, there is risk that comes in trusting others. Trust might be betrayed or a partner might lie and an individual might not know that their health was put at risk or that they made risky sexual

decisions. This relationship between trust and safer sex decisions only becomes more complicated when multiple partners are involved because the safer sex decisions that are made between partners are impacted by the safer sex decisions made by other partners and people may not have all of the information needed to make the safest decisions in the moment.

In response to the third research question regarding how participants describe the importance of safer sex communication in polyamorous relationship, the findings show that participants described communication as an important component of polyamorous relationships generally and safer sex specifically. When they discussed safer sex communication to maximize safety, there were two important aspects, communication strategies and content.

Both the format and content of the communication was noted by participants. Generally, safer sex communication occurred at the beginning of the relationship and before the relationship progressed to include sexual activity. It also occurred throughout the relationship both to check-in on the relationship as well as in response to an incident. Safer sex discussions were described as weaved into getting to know the other person and was mixed in with defining the relationship. Then as the relationship progressed, participants described participating in conversations when there was an indication that there was a need for further discussion. The indications included events like the potential to invite a new partner into the relationship dynamic, but also included emotional prompts like feeling insecure in the relationship or upset with a partner. Discussions of safer sex seemed to be interwoven into regular conversations that people had with partners and not necessarily separate specific safer sex conversations. This pattern of

conversation deserves more scrutiny because while it may be beneficial to the health of participants to have constant ongoing presence of safer sex expectations in conversation; however, because safer sex topics are integrated with other topics, participants may think that they discussed safer sex concerns when they actually were not explicitly covered.

Several participants described their expectation to engage in safer sex conversations as the idea that people in these relationships are adults and are expected act like adults. It seems that participants were attributing discussing safer sex and relationship expectations to be an indication of maturity. To be a mature and responsible adult (and potentially a trustworthy adult) people should be able and willing to discuss safer sex and relationship topics. Additionally, acting like an adult seemed to be a desirable characteristic as participants seemed to consider themselves mature and responsible. Acting like an adult and maturity are both very subjective concepts and therefore may not be an actual indication of whether engaging in sexual activity with an individual is actually safe. Also, discussing safer sex and actually practicing safer sex may not always coincide, so there may be a false sense of security in having safer sex conversations that mark someone as acting like an adult, when potentially they are not actually practicing safer sex. This concept of acting like an adult also deserves further research as it may potentially be useful to health professionals developing safer sex promotional programs as a way to be uphold a desirable characteristic.

In the safer sex conversations, participants explained that these discussions included establishing the rules of sexual activity and sexual safety across relationships with multiple partners. The multitude of safer sex practices that participants discussed using, like testing or birth control and vasectomy, are part of these safer sex

conversations. Participants shared that these conversations were very direct and clearly listed the ways that they are protecting themselves and explaining to their partners what is expected from them. Through these conversations, participants described a sense of creating a bond in the relationship. This bond is initiated through the opportunity to disclose STI status and then develops as partners have the opportunity to adhere to each other's expectations. A particular challenge of these conversations is that miscommunication can occur that negatively impacts the utility of the conversations and puts people at risk.

This study highlights the interchange between communication and safer sex experiences as described by participants. For example, participants' abilities to discuss safer sex boundaries and navigate multiple partners in relationships relies heavily on successful communication between partners. Additionally, integral aspects of safer sex like trust and the importance of trust between partners with different sexual histories, experiences, and expectations is developed through the communication between partners. The components of successful safer sex communication described by participants that include early and frequent communication, direct communication, and communicating "like an adult" were also aspects of successful communication in building trust, establishing safer sex boundaries, and navigating the interplay between physical, emotional, and communicative aspects of safer sex. This study demonstrates that the implementation of communication and the necessity of engaging in communication multiple times with various levels of success ultimately improves not only the ability of participants to engage in safer sex communication but also increases the likelihood that

safer sex communication they do engage in actually produces safer sex behaviors and successful relationships.

Individuals who identify as polyamorous, approach communication knowing that they are coming from a non-normative relationship style and the vocabulary participants use situates them in their relationships as well as in their non-normative polyamorous relationship experiences. Communication is an explicit tool that participants use to ensure successful relationships and to have safer sex. Poly people establish a personal and individual understanding of relationships and sexual activity and have a conscious awareness that communication helps them navigate relationship structures and experiences that are not modeled and that must be negotiated through communication to be successful. The simplicity and centrality of communication in polyamorous relationships demonstrates the importance of communication throughout safer sex understandings and experiences.

