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Attitudes and Beliefs Related to Risk of Sexually Transmitted Infection in Swingers Who Do Not Use Condoms

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2020

Abstract

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by

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MPhil, Walden University, 2019

MS, Walden University, 2011

BA, Rowan University, 1992

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Sexually transmitted infection (STI) affects the public as a hidden epidemic of contagious disease with significant economic and health impacts. There are 110 million living with STI in the United States, with 20 million new infections annually. Condom use can reduce STI, but some people have sex without condoms, with risk for contracting or transmitting STI increasing when a person is in the same sexual network. Swingers are a growing sexual network and are a group at high risk of developing and spreading STI. The purpose of this generic qualitative study was to develop an understanding of the attitudes and beliefs of swingers related to the risk of contracting STI among swingers who do not use condoms. The health belief model formed the theoretical framework of the study. A description of the individual swinger's experiences, attitudes, and beliefs was collected during face-to-face interviews with 18 participants. Results showed that participants were knowledgeable about the nature and consequences of STI, and they continued to engage in high risk sexual behaviors. The findings identified cognitive dissonance—a distinct separation between logical/cognitive and emotional/affective factors in decision making related to sexual health, specifically condom use. This was due to the pleasure-seeking norms of this group and the lack of expectations and requirements related to condom use. It was determined that only when condoms were required in order to have sex, participants would utilize them. Implications for social change include the development of prevention strategies that address the cognitive dissonance present in high risk sexual behaviors.

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Dedication

This work is dedicated to those who rise above and persist, even when life seems impossible or when goals appear beyond reach. This includes those I have had the honor of serving in my clinical work; supporting them has inspired me and taught me valuable lessons on how to live, grow, and evolve. Also, to my colleagues who promote health and wellness by serving those in need with unfaltering kindness and humor. You are the true superheroes in our society.

I dedicate this to Scott Brown without whose support and encouragement I would never have begun this effort. Thank you for reminding me of what I could become, telling me of the lotus flower, springing up through swampy waters, reaching for the sun. Also, to my siblings, Patricia, Randy, Martin, and Betsy. I eagerly await our continued growth together in this life: this is a big one for me. To my aunts, Bette and Jane. As a child, they demonstrated that more was possible beyond where I was, that there was an over the rainbow place I could be someday. To Meggin, the first doctor in the family, for leading by example. To Katie, who has saved my life both literally and figuratively: your years of unwavering belief in me have been invaluable.

And to my son, George R. Brown. You remain my best endeavor. May you learn from being by my side through this process that even when things become difficult, they are still worth doing. You have sacrificed for this too, as my time and energy were often taken from you to do this work. This is for you, truly.

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Chapter 1: Introduction to the Study

The Centers for Disease Control and Prevention (CDC, 2017) has reported that sexually transmitted infection (STI) has significant economic and health impacts. Though condom use reduces the risk of STI, some people have sex without condoms (Crosby et al., 2014; Young, Marks, Zaikman, & Zeiber, 2017). Swingers are a group with a high risk of developing STI due to some of their behaviors (Platteau, van Lankveld, Ooms, & Florence, 2017). Swingers are a growing sexual network with estimated numbers that vary, as this group is not often measured and studied (Harviainen & Frank, 2016). Although discussion of condom use is noted in an undetermined percentage of swinger sexual practice, there is an unknown percentage of swingers who have unprotected sex (Frank, 2018). This subgroup of swingers having sex without condoms as regular practice identify as *bareback* (Avila, 2014). This term was originally used to describe sex between men who do not use condoms for anal penetration (Brisson, 2017), and swingers have adopted this term to describe their own penetrative sex, describing both heterosexual and homosexual activity within this group (Frank, 2018).

Background

STI is a collective term for 35 infections transmitted primarily through sexual activity (World Health Organization [WHO], 2018). The CDC (2017) has estimated the number of people living with STI to be 110 million in the United States, with 20 million new infections annually. STIs have implications for fetal health, sexual function, reproductive health and fertility, cancer, chronic illness, and death (U.S. Department of Health and Human Services [U.S. DHHS], 2015). Further, there is an increasing

economic burden related to STI, with an estimated cost to the American healthcare system of 16 billion dollars annually (CDC, 2017). Without effective public awareness through impactful prevention, the spread of STI will continue to incur large scale costs to the healthcare system and to the health of individuals affected as well as to their partners and families (Weitzman, Barber, & Kusunoki, 2019).

Risk for contracting or transmitting STI increases when a person is linked sexually to multiple persons also at risk in the same sexual network (U.S. DHHS, 2015). Sexual networks consist of people connected by successive or concomitant sexual partners (Neikamp, Mercken, Hoebe, & Dukers-Muijrers, 2013). One example of a sexual network is swingers. This is a group that is collectively self-described as participating in consensual nontraditional monogamy (CNM) or couples who engage in sexual activity with multiple partners as regular practice (Kimberly, 2016). Swingers are committed couples, married, or partnered and describe their relationship as primary, although they participate in permitted nonmonogamy in the form of sexual activity with others (Vaillancourt & Few-Demo, 2014). Nonmonogamy is becoming an increasingly accepted sexual status due to its growth as a sexual practice in America (Kimberly & Hans, 2015). But the study of behaviors and practices related to groups practicing CNM has been limited, and a concise understanding of the group engaged in swinger culture is needed due to its fast growth (Brewster et al., 2017).

Estimates report that there are 1 to 8 million swingers in the United States, with this number on the rise (Kimberly, 2016). Researchers have also estimated the overall prevalence as less than one half of a percent to 4% of the U.S. population (Brewster et al.,

2017). Despite the sizable numbers engaging in this practice, there is little information on how sociocultural, socioeconomic, and institutional frameworks are connected to or influence swinging behaviors (Frobish & Griffiths, 2013). This lack of knowledge has been acknowledged by researchers (e.g., Conley et al., 2013; Rubel & Bogaert, 2015), and there remains a lack of data from national surveys that could provide reliable estimates for swingers' current numbers or general makeup. CNM is common among a diverse range of cultures and sexual orientations, with both heterosexual and homosexual participants (Haupert et al., 2017). The limited information about this group also suggests that there is a link between swinging and the transmission of STI; however, there is little evidence to illuminate this relationship (Moors, Matsick, & Schechinger, 2017). Notably, this large and growing group has an unknown percentage of members having sex without condoms as regular practice, placing them at an increased risk of STI (Frobish & Griffiths, 2013). Understanding the attitudes and beliefs of members of this sexual network related to risk could inform public health intervention related to STI.

Problem Statement

About 10.4% of swingers have a STI (Neikamp et al., 2013), but swingers do not typically identify as such in STI testing (Brewster et al., 2017). The preferred anonymity of this group contributes to the lack of concise recorded data about swingers' beliefs and practices related to condom use (Neikamp et al., 2013). Therefore, swingers who bareback are an important group to study, as there is STI risk inherent to their sexual behavior (Brewster et al., 2017; Neikamp et al., 2013). Although the research regarding swingers and STI illuminates important findings, little research has been conducted on

the high-risk population of swingers and their beliefs about the risk of STI. Given such, further research is warranted on this topic. Understanding the beliefs of this group related to risk contributes to an understanding of why swingers contract STI despite the availability of methods to prevent its contraction.

Purpose of the Study

The purpose of this generic qualitative study was to develop an understanding of the attitudes and beliefs of swingers related to the risk of contracting STI among swingers who do not use condoms. Research indicates an optimistic attitude among some swingers despite the high-risk nature of their sexual activity, even though they report fear of contracting STI (Bentzen & Traeen, 2013). Exploring swingers' perceived vulnerability to health risks along with the perceived severity of the threat of STI can provide information about what is considered by this group when making the choice not to use a condom. By developing an understanding of the beliefs and attitudes related to condom use and STI in this group, this research can inform the process of STI prevention in a larger societal context. STI prevention informed by an understanding of these health decision-making attitudes and beliefs may lead to a more targeted message to groups at risk, influencing prevention and reducing the spread and impact of STI.

Research Question

What are the beliefs and attitudes that influence swingers' decisions to engage in unprotected sex with multiple partners despite the high potential for STI contraction?

Theoretical Framework

This study was grounded in the health belief model (HBM), which addresses the knowledge, opinions, and actions of a person in their consideration of health and disease (Agnew, Harvey, VanderDrift, & Warren, 2017). The HBM is a longstanding and respected model in research related to STI prevention (Champion & Skinner, 2008). The HBM indicates that beliefs about risk for a disease or health problem and perceptions of the benefits of acting to avoid it influence actions and therefore perception and attitude impact health decision-making (Montanaro & Bryan, 2014). Predictions of the HBM include a perception of susceptibility to and severity of a negative health outcome as well as an evaluation of barriers to action and consideration of the benefits of acting to prevent the negative outcome (Champion & Skinner, 2008).

The HBM was applied to outline the inquiry in the questionnaire utilized in this study. A detailed explanation of how beliefs and attitudes as well as cognitive and affective factors figure into decision making related to health risks are included in Chapter 2. Exploring the choice to have high-risk sex with multiple partners based on the HBM framework while examining both the cognitive and affective components of this decision can provide an understanding of how sex-related health decisions are made (Montanaro & Bryan, 2014). Understanding how swingers view risk of STI in sexual situations and the attitudes that affect how they make decisions related to risk defined the research question in this study. Another strength of the HBM is that it has implications for intervention design, making testable predictions related to the payoff of changing behaviors and the impact of doing so (Darteh, Kumi-Kyereme, & Asuwabo-Asare, 2016).

Nature of the Study

To develop an understanding of beliefs and to recognize attitudes related to STI in this group, a generic qualitative study was implemented. A generic qualitative study can be used to explore what people believe and identify what that belief may point toward, focusing on actual opinions versus the structure of a process (Percy, Kostere, & Kostere, 2015). This approach is used to produce information about attitudes and beliefs about an experience that contributes to a larger representation of a population (Percy et al., 2015). I examined swingers' beliefs and attitudes related to sexual health risk, understanding perceived susceptibility and vulnerability to contracting STI. Data were collected through structured interviews using a selection of persons participating in the swinger lifestyle. This study documents significant statements to identify clusters of meaning, providing a representation of the beliefs of swingers who bareback. A textual description of the individual's experience was collected in face-to-face interviews.

Convenience sampling was utilized, as swingers attending group events were solicited for interviews when confirming their attendance at the events. Swingers of different sexual orientations were included, as the swinger population is made up of persons of multiple sexual orientations (Rubin et al., 2014). A group of 18 individuals was included, with special attention to the selection process applied to achieve similar numbers of male and female participants as well as representation from swingers identifying as heterosexual and homosexual. Those identifying as gender nonbinary and transgender would have been included if they presented during the sampling. The unit of analysis was individuals. Effective qualitative studies on the attitudes and beliefs of

swingers have included a similar number of participants (Bentzen & Traeen, 2013; Vaillancourt & Few-Demo, 2014).

Definition of Terms

Affective factors: Beliefs based on positive or negative feelings about a subject (Shimp, Marshall, Beas, Bizon, & Setlow, 2015).

Bareback: A person who chooses to have sex with a partner without the use of a condom (Avila, 2015). This term has also been used traditionally in gay culture to describe the act of engaging in anal sex without using a condom (Brisson, 2017).

Cognitive dissonance: The state of holding two or more conflicting beliefs that are inconsistent, causing a person to encounter psychological discomfort and difficulty with making decisions (Cooper, 2019).

Cognitive factors: Logical beliefs based upon known facts about a subject (Shimp et al., 2015).

Collective sex: Sexual engagement that involves more than two partners is collective. It is also referred to as group sex (Frank, 2018).

Condom: A condom is a prophylactic barrier device. It is a thin covering worn on the penis or inside the vagina (female condom) during sex to reduce the probability of pregnancy and the spread of STI. Condoms are disposable sleeves most commonly made from latex and less commonly from polyurethane or lamb intestine (WHO, 2018).

Condom use: Use of a prophylactic condom of any type to prevent pregnancy and the potential spread of STI (Young et al., 2017).

Confirmation bias: The tendency to interpret evidence or events as strengthening existing beliefs as a type of cognitive bias. This can be irrational and opposite to the facts of a situation (Sleeger, Proulx, & van Beest, 2019)

Consensual nonmonogamy (CNM): CNM is an umbrella term that covers polyamory, swinging, and other forms of open relationships. CNM relationships include more than one partner with the consent of all partners involved. It is also described as ethical and responsible nonmonogamy (Moors et al., 2017).

Group sex experience: An event or instance where multiple people meet to engage in sexual activity where more than two partners are present. This is also known as collective sex (Frank, 2018).

Health belief model (HBM): The HBM is a model used by health science and social science researchers (Champion & Skinner, 2008). The HBM theorizes that beliefs about the risk of a disease or health problem and perceptions of the benefits of acting to avoid it influence actions related to health decision-making (Montanaro & Bryan, 2014).

Health disparity populations: Individuals in sexual and gender minority groups are identified as health disparity populations. These groups encounter increased challenges from stigma and discrimination due to being outside of the most dominant social group; and their minority status can serve as a barrier to maintaining health (National Institute on Minority Health and Health Disparities, 2019).

Heteronormativity: Denotes a view that promotes heterosexuality, predicated on the gender binary as the normal, default, and preferred sexual orientation and behavior. It

assumes that sexual relationships are most appropriate with persons of the opposite gender (Ferrer, 2018).

Heterosexuality: A sexual orientation with sexual attraction between a man and a woman (Moser, 2016).

Homophily: The tendency for people to seek out, be attracted to, or connect with those who are similar to themselves (Utz & Jankowski, 2016).

HIV/AIDS: HIV is a sexually transmitted/blood borne viral disease that can lead to AIDS, which currently has no cure and can result in death. HIV kills or damages the body's immune system cells, with AIDS being the most advanced stage of the infection (CDC, 2017).