This study offers the opportunity to explore in-depth how communication is central to the ARRM and to critique the ARRM in that it oversimplifies the role of communication in the stages. The ARRM incorporates communication as an individual's ability or inability to discuss sexual matters in a constructive problem-solving manner that impacts a sexual partners' participation in the reduction of high-risk behavior (Catania et al., 1990). In this description, the impact of communication throughout the stages in the ARRM is missing. While it is important that individuals have some level of skill related to communication, this skill is informed by the other psychosocial factors explicated in the model, like knowledge of risky behaviors and sexually transmitted infections, self efficacy, and perceived susceptibility. Additionally, there is a reciprocal

nature between communication and psychological factors; as individuals increase their communication skills there may also be an increase in the impact of the other psychosocial aspects like information seeking, self-advocacy, and acting solutions, among others. Communication is an overarching aspect that is a central component that facilitates the three stages and people's decision making and behaviors.

In terms of the fourth research question regarding the relationship between safer sex and relationship negotiation in polyamorous relationships, this research found that relationship negotiation was a communication strategy that participants engaged in with new partners and established partners to ensure successful relationships. Relationship negotiation was a construct elaborated in the following ways: to define relationships, to manage multiple partnerships while maintaining relationship satisfaction, and to negotiate issues that included safer sex conversations.

Firstly, defining the relationship between two partners was an important aspect of relationship negotiation as well as the willingness, comfort, and process of adding new partners. Secondly, because polyamory often involves multiple partners, relationship negotiation was important for navigating various partners. Relationship negotiation occurred between two partners and in group discussions, especially when decisions impact multiple partners. General relationship topics were part of relationship negotiation and they included safer sex conversations. Thirdly, polyamorous people interviewed said that they negotiated relationship expectations as well as safe sex practices, and these negotiations often occurred together. These negotiations are important for ensuring that all partners were happy in the relationships and negotiations cultivated a sense of trust and intimacy between partners. Participants described relationship negotiation as

communication that was unique to their polyamorous relationships and not something that occurred in their monogamous relationships.

Significance of the Research

This section will relate the most significant findings from this study to relevant areas of research in the scholarly literature on safer sex, sex communication, and polyamory. Consistencies with previous research will be discussed as well as instances when this research suggest challenges and extensions of previous research.

Risk profiles of polyamorous individuals. This research focused on a small sample of people who identified as polyamorous and did not include a sample of monogamous people, therefore we are unable to make direct comparisons between these two groups. However, the low risk scores reported by participants in this study are consistent with the findings from Lehmiller's (2015) investigation of behaviors such as condom use, STI testing, and cheating behaviors between individuals who identity as CNM and monogamous. Individuals who identify as CNM reported safer behaviors than people that considered themselves monogamous. The finding that polyamorous people in this study report being at a lower risk for contracting STIs is inconsistent with the recommendation from the CDC (2016), The American College of Obstetricians and Gynecologists (2017a, 2017b), Mayo Clinic Staff (2016), and Office of Women's Health (2015), who report that engaging in sexual activity with more than one partner as a risk factor to contracting STIs. There may be a pattern showing that polyamorous people and other people who identify as CNM are safer than monogamous people; however, more research is needed to determine to explore the risk behaviors differences between monogamous and polyamorous people.

Traditionally, a large percentage of sexual risk reduction campaigns for adults have focused on three facets: (a) use a latex condom, (b) reduce number of sexual partners, and (c) have sexual intercourse only in monogamous relationships (Swan & Thompson, 2016). However, this research indicates that there is potentially a need to expand the focus of safer sex campaigns to include relationships that include multiple partners. The low actual risk and perceived risk in the group under study suggests that delimitations for sexual health and safer sex expand into additional aspects of emotional and social interaction that may protect individuals. More research is needed to understand what factors are influencing the low risk reported in this research that can then be applied to safer sex campaigns as well as to other relationship styles.

In addition to reporting lower actual risk, participants also reported low perceived sexual risk, so their perceptions matched their reported risk. This was not surprising as the reason that participants gave for their perception was that they engage in safer sex practices. While participants perceived themselves to be at low risk, they also shared stories where other people or society saw them as risky. These stories about others perceiving it to be risky to be in polyamorous relationships echoes the arguments made by Southern (2017), who found that societal and medical professional perceptions of the riskiness of polyamorous relationships may be biased because of the non-normative style of the relationships.

This lower risk of the sample in this research suggests that safer sex practitioners and researchers challenge the societal biases that they may subconsciously engaging when working with polyamorous people and research should explore what protective factors polyamorous people are engaging in that may be useful for safer sex promotion

more broadly. Research should explore whether aspects of polyamorous relationships might counter the practical challenges of safer sex behaviors in monogamous relationships.

Participants had many critiques of the survey used to assess their sexual risk. The discussions of safer sex practices used by the participants were considerably more inclusive of practices included in the questionnaire. Additionally, when asked what the questionnaire was missing, participants listed additional aspects that they thought would improve the accuracy of the safer sex questions to include things that reflected their actual relationships and sexual activity.