LGBTQ: The currently accepted acronym to identify the sexual minority groups who identify as lesbian, gay, bisexual, transgender and queer individuals (Walker, 2014).

The lifestyle: A person engaged in swinging is described as a person in the lifestyle (Kimberly & Hans, 2015).

Monogamy: The socially predominant American view of partnership where exclusive sexual activity with one partner is expected by both parties (Haupert et al., 2017).

Nonconsensual nonmonogamy (NCNM): Relationship infidelity or cheating on agreed-upon relationship principles related to engaging in relationships outside the primary dyad (Ferrer, 2018).

Online connecting place: A website designed to facilitate connection to others who are interested in connecting to other swingers (Frobish & Griffiths, 2013).

Open relationship: Open relationships are defined by a lack of rules and limits around sexual and/or emotional connections while the primary relationship remains intact for partners (Brewster et al., 2017).

Polyamory: Polyamory is a type of CNM, where those in committed relationships seek romantic and emotional connection to additional partners (Rubel & Bogaert, 2015).

Sexual behavior: What individuals and groups of people do to and with others to express sexual desire. Sexual behavior can be an expression of person sexual interests, used to arouse a partner, or as a prelude to other sex acts (Moser, 2016).

Sexual concurrency: Overlapping, successive, or concomitant sexual relations with sexual partners (Platteau et al., 2017).

Sexual network: This is a group of individuals who have sexual concurrency (Frobish & Griffiths, 2013).

Sexually transmitted infection (STI): A collection of infections transmitted through physical, primarily sexual contact, caused by bacteria, viruses, or parasites (WHO, 2018).

Sexual minority group: Individuals in sexual orientation categories who fall outside of socially accepted heteronormative monogamy (National Institute on Minority Health and Health Disparities, 2019).

Sexual orientation: An individual's inherent identity in relation to the gender to which they are sexually attracted and/or desire to have relationships—emotional, romantic, or sexual (Moser, 2016).

Swinger: A person active in a lifestyle where persons in a committed relationship engage with other partners for sexual activity (Rubel & Bogaert, 2015).

Transmission: The spread of a bacteria, virus, or parasite from one person to another (Young et al., 2017).

Venue: For purposes of this study, a venue is a place where swingers engage in behavior for the purposes of connecting sexually. This could include a hotel, resort, nightclub, or private home (Cornwell & Schneider, 2017).

Assumptions and Limitations

The intention of the research was to hear the opinions and beliefs of each of the participants, and only at the data interpretation stage of the research did shared or common themes become active components. The goal was to identify common or shared experiences, beliefs, and attitudes and to unite them as a single narrative about the nature of the bareback swinger experience related to STI concern. This narrative is inclusive of diversity in gender and sexual orientation. Epoche was practiced by setting aside personal bias as to known sexual health risks associated with choosing not to use condoms in sexual activity in order to fully capture the meanings in this group's lived experiences.

Due to the private nature of this group, considerable effort was required to gain access. Limitations include challenges due to the group's emphasis on privacy, causing the swinging lifestyle to be rarely seen by social researchers (Kimberly, 2016). Further, cultural contexts related to taboo sexual issues must be understood in depth by the researcher to access the hidden society that is to be explored and sexual activity considered taboo occurs in secured environments with barriers to entry (Harvianen &

Frank, 2016). The structured, one-on-one interviews captured participants' meanings related to STI risk by encouraging swingers to be open about their experiences through provision for complete anonymity in a judgment-free interview.

Scope of the Study

Little research has been conducted on swingers and their beliefs about the risk of STI, so research with this group was warranted. Participants were identified as those who were engaged in swinging and do not use condoms as regular practice. Participants in sexual subcultures like swinging may not fit into the conventional descriptions of heterosexual, homosexual, or bisexual identity (Albury, 2015). This study was primarily identifying beliefs and attitudes of persons who identify as swingers, without study directly of sexual orientation or gender. Participants can have concurrent affiliations with heterosexual, homosexual and bisexual identities, and this could confound academic research and sexual health policy (Albury, 2015). Although consideration to include multiple self-identified sexual orientations was implemented, the focus on the specific identity of swinger reflects the intent of the study.

Significance of the Study

STI is an increasing public health problem on a large scale despite their preventable nature (WHO, 2018). Understanding how people view exposure to STI in high-risk situations can inform more effective and targeted prevention efforts and public health programs. Thus, exploring swingers in the context of their elevated STI risk is an opportunity to develop increased knowledge about why STI is spread when the use of condoms for protection is an option. Sex with multiple partners is a high-risk health

situation potentially leading to the spread of infection on a large scale that can cause health problems and even death (Conley, Moors, Matsick, & Ziegler, 2015). This study was conducted to explore the attitudes and beliefs that influenced participants to have sex without engaging in preventative behavior even when the perception of some level of risk for STI was present.

This study provides insight into a subgroup that has not been studied in this context. Exposure to STI can be attributed to faulty methods that people utilize to make decisions about sexual partners and situations (Sparling & Cramer, 2015). Increased understanding of what swingers believe about risk that leads to the choice to have unprotected sex can contribute to the larger issue of how individuals in our society make important decisions about their health.

Prevention also plays a key role in the magnitude of the spread of infectious disease (WHO, 2018). Cues to action from a preventive intervention could reduce the spread of STI by changing the expectations about the impact of elevated risk behavior (Darteh et al., 2016). Data related to lifestyle behavior are essential to guiding prevention efforts (U.S. DHHS, 2015). Developing more impactful STI prevention efforts shaped by an understanding of specific sexual health beliefs and attitudes can create more effective public health efforts, creating social change through reduced rates of STI.

Summary

In this chapter, the subjects of STI and swingers were introduced, with definitions provided of key terms. An overview of the study was presented as well as information

related to the plan for the research process. The next chapter presents information related to the literature review and theoretical framework.

Chapter 2: Literature Review

Introduction

In this chapter, I explore the research related to swingers who do not use condoms as well as the impact of STI. The focus is on the prolific nature of STI and its impact on those who have sex with multiple partners in a sexual network. This review addresses the growth of CNM as an emerging sexual practice and the growth of swinger culture since its initial recognition in research during the 1970s. Challenges to swinger research are also explored as well as considerations for health promotion in this unique population. The risk-taking nature of swingers who bareback is also explored with a focus on describing beliefs related to condom use. Understanding the attitudes and beliefs of swingers considers both affective and cognitive processes, which is discussed in this literature review. The HBM, the theoretical framework of the study, is also explored in this chapter. This model provides a theoretical lens to health decision making—in this case, the choice to use a condom to reduce the risk of contracting a sexually transmitted infection. Exploring how people make decisions about their health can inform future prevention efforts by identifying the relevance of both cognitive and affective processes.

Literature Search Strategy

Utilizing the Walden Library and Google Scholar, I began an exhaustive search of multiple databases including Academic Search Complete, ProQuest Central, Psych INFO, and SocINDEX. Keywords for searches initially included, but were not limited to, *swingers, condom use, health decision-making*, *sexual risk-taking* and *sexually transmitted infection*. Upon the discovery that there was limited research related to

swingers, I extended the search to include keywords to include *consensual nonmonogamy*, which provided a range of information that was applicable though not entirely specific to swingers. In addition, maintaining parameters to include only research conducted in the United States was limiting, so additional valuable and applicable research was found from studies completed in several other countries. Research was chosen for review here based on its relevance to the subjects closely linked to the study.

Literature Review Related to Key Concepts

Sexually Transmitted Infection

STI is the most common infectious disease in the United States with significant economic and health impacts (CDC, 2017). The CDC (2017) estimated the number of people living with STI to be 110 million in the United States, with 20 million new infections annually. STI refers to 35 infections transmitted primarily through sexual activity, which includes chlamydia, gonorrhea, HIV/AIDS, and syphilis, which require mandatory reporting and are tracked by the CDC (2017). Also included under the STI umbrella are human papillomavirus (HPV), herpes simplex virus, trichomoniasis, chancroid, and more (WHO, 2018).

Sexually transmitted infections have negative implications for fetal health and mortality, sexual function, multiple types of cancer, and can result in chronic illness and even cause death (U.S. DHHS, 2015). STI also leads to reproductive complications and infertility, and because STI is associated with social stigma, it also has a substantial psychological impact (Mark & Dhir, 2015). The CDC (2017) has also reported an increasing economic burden related to STI, estimating the cost to the American

healthcare system at 16 billion dollars annually. Without effective public awareness through impactful prevention, the spread of STI will continue to incur large scale costs to the healthcare system and to the mental and physical health of individuals affected as well as to their partners and families.

Sexually transmitted infection and minority populations. STI is stigmatized, leading to social fear, which creates a reluctance toward testing and informing partners of positive test results or diagnoses (Conley et al., 2015). Further, there are increasing mental and physical health issues related to individuals in sexual minority groups in the United States who suffer a disproportionate burden of diagnosis of STI (Frank, 2018). Those in sexual minority groups who are already stigmatized may be significantly impacted by the additional stigma of acquiring STI (Frank, 2018). Sexual minority groups include LGBTQ individuals; men who have sex with men and women who have sex with women were noted as target populations for research and in need of progressive intervention programs to address the spread of STI (CDC, 2017). The National Institute on Minority Health and Health Disparities (2019) also described individuals in sexual and gender minorities as health disparity populations due to the challenges of stigma and discrimination particular to these groups, which serve as barriers to maintaining health.

Researchers have responded to the health disparities in sexual and gender minority groups by producing increasing numbers of sexual behavior studies related to individuals who identify as LGBTQ (Levine, Herbenick, Martinez, Fu, & Dodge, 2018). Like those in the LGBTQ community, the sexual minority group of those engaged in CNM are affected by stigma related to their relationships. But those in CNM

relationships are not well represented in empirical study or recognized by practitioners in health care; however, they are also sexual minorities with increasing numbers and can benefit from increased study and targeted health care (Levine et al., 2018). Individuals involved in CNM can be frequently engaged with concurrent sexual activity, as they may have overlapping partners in relatively short time periods. As a result, this group potentially plays a role in STI transmission on a large scale (Spauwen, Neikamp, Hoebe, & Dukers-Muijrers, 2015). The study of CNM has shown that risk behavior, like inconsistent use of condoms, presents a high risk for STI, and some studies of this group have shown that self-reported STI is occurring at a high rate (Platteau et al., 2017).

Consensual Nonmonogamy

Monogamy continues to be the most accepted sexual behavior in American culture (Herbenick et al., 2017). A high percentage of people believe that monogamy is considered the most appropriate choice for family and that it is the best choice for society (Platteau et al., 2017). Monogamy is also portrayed as a universal goal in much of science, media, and society (Conley, Piemonte, Gusakova & Rubin, 2018). Western culture traditionally asserts monogamy as the accepted and preferred norm for romantic relationships among heterosexual men and women (Edgar, 2016). Research has indicated a bias among Americans toward monogamous partnerships as the most natural, healthy, and safe (Frank, 2018). As a result, heteronormative monogamy is considered by most Americans to be the acceptable default partnership situation. These beliefs, although widely held, can develop some negative stereotyping toward the growing group of those involved in CNM (Grunt-Mejer & Campbell, 2016; Hutzer et al., 2016). CNM is a term

related to partners who agree that each will have relationships outside the primary partnership that could be romantic, sexual, and/or emotional (Haupert et al., 2017). CNM is a longstanding practice common among a diverse range of cultures and sexual orientations (Haupert et al., 2017). Participation in sex outside the primary monogamous relationship is often rejected by conventional viewpoints due to its incongruity with mainstream cultural precepts (Kimberly, 2016). But sexual health interventions based on monogamy or grounded in a chosen moral standard of monogamy are unsuitable, misplaced, and even detrimental in a modern culture that may not necessarily be entirely heteronormative (Levine et al., 2018).

Monogamy may be the predominant American view of partnership; however, the focus on exclusivity ignores the present diversity of partnerships that is largely unseen (Haupert et al., 2017). Those involved in CNM have been underserved by researchers and health care providers, and the study of behaviors and practices related to groups practicing CNM has been limited (Brewster et al., 2017). But current research is beginning to examine the construct of monogamy and its benefits to assess whether this historically long-standing positive perception is warranted (Edgar, 2016; Kean, 2018). This has led to the increasing conceptualization of CNM as a lifestyle descriptor and separate sexual identity (Levine et al., 2018). Increasing empirical evidence may increase awareness of other types of intimate experiences that do not fit the traditional heteronormative role of monogamy (Levine et al., 2018; Moors, 2018). Empirical research related to CNM has expanded over the past 20 years, led by social science scholarship (Haupert et al., 2017). Researchers have noted relationship qualities among

each of the CNM subgroups and have developed concurrent descriptions and characteristics (Conley & Ziegler et al., 2013; Grunt-Mejer & Campbell, 2016; Jenks, 2014; Moors et al., 2017). However, minimal research from a public health approach has addressed sexual health concerns related to CNM and associated sexual behaviors. The examination of relationships, rules, and perceptions outnumber the research into health practices, sexual decision-making, and health outcomes (Ferrer, 2018). Even with statistics emerging noting a high incidence of CNM, not much is known about the prevalence of CNM relationships or factors related to practices in these relationships (Haupert et al., 2017).

Despite a lack of research on CNM, studies have helped describe the nature of these relationships. These relationships can be sexual and emotional in nature, with limits placed on sexual engagement or emotional connection. There are three separate divisions within CNM: polyamory, open relationships, and swinging (Rubel & Bogaert, 2015). Polyamory is typically described as those in a couple seeking additional relationships that are romantic, loving, and emotional in nature. Open relationships are defined by a lack of rules and limits while the primary relationship remains intact for partners (Brewster et al., 2017; Haupert et al., 2017). Swingers are defined by pleasure seeking, sex-focused activity (Houngbedji & Guillem, 2016). What unites these three subgroups under the label of CNM is that although they are each different, those involved agree to nonmonogamy and communicate openly to maintain the primary partnership in that context (Levine et al., 2018). Relationships can be considered linked by sets of rules determined by partners. For instance, traditional monogamy is based on the rule that the

only sexual activity or romantic partnership occurs within the dyad, making faithfulness the cornerstone of contemporary monogamy. In CNM, individuals remain committed to each other but make an additional agreement that they will be involved in concurrent relationships to meet sexual and/or emotional needs (Conley et al., 2013).