The ARRM places perceptions and behaviors in a reciprocal relationship to each other, where the less risky people perceived themselves to be, the less likely they are to change their high-risk behaviors (Catania et al., 1990). This study would support this relationship as the justification for low perceptions of sexual risk given by participants was specifically the safer sex practices that they employ. The component that is lacking in this relationship is accuracy in assessment of efficacy and susceptibility. Participants considered themselves to be protecting themselves through safer sex practices, but these practices were nuanced and varied from protecting from STIs to protecting from unwanted pregnancy to protecting their emotional well-being. Additionally, some participants placed the risks of pregnancy or risks to emotional well-being as more salient to them than protecting from STIs, so they considered themselves to be engaging in safer sex practices, but these practices may not actually be protecting them from STIs.

The findings from this research support the reciprocal relationship between perceptions and behaviors, but this relationship is likely moderated by accuracy in the

perceptions. Future research should explore these relationships and the ARRM may need to expand to include the influence of accurate assessment on perceptions and behaviors.

Safer sex narratives. All participants discussed condom use and getting tested for STIs when they were asked about safer sex practices they use. After these basics were referenced, all but one participant gave a variety of different practices that they use to protect themselves. The safer sex behaviors mentioned by participants were consistent with the recommendations from The American College of Obstetricians and Gynecologists (2017a, 2017b), Mayo Clinic Staff (2016), and Office of Women's Health (2015) that protective factors include getting vaccinated, using condoms, getting tested for STIs, and communication. The participants did adhere to other recommendations like being monogamous, limiting number of sex partners, and, in some instances, did not even discuss some of the other recommendations like not abusing alcohol or drugs (The American College of Obstetricians and Gynecologists, 2017a; The American College of Obstetricians and Gynecologists, 2017b; Mayo Clinic Staff, 2016; Office of Women's Health, 2015). Of these protective factors, the one that was discussed the most was communication and the role that communication plays in establishing safer sex expectations.

However, in addition to using condoms and getting tested, participants expanded the inventory of safer sex practices beyond that to include physical and emotional safety as well as the challenges of safer sex. About half of the participants seemed to consider protecting against pregnancy as equally if not more important than protecting against STIs (e.g. you can treat infections, but children are not a treatable issue). Because of the focus on preventing pregnancy as a priority, participants discussed vasectomy and birth

control as the first step in protecting themselves and then if those are in use, there is not a need for condoms. This emphasis on protecting from unwanted pregnancy was consistent with a study conducted by Flood (2003) where the focus on protecting from unwanted pregnancy was handled through oral contraception rather than condom use.

Participants in this study considered themselves to be acting in a safer sex manner even though they were not as safe as they could be. Participants did understand that not using condoms meant that they were at risk for contracting STIs but considered other practices like trust and communication as sufficient for protecting themselves. This finding suggests that health campaigns that endeavor to increase safer sex behaviors should broaden their focus from STIs only to include protecting from unwanted pregnancy and perhaps should include reporting the effectiveness of various types of protective actions for protecting against STIs and unwanted pregnancy.

When participants discussed practicing safer sex, several of them emphasized having a set of safer sex boundaries. Participants considered themselves to be practicing safer sex because they had set specific expectations that they adhered to and expected partners to adhere to as well. While the formal recommendations for practicing safer sex do not include setting boundaries as a way to protect oneself, Tevendale et al. (2009) found goal setting and decision-making skills predicted a higher percentage of condom use in males. Boundary setting as discussed in this research may be similar to Tevendale et al.'s (2009) concept of goal setting and therefore, there may be a protective aspect to setting boundaries for safer sex behaviors. More research is needed on the process and outcomes of setting safer sex boundaries, however, before any conclusions regarding their relationship to safer sex practices can be made. In addition to setting the boundaries,

participants communicated those boundaries to partners. Communicating about safer sex has been found in the literature to be related to more condom use (Crepaz & Marks, 2003; Lam et al.,2004), so there is a protective component to engaging in safer sex communication. More research is needed to see whether people who engage in safer sex practices other than condom use receive the same protective outcomes when communicating about those safer sex behaviors.

Trust emerged as a theme in every participant's narrative when asked about safer sex. They view trust as a sentiment that builds over time and is an important consideration in relationships as well as sexual activity. This finding was consistent with Goldenberg et al., (2015) who described trust in intimate relationships as a dynamic concept and trust being built over time. Also, trust being equated with the belief that a partner would never intentionally do anything to harm their partner, such as transmitting an STI or HIV (Goldenberg et al., 2015) was consistent with how participants indicated that trust is an important part in deciding what safer sex practices they engage in with partners during sexual interactions. Trust in polyamorous relationships is complex because it involves multiple people with their own history, experience, and trust expectations, but these complexities may lead to stronger feelings of trust, intimacy, and satisfaction with their partners compared to people in monogamous relationships as found by Sequin et al. (2017).

The relationship between safer sex and trust is complex because as people trust their intimate partner, they report less embarrassment discussing and using condoms (Pilkington et al., 1994), but also felt that engaging in safer sex communication (like sexual history or asking for condom use) was a breach of trust and could damage an

intimate relationship (Gavin, 2000; Madiba & Ngwenya, 2017; Reddy, 2004). This apparent contradiction was also seen in the findings of this study as participants recognized that trust is inherently risky and they felt that trust was needed in order to progress a relationship to sexual activity, but they also understood that potential partners might not fully disclose information that may place them at risk of contracting an STI.

Trust as an emotional factor in participants' safer sex decisions was consistent with the emotional aspects of sexual relationships as described by Rosenthal et al. (1998) who discussed the meaning of love as stable and how the concept of condom use is not consistent with love as stable, such that if a person loves someone, then a condom is not needed, and by bringing up condom use, introduces some challenge to the status of the relationship as stable. Considerations for the emotional aspects of sexual relationships, like trust, passion, love, and romance, challenge safer sex researchers and practitioners to push the envelope of the "ideal" safer sex situation and explore how these emotions complicate the reality of these interactions and thus impact people's health decisions and safer sex behaviors.

The findings of this research also aligned with aspects of the ARRM, such as knowledge and perceptions influencing safer sex behaviors (Catania et al., 1990). Psychosocial aspects highlighted in the ARRM, like social networks and norms and communication influencing individuals' labeling and committing to safer sexual behaviors were echoed in participants' stories of how they make safer sex decisions. However, the ARRM does not currently address the role of emotions in sexual decision making. The findings from this study suggest that the ARRM needs to consider how emotions as a psychosocial aspect influence sexual decision making, both in how

emotions might support safer sex behaviors or derail effort to engage in safer sex behaviors.

Importance of communication in safer sex behaviors. Participants described communication as an important component of polyamorous relationships generally and safer sex specifically. The fluid and organic nature of safer sex communication was important to ensure partners know what to expect in new sexual interactions and to ensure an ongoing sense of safety and pleasure throughout sexual interactions. As highlighted in several of the narratives, early and frequent safer sex communication is important to comfort and safety. As participants reported, their conversations with partners covered a variety of topics and while condoms were often included, safer sex discussions were not limited to condoms. The fact that safer sex conversations included a variety of topics means that research on safer sex communication that primarily focuses on condom use because of the belief that the only protective communication is communication that leads to condom use behavior (Troth & Peterson, 2000) may be too limited and may be seen by some people as irrelevant to their reality. The safer sex communication used by participants included aspects that previous researchers have considered important, such as asking a potential partner about STI testing results or HIV status (Kosenko, 2011; Lear, 1995), the intention to wear condoms during sexual acts (Noar et al., 2006) and self-efficacy in terms of safer sex behaviors (French & Holland, 2013).

Safer sex communication was also described by participants to be tailored to fit the situations and partners. Safer sex researchers have also found that safer sex communication varies by situations. For example, there are differences between the safer

sex communication preferences and safer sex expectations in heterosexual versus homosexual couples (Holmberg & Blair, 2009). Participants in this study discussed safer sex communication in a broad sense, so it would be interesting for future research to see whether there are differences between safer sex communication in polyamorous people when they engage in sexual activity with same gender and different gender partners and whether these differences lead to differences in safer sex behaviors.

Additionally, participants in this research offered examples of their safer sex communication and expectations developing over time, which is consistent with findings from Troth and Peterson (2000) who found that sexual experience, sex education histories, and personalities influenced the willingness of individuals to engage in safer sex communication and behaviors. Because safer sex communication varies across situations and is influenced by various factors, more research would be beneficial to understanding how safer sex communication changes in polyamorous relationships and why polyamorous people in this research report such comfort engaging in this type of communication.

According to the interviews, it was important for safer sex communications to occur at the beginning of relationships, as well as throughout the relationship, particularly when there is an incident that partners need to be aware of. The participants emphasized the importance of direct communication for safe sex throughout relationships, from establishing relationships to setting expectation for sexual activity and even when engaging in a sexual act. This finding was consistent with research by Buysse and Ickes (1999) that found that safer sex communication changes overtime, especially between new partners and people in established relationships. This finding was not consistent with

a study by Reynolds-Tylus et al. (2015) that found that safer sex conversations would not occur until after a casual relationship turned into a committed relationship. The participants in this research study clearly indicated that safer sex conversations were important before an initial sexual encounter, but these conversations would continue throughout the relationship.

Additionally, Reynolds-Tylus et al. (2015) found in their research that there were limited opportunities to have safer sex conversations in casual relationships, whereas in committed relationships there were more opportunities for these types of conversations. The participants in this research described ensuring that safer sex conversations occurred before sexual activity was initiated. This difference warrants more research as there may be an expectation in polyamorous relationships to have safer sex conversations that might be protective, but that expectation may not present for monogamous or casual relationships, but it might be beneficial for people in these styles of relationships to adopt similar safer sex conversations. There is also a need for more research to examine safer sex conversations and decisions over time from initial sexual encounters, to casual relationships, to established relationships as well as in a variety of relationship models.