Additionally, although there is a knowledge gap on those who participate in CNM (Conley et al., 2013; Rubel & Bogaert, 2015), some studies are beginning to develop an estimation of those participating in CNM as an increasingly large group of people (Haupert et al., 2017; Grunt-Mejer & Campbell, 2016). A United States population-based study reported that extradyadic sex is prevalent, with 25.2% of men and 14.5% of women reporting sexual intercourse with an additional partner while in a committed relationship (Haupert et al., 2017). This was duplicated in a study in Belgium, with the average number reported as 23.7% of men and women in committed relationships engaging with other partners (Platteau et al., 2017). Using a probability sample of United States adults, Herbenick et al. (2017) also found that 1.5 % of those in relationships described their relationship as open. Another nationally represented probability sample of adults in the United States demonstrated a rate of 4% of adults are presently in relationships described as open (Levine et al., 2018). According to another study, one in five American adults report partaking in CNM at some point in their life (Haupert et al., 2017). Another study reported an estimated incidence of CNM at 1.2 to 9.8 million people, or less than half a percent to 4% of adults in America (Brewster et al., 2017).

In addition to the increasing number of those participating in CNM, Americans have demonstrated increased curiosity related to CNM (Hutzer et al., 2016; Jenks, 2014;

Moors, 2018). Google searches related to CNM have rapidly increased over the past 10 years (Moors, 2017). Corresponding with people exploring CNM, multiple guides and publications, both scientific and popular in nature, have appeared (Moors et al., 2017). Some scholars argue that CNM is developing into such a common practice in the United States that it could become accepted as an American sexual norm (Kimberly & Hans, 2015; Moors et al., 2017), creating a new model for how people maintain and choose partnered relationships (Vaillancort & Few-Demo, 2014).

Swingers

In the United States, sexual exclusivity, or monogamy, remains the norm for committed couples, even in the face of social changes impacting the feasibility of monogamy (Edgar, 2016). But monogamy is difficult for some individuals after longer periods of being single due to the age of marriage growing older, increased acceptance and incidence of premarital sex, evolving gender roles that affect relationship dynamics, increased opportunity for meeting extra partners through technology, and the increased social emphasis on the expectation for sexual satisfaction (Kean, 2018). Nonmonogamy is becoming an increasingly accepted sexual status due to its growth as a sexual practice in America (Kimberly & Hans, 2015). Sex is also growing into a more palatable conversation topic among people, but it is understood differently by diverse groups of people (Conley et al., 2018). Sex can be defined as an expression of love and commitment, as a physical release or escape, or as recreation or play (Harviainen & Frank, 2016). Swinging makes it possible for people to address all aspects of sex by

exploring their own sexual needs and desires with several partners in the context of a foundational, committed primary partnership (Bentzen & Traeen, 2013).

Swingers are a subgroup of CNM who share partners for sexual purposes, and swinging is described as a lifestyle by its participants (Kimberly & Hans, 2015; O'Byrne & Watts, 2011). This is a group that is collectively self-described as nontraditional monogamy or couples who engage in sexual activity with multiple partners as regular practice (Kimberly, 2016). Swingers are committed couples, married or partnered, who describe their relationship as primary, although they participate in permitted nonmonogamy in the form of sexual activity with others (Vaillancourt & Few-Demo, 2014). Swingers fluctuate from being a heterosexual couple living in a traditional way to individuals who are fulfilling their sexual desires in nontraditional ways (Frobish & Griffiths, 2013). Swingers are primarily committed heterosexual couples who consensually engage in extra relational sex primarily but not exclusively with other committed couples for recreational purposes (Kimberly & Hans, 2015). Although swingers are largely and consistently identified as heterosexual (Rubel & Bogaert, 2015), there is a recognized element of female bisexuality present in swinging activity (Lehmiller, 2015). Male homosexuality and bisexuality in this group is less prevalent (Houngbedji & Guillem, 2016). Homosexual committed couples who are engaged in swinging are even less documented and researched than heterosexual couplings (Albury, 2015).

Swingers have also been found to be more sexually active compared to the general public, have higher rates of sexual desire, and are more open to new sexual

experiences (Vaillancourt & Few-Demo, 2014). They desire more frequent sexual activity and talk more openly and honestly about sexuality and sexual fantasies (Platteau et al., 2017). Proponents of swinging report a lifestyle that promotes happiness, with no need to disconnect from the security of home, marriage or family (Edgar, 2016). One study has demonstrated that swingers are very satisfied with their lives, participating in the lifestyle for enjoyment, fantasy exploration, social interaction, and sexual fulfillment (Wilt et al., 2017).

Despite the increase in nonmonogamy, there are social and cultural pressures on committed couples to maintain what is considered by the majority to be normative sexual behavior, with infidelity noted as immoral (Edgar, 2016). But sexual activity within swinging is not defined as infidelity by its participants, despite the popular societal belief that committing to sexual monogamy is the moral way for couples to behave (Conley et al., 2018). However, swingers are often labeled deviant and immoral by those outside the lifestyle (Wilt et al., 2017).

The history of swinging. In 1940s, "key clubs" in the United States began a practice that came to be known as "wife swapping" (Fang, 1976). Later, this was collectively related to as swinging, and is now largely referred to by its participants as the *lifestyle* (Kimberly & Hans, 2015). In the United States, the emergence of swinging is often considered a result of the sexual revolution of the 1960s and 1970s, where the belief that sex can be recreational, and that it is acceptable for both men and women to engage and initiate sex began to form. Initially, in that time period, swinging was sometimes associated with utopian, revolutionary, and progressive ideals about morality (Harviainen

& Frank, 2016). Research done in the 1970s (Bartell, 1971; Cole & Spaniard, 1974) reported that one to two percent of couples in the US were engaged in swinging. Measures in the 1990s reflected rising numbers of persons in the lifestyle, some noting rates as high as 15% of couples engaging (Jenks, 2014). By the 1970s, publications on swinging, open marriages and group sex experiences were more frequently published and more readily available to the public and in the social science community (Rubin, 2001).

In a larger study in 1997, researchers corroborated that potentially 15% of couples in the United States had experimented with swinging (Brewster et al., 2017). Throughout the 1990s the number of swinger-related enterprises to include clubs, on site-meeting places like swinger bars, and travel agencies catering to swingers increased at a rapid rate (Wilt et al., 2017). These organizations exist currently, with the addition of multiple, high membership websites for meeting like-minded people in the lifestyle (Harviainen & Frank, 2016). Swing clubs with physical locations where people could meet and have sex were listed with the North American Swing Club Association and doubled to 400 in number between 1987 and 1997, with over 300 clubs currently affiliated with North American Swing Club Association with an estimated 3 million swingers part of these clubs at the turn of the century (Rubin et al., 2014). There are currently at least 11 major swinger conventions held annually in the United States alone, drawing between 300-3,500 attendees at each event (Vaillancourt & Few-Demo, 2014).

The swinger population. Swingers are a growing sexual network with estimated numbers that vary, as this group is not often measured and studied (Harviainen & Frank, 2016). Frobish and Griffiths (2013) noted that there is little information on how socio-

cultural, socio-economic, and institutional frameworks are connected to or influence swinging behaviors. Sexual and psychological health-related issues could potentially be associated with swinging, but this remains relatively unexplored (Bentzen & Traeen, 2013). This lack of knowledge has been acknowledged by researchers (e.g., Conley et al., 2013; Rubel & Bogaert, 2015), and there remains a lack of data from national surveys that could provide reliable estimates for swingers' current numbers. Exact estimates are hard to find in research because swingers are a hidden population (Mogilisti et al., 2017).

The secrecy surrounding swinging is largely to protect the privacy of the group, and its club-like nature (Mercer, 2017) preserves this privacy for its members. The most current estimates report that swinger's numbers could be one to eight million in the United States, with this number on the rise (Kimberly, 2016). Brewster et al., (2017) estimated the overall prevalence as less than one half of a percent to 4 percent of the Unites States population. Even if exact numbers are not present, research has demonstrated the growing nature of this group in the past several decades, with estimates ranging from one to eight million persons in America engaged (Ruzansky & Harrison, 2019). The closest to consensus is that there is a range of one to fifteen percent of couples in the United States that have participated in the lifestyle at one point in their lives, with this number growing, substantiated by older studies showing lower percentages of participation (Kimberly, 2016; Rubin et al., 2014; Vaillancourt & Few-Demo, 2014; Wilt et al., 2017)

Empirical research reinforces the homogenous nature of swingers (Brewster et al., 2017; Jenks, 2014). Research has provided a view of swingers as similar as a group in

race, age range, income and education (Rubin et al., 2014). Swingers are typically Caucasian, heterosexual couples who are financially comfortable (Kimberly, 2016). Through a large national sample, it was determined that swingers are mostly socio-economically middle to upper class. In most studies, this group is associated with above average rates of education and income as compared to heterosexual monogamous partners (Mercer, 2017). The consensus is that the group is largely populated with professionals (Kimberly, 2016). Jenks (2104) corroborated that swingers are 90% Caucasian, have more formal education than the general population, and are more likely than non-swingers to belong to religious organizations. Drawing general conclusions about the association of political and religious affiliation is difficult based on the existing data (Haupert et al., 2017). They are also noted to have experienced abuse or family dysfunction at the same rate as the general population (Herbenick et al., 2017). Studies report a mean age of 39 (Jenks, 2014) with other studies noting a typical age range of 28-45 years for participants (Frobish & Griffiths, 2013).

Swingers as a sexual network. Swingers are considered a sexual network, due to sexual concurrency, or engaging in overlapping sexual relations involving different/multiple sexual partners (Platteau et al., 2017). Sexual networks consist of people connected by successive or concomitant sexual partners (Neikamp et al., 2013). Networks develop and grow based on referential creation, with people who have initiated connections in the past being likely to initiate new connections (Utz & Jankowski, 2016). In the peer-reviewed research performed by Brewster et al. (2017) analyzing the research on swingers, the authors believed that a concise understanding of the group engaged in

swinger culture is needed due to its fast growth. Niekamp et al. (2013) confirmed the relevance of studying sexual affiliation networks to understand STI epidemiology. Sexual concurrency is considered a significant risk factor for acquiring STI even though this notion is sometimes challenged (Frank, 2018; Platteau et al., 2017). In response to that challenge, it is important to note that STI screening recommendations already suggest regular testing for anyone with more than one sexual partner in the interest of maintaining personal health and public safety (CDC, 2017; Frank, 2018).

Research on sexual networks provides a view of how STI is spread through sexual groups (Weitzman, Barber & Kusunoki, 2019). These studies can point to who has the highest risk of becoming infected, who is a significant spreader of STI, and how certain risk behaviors influence the spread of STI (van Liere, Hoebe, Niekamp, Koedijk, Dukers-Muijrers, 2013). This is especially important because the risk for contracting or transmitting STIs increases substantially when a person is linked sexually to multiple persons who are also at risk in the same sexual network (U.S. DHHS, 2015). Sexual networks and social contexts can provide considerable influence on risk behaviors and even facilitate STI transmission (Spauwen et al., 2015) Networks consist of interconnected components, so an outbreak of STI at one location will typically not remain in one area and will spread to other connected areas (Neikamp et al., 2013).

Studies of sexual networks have been essential for understanding STI outbreaks in various instances and locations (D'Angelo-Scott, Cutler, Friedman, Hendriks, & Jolly, 2015). In one study, the authors concluded that because swingers have a connected sexual network, they would benefit from a more individualized STI prevention effort,

particularly one that considers their unique network factors (Spauwen et al., 2015). Results of a study tracing a sexual affiliation network of swingers demonstrated that swingers were having sex locally as part of a single group that divided into smaller groups and were engaging within a moderate average geographic distance (Neikamp et al., 2013). As a result, the swingers in the network were highly interconnected through their affiliations, enabling STI to eventually reach many in the network when one person was infected (Neikamp et al., 2013).

Collective sex is part of swinging activity (Ruzansky & Harrison, 2019). Some couples swap partners, some engage in sex together as a small group, and some participate in large-scale group sex (Kimberly, 2016; O'Byrne & Watts, 2011). Collective sex is inherently a high-risk behavior due to interaction with sequential and/or multiple simultaneous sexual partners (Weitzman et al., 2019). Swingers in one study reported a higher frequency of engaging in oral, vaginal and anal sex compared to national samples from couples in the general population (Platteau et al., 2017). As a result, multiple exposure to potential sources of STI can occur within a single event (van Liere et al., 2013). Transmission of STI through infected fluids is more likely with multiple exposures, and tissue damage can occur due to repeated vaginal, oral and anal sex acts that can increase the likelihood of transmission of STI (Rice et. al., 2016). Some collective sex environments support reduction of STI risk by suggesting practices that reduce risk, like using condoms and changing condoms with each partner, using condoms and changing condoms on sex toys between partners, washing genitalia between partners, avoiding communal lubricant, withdrawing before ejaculation into the body, and hand

washing and mouth rinsing (Frank, 2018; Kimberly, 2016). People participating in swinging are encountering a higher number of sex partners through their activities, as well as parallel contact with one another through sexual networks, thus constituting a high-risk group for contracting STI (Dukers-Muijers et al., 2017; Houngbedji & Guillem, 2016; Lehmiller, 2015).