The importance of clear, direct safer sex conversations was important in building a sense of safety and intimacy between partners. Safer sex communication is layered and being open to unknown aspects of communication was important to creating a sense of safety in the relationship. This finding of safer sex creating more intimacy was consistent with research that found that safer sex communication was a protective factor to reduce the risk of contracting STIs by increasing condom use, but it was also positively linked to closer and more intimate sexual relationships (Cobb, 1997; Sevelius, 2009). Engaging in

safer sex conversations may lead to more intimacy because such conversations may lead to discussions of other topics that are important to sexual health as well as other aspects of the relationship (Reynolds-Tylus et al., 2015). There may be additional benefits to this increase in feelings of intimacy because as Dennis (2006) found, the more intimacy increased, the more people cared for the wellbeing of their partners. The relationship between safer sex conversations and intimacy between partners deserves additional research to better understand the long-term benefits of safer sex communication as well as the more intangible benefits beyond increasing the likelihood of wearing a condom during sexual activity.

The ARRM emphasizes the role of effective communication about sexual issues in setting commitment to change and in taking action to engage in safer sex practices. Catania et al. (1990) emphasized the protective nature of a communication process that occurs in a constructive problem-solving manner. Participants in this study shared stories that highlighted the importance of communication in their polyamorous relationships, and in some instances directly contrasted the communication that occurs in polyamorous relationships as being better than that which occurs in traditional monogamous relationships. More research is needed to explore the ARRM in different relationship styles to consider how psychosocial aspects that might be unique to different relationship styles may influence the safer sex decisions made by individuals in those relationships.

Safer sex communication and relationship negotiation. Relationship negotiations were conversations that participants had with partners that covered a variety of topics in an effort to ensure successful relationships. The negotiation process was important in defining relationship expectations and to ensure that all partners have a

common understanding with each other. Safe sex communication was considered by participants to be a part of relationship negotiations. Their descriptions of relationship negotiations were consistent with Dako-Gyeke (2013), who described relationship negotiation as involving the exchange of information between partners and navigating partner responses to requests. Relationship negotiation was inherently part of polyamorous relationships for the majority of participants and the expectation that partners would engage in this type of communication was not part of their monogamous relationship experiences. In polyamorous relationships, it's important to include the perspectives of the various partners in relationship conversations because people bring their own needs and expectations to the relationship and the decisions made between people impact the web of relationships that includes additional partners. This means that relationship negotiations happened between each person and the group as a whole. For example, a unique context for relationship negotiation in polyamorous relationships was the hierarchy in negotiations regarding whose concerns were addressed when multiple partners were involved, where primary partners and spouses tended to get priority in negotiations. There is currently no literature on relationship negotiation in polyamorous people that explores the unique experiences that polyamorous people experience. Additionally, current research on safer sex negotiations focuses on the interactions of two people, so the interplay of negotiations between levels of relationships cannot be extrapolated. More research is needed to understand more about the relationship negotiation process in polyamorous relationships as well as the similarities and differences between polyamorous relationships and other relationship styles.

In addition to the combination of people involved, personality and personal communication styles also played a role in relationship negotiations. These conversations tended to be direct and expectations were explicitly communicated to partners. The style of communication was both consistent and inconsistent with aspects of research by Lam et al. (2004). This research was consistent with the finding by Lam and colleagues (2004) that people generally used direct-verbal communication when negotiating condom use. However, Lam et al. (2004) also found that people used other communication strategies like indirect and non-verbal strategies, which participants in this research did not describe as their process for negotiations. There may be some bias in the research regarding this preference for direct communication as people who feel more comfortable discussing safer sex are probably more likely to agree to be in this research. Therefore, more research is needed to understand that nuances of relationship negotiation in polyamorous relationships and how they may be consistent or inconsistent with other relationship and safer sex negotiation experiences.

Research on safer sex communication has found that saying anything is better than saying nothing (Reel & Thompson, 2004) and the most effective way to communicate safer sex is through consistent, stable, direct requests (Hall, 2016). Participants described their negotiation processes as direct and occurring through-out the relationship, so this may indicate that polyamorous people who engage in this style of negotiation have protective aspects to the process. More research is needed before any specific conclusions regarding the protective nature of relationship negotiations can be made, but research on safer sex communication leading to safer sex (Lam et al., 2004;

Noar et al. 2006; Tschann et al., 2010) suggests that there may be a relationship between communication and safer sex behaviors here as well.