Prior to the HIV epidemic, many identified collective sex environments to be deviant subcultures, portraying them as places where there was hedonistic sexual activity with no concern for STI transmission (Moors, 2017). Collective sexuality is linked to certain types of sexual behaviors to include increases in frequency and duration of sex, and non-mainstream sex practices to include fisting, anal sex, anal play or rimming, prolific use of sex toys and other associated gear, and attendance at sex clubs (Frank, 2018). There has been a resurgence of empirical pursuit, with Brewster et al., (2017), Conley et al., (2013) and Rubel & Bogaert (2015) conducting reviews of the literature. Swingers are described in much of this research as an emerging high-risk group for STI. This is characterized by behaviors that include having multiple sex partners, engaging in group sex, and participating in a high rate of unprotected sex (Houngbedji & Guillem, 2016). However, some research suggests that increased STI risk is not simply related to having sex with concurrent and/or multiple partners, but that it is rather a consequence of these behaviors in concert with failing to engage in safe sex with a partner who is infected (Senn, Scott-Sheldon, & Carey, 2014). This suggests that there is a link between swinging and the transmission of STI, however, some scholars have contested that there

is an insignificant body of evidence to fully illuminate this relationship (Moors et al., 2017).

Swingers and sexually transmitted infection. Despite reported condom use, a link between STI and swingers has been consistently documented in older research (Mullen, Staunton, Debattista, Hamernik, & Gill, 2009). A series of studies on the prevalence of STI among swingers has been published by Dutch teams, with statistics gleaned from STI clinics, noting older-aged heterosexuals with high rates of STI, including a cluster of swingers infected with HIV (Dukers-Muijrers et al., 2017). Research completed by Neikamp et al. (2013) found that 10.4% of swingers at a Dutch STI clinic were infected with at least one STI, indicating that the group was at increased risk due to their sexual practice. The authors concluded that swingers are highly vulnerable to STI acquisition, noting that swingers were infected with STI at high rates and suggested universal testing protocols for swingers as an important public health measure (Neikamp et al., 2013). The authors noted Chlamydia as the most frequently reported STI among the swinger population, with 14.1% of individuals tested at the Dutch clinic diagnosed. This was followed by Gonorrhea at a rate of 6.4%. These results are in line with findings in the European general population, where Chlamydia and Gonorrhea are the most diagnosed STI (Lowndes & Fenton, 2014).

In a survey in Belgium, respondent swingers reported that 25.7 % had at one time received an STI diagnosis (Pitpitan et al., 2016). Swingers in a Dutch study tested at 20.7% currently infected (Dukers-Muijrers et al., 2017). This is higher than the general population reports of STI in Belgium at 3.6%, but lower than the proportion found in

swingers in the Netherlands of 39% infected with STI (Platteau et al., 2017). One study in the Netherlands reported a clinic where swingers averaged a 10% infection rate, compared to men who have sex with men at a rate of 20%, people under 25 years old at 17%, male prostitutes at 38% and female prostitutes at 11% infected. The rate of 10% of swingers reporting a diagnosis of STI can be compared to the rate of 1% in the general public (Mercer, 2017).

Comparing swingers to individuals involved in NCNM, or relationship infidelity, swingers were more likely to use condoms and more likely to get tested for STI (Lehmiller, 2015; Levine et al., 2018). One study noted that swingers are more likely to test for STI and repeatedly test than those who are not in the lifestyle (Dukers-Muijrers et al., 2017). Despite this, studies continue to expose serious risks for swingers through self-reported behavior for acquiring STI, and high rates of STI self-reported diagnoses (Bentzen & Traeen, 2013). Short intervals of time between sexual encounters may not allow for symptoms to develop, which makes screening less likely to happen in a timely fashion (Weitzman et al., 2019). This factor could explain why swingers as a sexual network can unknowingly spread STI (Platteau et al., 2017). Complicating the empirical research picture, however, is that swingers do not typically identify as such in STI testing (Brewster et al., 2017). Empirical knowledge of this lifestyle, the true rate of STI, and the sexual risk behavior taking place in swinger's arenas, particularly with regards to sexual health and the spread of STI remains limited (Bentzen & Traeen, 2013). It is noted by Neikamp et al. (2013) that the preferred anonymity of this group contributes to the dearth

of recorded data about swingers' beliefs and practices related to condom use and sexual risk.

Swingers and condom use. The largest contributing risk factor for contracting STI is engaging in unsafe, unprotected sex (Lewis, Litt, Cronce, Blayney, & Gilmore, 2014). In the United States, 19-20 million persons develop new STIs annually, including 50,000 with HIV, despite that this rate of infection could be reduced with the simple implementation of condom use (CDC, 2017). High risk individuals have a consistently low use of condoms (Senn et al., 2014). The risk of STI is proven to be greatly reduced with consistent and correct use of condoms, yet rates of non-condom use remain high in all adults (Rendina, 2015). A national study of sexually active single adults noted the overall prevalence of condom use at 24.8% of sexually active persons. In the same study, adults with at least one sexual risk behavior reported the use of a condom at 33.8% (Nasrullah, Oraka, & DiNenno, 2017). This means that most sexually active adults are not typically using condoms for sex (Young et al., 2017).

One study suggests that perception of monogamy as a situation low in risk for STI could be mistaken, because of the prevalence of infidelity in committed relationships (Swann & Thompson, 2016). Comparisons of monogamous and CNM groups related to STI rates are rare and have yet to consistently establish whether rates of STI differ between the groups in the United States (Haupert et al., 2017). Comparing STI rates correctly is also compromised by the assertion in current research that those involved in monogamy are engaging in infidelity at high rates (Lehmiller, 2015). One study noted that those in monogamous relationships report similar diagnostic rates of STI (Haupert et

al., 2017). Another study reported that engaging in CNM is linked to positive aspects of sexual health due to greater communication of sexual risks and more frequent use of condoms in extra dyadic sex (Frank, 2018). Researchers have in turn suggested that it is important to address the assumptions of those involved in monogamy that they are safe from STI (Haupert et al., 2017). Swingers and those engaged in NCNM, or infidelity in committed relationships, can both be considered to have sexual concurrency, which is a risk due to multiple partners involved in sexual situations (Amin, 2014). Different patterns of behavior related to condoms have been described for swingers than for those who report infidelity, with higher levels of condom use reported among swingers versus those engaged in NCNM (Platteau et al., 2017). Researchers have suggested that those who are open about and freely adopt CNM sexual practices may be more experienced in negotiating safe sex practices and open to engaging in STI testing than those who are engaged in infidelity (Levine et al., 2018). It could be considered that the open communication related to sex in swingers and CNM persons are protective factors related to sexual risk behaviors, versus those engaged in NCNM (Mogilski et al., 2017).