While the majority of participants described similar relationship negotiations (as described above), it is important to note two participants who gave very different understandings of relationship negotiation. One participant described a fatalistic approach to life where negotiations do not have a role to play in relationships because discussions are not needed. This participant described the establishment and evolution of relationships as adhering to underlying philosophical principles and the individuals involved seemingly do not play an active role in determining their role in the relationship. More research would be needed to understand how common this style of perspective on relationships is and how this life view influences safer sex decisions. Another view on relationship negotiations was that they are not important and instead no negotiation is involved at all, either potential partners agree to the terms set forth by the individual or there is no further involvement. This description of safer sex communication is inconsistent with research that safer sex negotiation involves persuasion or convincing a partner to wear a condom (Reynolds-Tylus et al., 2015; Rinaldi-Miles et al., 2014). This description of relationship negotiation mirrored the experiences of trans men in a study by Sevelius (2009):when engaging in sex work, the trans men had very rigid safer sex expectations, but that when they were with their romantic partners, they often engaged in sex without condoms to differentiate their experiences the meanings in the sexual activity. This hard line when it comes to initiating sexual activity with a potential partner may be the most safe because the highest standards for safety are required for any involvement, but more research is needed to determine how common this approach is by

other individuals, in what contexts, and in what instances would that hard line potentially soften to the point where an individual may begin to engage in less safe sexual activity.

The ARRM contextualizes the commitment to change as complex due to the various risk levels of different sexual acts as well as the need to make safer sex decisions across different sociosexual contexts like relationship style, length of relationship (Catania et al., 1990). The stories shared by participants in this study highlight these complexities and the process that participants often use to navigate these complexities is relationship negotiation. Additionally, the ARRM emphasizes the importance of an individual's ability to communicate verbally about sexual issues in order to effectively engage one's partner in consistent safer sex behaviors (Catania et al., 1990). Polyamory offers a unique community within which to explore the role of communication in safer sex decision making because of the relationship negotiation process described by many participants as a fundamental component of their polyamorous relationships. Also, while this study would support the ARRM's description of the importance of sociosexual contexts in safer sex decisions, the relationship negotiation process described by participants would push the theory to consider the group decision making process rather than an individual decision-making process that is informed by others. Participants described their safer sex decision-making process as a group effort negotiation often across partners not involved in the immediate sexual activity, rather than a decision they make for themselves based on concerns and desired expressed by partners.

Implications

The findings of this study suggest a range of implications for research and practical applications in health communication that include the following: expanding

measurement instrument to include psychosocial and emotional components of safer sex, practical challenges to safer sex decisions, practice non-judgmental care, incorporating communication is safer sex interventions, and including various audiences as the target for interventions.

First, there is a need to expand the standard questions asked to people in surveys, measurement instruments, and interview protocols about their sexual behaviors to move beyond the biologically based dimension to include the psychosocial and emotional components of safer sex decisions. Also, when working to measure and reduce the risk behaviors, focusing on the positive aspects of safer sex, like fulfilling sexual interactions and building trust, may resonate more strongly with patients than focusing strictly on the STI protection aspect of safer sex.

Second, it is important to take into consideration practical challenges to safer sex behaviors like phases of relationships, relationship dynamics, number of partners, types of sexual acts, as these different experiences and contexts can ultimately influence how people behave and what types of safer sex decisions they make.

Third, it is imperative that safer sex health educators and practitioners do not judge patients when they disclose their sexual behaviors. This disclosure can be sensitive, and judgment from a medical professional can negatively impact the patients' honesty and, ultimately, the accurate assessment of their health behaviors.

Fourth, when educating individuals about safer sex, health educators and practitioners should consider not only explanations of how to be safe, but also how to communicate about sex and safer sex with a partner. Safer sex communication interventions should encompass a variety of safer sex practices that include but are not

limited to condom use, pregnancy prevention, and safety during a variety of sexual acts, for example, kink or other less common sexual acts. These conversations should also include a wider repertoire of terminology so that people can have a better understanding that safer sex is related to a multitude of behaviors. This type of conversation should aim to teach individuals how to set reasonable expectations for positive behaviors as well as realistic expectations for when partners are engaging in riskier behaviors.

Fifth, while many sex education programs in the US target teenagers or young adults, safer sex interventions should consider targeting adults of all ages so that considerations such as safer sex in long-term relationships and marriage as well as safer sex into older adulthood can be included. In safer sex education, there is a need for health educators to fight myths and misconceptions to empower all people to have the skills, knowledge, and self-efficacy they need in order to practice safer sex and advocate for their safety in a way that is cognizant of their position in life and the dynamics of the relationships that adults and older adults engage in.

Therefore, there is a need for health educators to train people in health communication to address issues such as deciding on one's personal safer sex expectations and then how to communicate those expectations to potential partners and how to negotiate these expectations in instances where partners are not on board with the safer sex practices proposed by an individual. Training in safer sex communication might be particularly important because people are often unable to model other successful safer sex communications because of lack of exposure to such communication interactions. Therefore, having the opportunity to engage in safer sex communication in a low-stake

training opportunity can help develop the skills and efficacy that people might need to ultimately be effective in negotiating safer sex with a partner.

Ultimately, safer sex health educators and practitioners need to incorporate the discussion of lived experiences and practical life challenges that impede a person's ability to engage in safer sex practices. This means challenging heteronormative and monogamous social expectations so that individuals can develop skills that they need to actually engage and advocate for safer sex in their relationships.

Limitations

This study used a small sample and the scope of this project was limited to narrow and specifically exploring how individuals who identify as polyamorous understand and communicate about safer sex, which limits generalizability. Approaching the interviews with questions that explored the topic of safer sex more broadly to include probing questions regarding the emotional and relationship aspects of safer sex might have added to the quality of the findings from the study.

Additionally, there may be bias in this sample because the selection of participants, recruited through snow ball sampling, may potentially consist of only people who are open to talking about safer sex and therefore, are more likely to engage in safer sex communication in their everyday life, which may obscure a range of behaviors and practices that occur within the polyamorous communities. The experiences of those who feel great discomfort with discussing sex in general may not be represented in this study. Even with these limitations, this study opens the door for exploration into the nuances and complexity of safer sex behaviors and communication.

Future Research

Future research should include how to design assessment instruments and interventions that incorporate an expanded view of safer sex practices. While condom use is one of the safest ways to protect oneself, there are many instances where condom use might not be the most realistic way for an individual to be safe. Therefore, including practices such as communication strategies surrounding expectations, trust, negotiation, and setting boundaries in research inquiries might bring new insights into how to encourage people to engage in safer sex practices. While these concepts might be more difficult to measure than condom use, it is important to include them in research so that safer sex research can endeavor to address the health crisis of the increase in STI rates. Balancing the goal of generalizability of positivist scientific approaches with addressing unique individual and sub-groups realities can be difficult. However, adding an emic, more nuanced understanding of individual experience may facilitate health interventions that are more relevant to people in everyday life.

Additionally, future research should include the intersection of safer sex with identity, gender, sexual orientation, and sexual subcultures including polyamory as well as pan, transgender, and other forms of expressing one's sexuality. Future research should consider how communication about safer sex changes overtime, including over the course of romantic relationships as well as through the lifespan, and how these factors ultimately impact safer sex decisions. More research is needed to understand the web of relationships that people who are polyamorous experience and the ways that the behaviors and decisions of one individual can ripple through of web of relationships. Further research should also explore the differences and similarities between relationship

negotiation communication that occurs in polyamorous relationships and the types of relationship communication that occurs in other relationship models.

Appendix A

Detailed Demographics

Table 5

Detailed Demographics

Category	Frequency
Education Level	
Associate Degree	1
Some College	2
Bachelor's Degree	2
Some Post-Grad	3
Master's Degree	4
Doctoral Degree	1
Relationship Status	
Single	5
Cohabitating	1
Married	5
Separated	1
Divorced	1
Currently in a Relationship	
Yes	11
No	2
Ever Contracted a STI	
Yes	5
No	8

Note. Participants with multiple partners were not able to answer relationship questions for all partners due to questions asking about a single partner.

Appendix B

Interview Guide

I am interested in safe sex and relationship negotiation (the conversations involved in starting and maintain relationships) in polyamory. Please know that you don't have to share anything that you don't want to and you can stop the conversation at any time. Please take effort to leave out people's names.

1. Tell me about your experience with polyamory.
2. What does sexually active mean to you?
3. How do you understand safe sex?
    a. How do you practice safe sex?
    b. How easy/difficult do you find it to practice safe sex?
    c. Share a positive experience/negative experience you had with safe sex?
    d. What contributed to this understanding? How did you develop this understanding?
    e. Do you consider yourself to be risky sexually or at risk for STIs? Why?
    f. What are the benefit to having safe sex? What are the disadvantages of having safe sex?
4. How does safe sex change over time?
5. How do you talk about safe sex with a partner? What types of communication do you use (e.g. verbal, non-verbal)?
6. Is safe sex a component of a relationship negotiation? How?
7. Describe the relationship negotiation process.

a. What does it involve?

b. When does it occur?

c. How often do you do it?

d. What are the risks/benefits?

e. How do relationship negotiations change over time?

f. How do you decide what information about yourself/others to share and what to keep private? What are your privacy expectations, what is the disclosure process, what about privacy of other partners?

8. Think about a time when you had a relationship negotiation, what was it like?

    a. How do you prepare, what are your expectations?

    b. In what ways do other partners influence a relationship negotiation?

Take Survey

9. What are your thoughts about the survey?

    a. Do you feel that it aligned with your understanding of safe sex?

    b. What was accurate?

    c. What was missing?

10. Do you have any questions for me?

Thank you for sharing your story with me.

Appendix C

Safer Sex Survey

Demographic Questions

1. Age:

2. Gender:

3. Please indicate the ethnic/racial group to which you belong:
_____Mexican American
_____Mexican National
_____Other Latin/Hispanic origin (please specify) _____
_____White
_____African American
_____Asian American
_____Native American
_____Other (please specify) _____

4. What is your level of education?
_____Less than High School
_____High School or equivalent
_____Some College
_____Vocational School/Associate's Degree
_____College Graduate (e.g. B.A., B.S.)
_____Some Post-Graduate training

5. I am:
_____Single (never married)
_____Married
_____Divorced
_____Widow/Widower
_____Separated
_____Living with someone

6. I am living:
_____ Alone
_____ With parent(s)
_____ With other family
_____ With friend(s)
_____ With roommate(s)
_____ Other: _____

The following questions deal with relationships and sexual activity. For the purposes of this study, we define sexual activity as consensual anal, oral, or vaginal sex.

7. Are you currently in a relationship? _____Yes _____No

If yes, please specify the length of time you have been in your relationship:

_____I have been dating someone for less than 6 months.
_____I have been dating someone for more than 6 months but less than a year.
_____I have been dating someone for over a year.
_____I have been married for less than 6 months.
_____I have been married for more than 6 months but less than a year.
_____I have been married for over a year.

We define sexual activity as consensual anal, oral, or vaginal sex.

8. Are you currently sexually active?
_____Yes
_____ No

9. How risky are you sexually?
_____ Not at all
_____ A little
_____ Some
_____ A lot
_____ Very much so

We define sexual activity as consensual anal, oral, or vaginal sex.

10 How frequently are you sexually active?

_____I have never had sex.
_____I have sex at least once a week.
_____I have sex less than once a week.
_____I have sex less than once a month.
_____I have sex less than once every six months.
_____I have sex less than once a year.

11. Please rate how knowledgeable you are about the following:

Chlamydia?	1	2	3	4	5	6	7
	Not at all			Somewhat		Very Much	
Syphilis?	1	2	3	4	5	6	7
	Not at all			Somewhat		Very Much	
Gonorrhea?	1	2	3	4	5	6	7
	Not at all			Somewhat		Very Much	
HIV/AIDS?	1	2	3	4	5	6	7
	Not at all			Somewhat		Very Much	
Other STIs?	1	2	3	4	5	6	7
	Not at all			Somewhat		Very Much	

12. Have you ever contracted a sexually transmitted disease?

_____Yes _____No

_____I have never been tested for a sexually transmitted disease

If yes, what sexually transmitted diseases have you contracted?

_____I don't know/I don't remember
_____Chlamydia
_____Gonorrhea
_____Hepatitis B
_____Herpes
_____HIV/AIDS
_____Human Papilloma Virus (HPV)/Genital Warts
_____Syphilis
_____Trichomoniasis
_____Other (please specify)_____

13 Have you ever used any contraceptive devices? _____Yes _____No

If yes, which have you used? (please specify all you have used)

_____I don't know/I don't remember
_____Male condom
_____Female condom
_____Birth control pill (such Ortho Tri-Cyclen or Yasmin)
_____Birth control patch (such as Ortho Evra)
_____Injected birth control (such as Depo-Provera)
_____Other forms of contraception (please specify)_____

14 At what age did you first have consensual sex? _____

15 Have you ever had un-consensual sex? _____ Yes _____ No

Now we are going to ask you questions about your sexual orientation and how you identify. Please circle one of the following responses to each question:

16. To whom are you sexually attracted?

1	2	3	4	5	6	7
Other sex only	Other sex mostly	Other sex somewhat more	Both sexes	Same sex somewhat more	Same sex mostly	Same sex only

17 How do you think of yourself?

1	2	3	4	5	6	7
Heterosexual only	Heterosexual mostly	Heterosexual somewhat more	Hetero/Gay-Lesbian equally	Gay/ Lesbian somewhat more	Gay/ Lesbian mostly	Gay/ Lesbian only

18 Sexual Risk Subscale of the HIV Risk-Taking Behavior Scale

1. How many people have you had sex with in the last month?

0. None
1. One person
2. Two people
3. 3-5 people
4. 6-10 people
5. More than 10 people

2. How often have you used condoms when having sex with your regular partner(s) in the last month?

0. No regular partner/no penetrative sex
1. Every time
2. Often
3. Sometimes
4. Rarely
5. Never

3. How often have you used condoms when you had sex with casual partners in the last month?

0. No casual partner/no penetrative sex
1. Every time
2. Often
3. Sometimes
4. Rarely
5. Never

4. How often have you paid for sex in the last month?

0. Never
1. Once
2. Twice
3. 3-5 times
4. 6-10 times
5. More than 10 times

5. How often have you used condoms when you paid for sex in the last month?

0. No paid sex
1. Every time
2. Often
3. Sometimes
4. Rarely
5. Never

6. How many times have you had anal sex in the last month?

0. Never
1. Once
2. Twice
3. 3-5 times
4. 6-10 times
5. More than 10 times

7. How often have you used condoms when you have had anal sex during each of the following time periods?

0. No anal sex
1. Every time
2. Often
3. Sometimes
4. Rarely
5. Never

8. How many times have you had oral sex in the last month?

0. Never
1. Once
2. Twice
3. 3-5 times
4. 6-10 times
5. More than 10 times

9. How often have you used condoms when you have had oral sex in the last month?

0. No oral sex
1. Every time
2. Often
3. Sometimes
4. Rarely
5. Never

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