The lack of condom usage and sexual concurrency are both factors that place people engaged in swinging at a particular risk of becoming infected with STI (Crosby et al., 2014). A study of swingers measuring STI concern, noted fear of contracting an STI was relevant for most participants (Bentzen & Traeen, 2013). STI is spread through person-to-person sexual contact and is specifically more likely to be spread within high risk groups (Mapp, Wellings, Hickson, & Mercer, 2017). A group is defined as high risk when their characteristics or behaviors consistently disregard standard views on risk

factors (Senn et al., 2014). Authors in multiple studies have noted that some in swinger culture do not consistently use condoms (Avila, 2015; Frank, 2018; Harviainen & Frank, 2016). Qualitative researchers suggest that rules regarding condom use in swinger sexual encounters are infrequently established and condom rules are not consistently adhered to when in place (Mercer, 2017). Authors in one study reported that one in five participants stated they prefer not to use condoms, and that half reported inconsistent use of condoms (Kimberly & Hans, 2015). The sexual behavior of swingers related to condom use and STI testing is diverse within the group, and some swingers appear cognizant of sexual health related risks (Frank, 2018). Authors in one study illuminated swingers as a group that assesses risk and takes precautions, with 63% reporting condom use and 63% reporting sharing of STI testing results (Brewster et al., 2017). This level of reported condom use, even though higher than other studies, demonstrates that condom use remains low for a group whose sexual behaviors place them at substantial risk for STI (Platteau et al., 2017).

The social dynamics of swingers' sexual practices vary by situation (Jenks, 2014). The rules, stated and unstated, develop expectations that influence sexual behavior in different ways (Harviainen & Frank, 2016). Swinger sex can unfold in myriad ways, as participants have distinct goals and concerns related to sex and socialization (Ruzansky & Harrison, 2019). Kimberly (2016) reported that it was difficult for some subjects to ask new partners to engage in safe sex, defined as sex using condoms. In this study, condom rules among study participants were less related to risk of infection and instead related to what they perceived as safe. An optimistic bias as the result of an exaggerated perception

of safety can be observed in shared sexual networks (ten Hoor et al., 2016). The settings inhabited by swingers can enhance these beliefs (Houngbedji & Guillem, 2016). Logistics as managed by event or meeting leaders can set the tone for issues for how the group behaves, to include cost management, accommodations, refreshments, and condom use (Harviainen & Frank, 2016). Condom use is noted to be more infrequent in private settings and more frequent in club settings: participants have reported that this is because risk is perceived to be lower in private settings than clubs (Kimberly, 2016). Most swingers are active in both settings, so this is potentially a flawed perception (Harviainen & Frank, 2016). In private settings, navigating safe sex decisions could be more like traditional dating scripts where asking a partner to use a condom can be interpreted as a sign of distrust or a signal that the asking party is infected (Bentzen & Traeen, 2013). This lack of rules in private settings related to safe sex can result in an increased threat of STI (Henderson, 2005).

Relationship-related condom attitudes are important predictors of condom use (Senn et al., 2014). Decision making about condoms can be based on what is perceived as a casual, unknown partner versus what is believed to be a casual known partner (Fridlund, Stenqvist, & Nordvik, 2014). Insufficient condom use among swingers is likely impacted by the emphasis on sexual pleasure-seeking in swinging encounters, because condoms can be perceived as reducing sexual pleasure (Mercer, 2017). Negative attitudes towards the experience of using a condom predicts more sex acts completed without a condom (Pitpitan et al., 2016). The decision to use condoms could depend on multiple factors, including whether the couples have previously had sexual experiences

together, or with other known partners (Kimberly, 2016). Another factor is the perceived status of partners as clean and disease free (Bentzen & Traeen, 2013). Concerns about condom use are relationship dependent, meaning that swingers may inconsistently make the choice to use condoms in certain environments, with certain people or even certain sexual acts (Nydegger, Ames, & Stacy, 2017). Some believed that condom use reduces intimacy and implies lack of trust of a potential partner, while others feared loss of pleasure (Senn et al., 2014). Some reported that condoms are so uncomfortable to use that this interfered with maintaining an erection (Kimberly, 2016). Some women reported vaginal irritation (Kimberley & Hans 2015). Difficulty with maintaining an erection was a common concern among men, even in younger age groups, suggesting performance anxiety in this sexual setting (Bentzen & Traeen, 2013). Young et al. (2017) reported that attitudes toward purchasing condoms can impact sexual health decision making. The authors discovered that purchasing situation and emotions influence a person's willingness to buy and use condoms.

Among older men, fear of erectile dysfunction was even more prevalent, with hesitation to use a condom related to fear of not sustaining an erection (MacDonald, Lorimer, Knussen, & Flowers, 2016). This is significant to note due to the reported age of swingers, averaging up into mid-life years (Houngbedji & Guillem, 2016). Studies have noted that condom use decreases with increasing age, with condom use in older adults low, and rates of STI in older adults increasing (Amin, 2014). In 2013 the CDC reported an increase in new HIV infections in the United States among people age 50 and over (Tuddenham, Page, Chaulk, Lobe, & Ghanem, 2017). Data from studies demonstrate that

older adults engaged in sexual health risk behaviors and were significantly less likely to use condoms during sex than their younger counterparts (Amin, 2014; Avila, 2015; Fridlund et al., 2014). The greater use of condoms among younger individuals may be potentially correlated with targeted national and local public health campaigns raising awareness among young adults as a result of the HIV/AIDS epidemic (Carson, 2017). These typically address the risk of STI and the positive impact that wearing a condom will have on decreasing risk. Nasrullah et al. (2017) discovered that older adults are less likely to use condoms, as noted in the authors' study of persons over 55 years old, where 87% of older adults in the United States reported not using condoms. It was found in yet another study that individuals over 50 were much more likely than younger people to report never using condoms in any circumstance (MacDonald et al., 2016).

Swingers who bareback. Sexual networks generate social networks, which influence STI risk by establishing shared norms related to how people behave, thus developing risk-related behavioral characteristics (Amirkhanian, 2014). Organized sex involves multiple partners and clear expectations, rules, and limits, resulting in groups that form, including some members while excluding others specific to these characteristics (Harviainen & Frank 2016). Online swinger-specific dating sites are the primary places to build networks of like-minded people (Frobish & Griffiths, 2013). The internet affects the way that people develop and join groups, in that they can make choices based on specific desired characteristics (Walker, 2014). Negotiation for contact varies across collective sex environments, as sex seeking is dynamic (Frank, 2018). There are influences that are legal, economic, technological, and social, that influence sexual

partner-seeking practices (Frank, 2018). Individuals may specifically select partners who exhibit the same risk behaviors (Lewis et al., 2014). When a group can evolve its specific identity and attract others, this allows a subculture to emerge (Frobish & Griffiths, 2013).

When individuals with similar attributes share a relationship, or participate in a group, this is described as homophily. Homophily emerges based on social influence and the process of social selection (Niekamp et al., 2013). Notably, swingers are a large and growing homophilic group who has members who have sex without condoms as regular practice, placing them at an increased risk of STI (Frobish & Griffiths, 2013). Frank (2018) reported that a review of various swinger environments discovered that a subgroup that specifically seeks other swingers who have sex without condoms is present. Swingers who have sex without condoms as practice self-identify as bareback (Avila, 2015). Differences in preferred sexual activities and attitudes towards inclusiveness can be observed across the population, and not all swingers affiliate as bareback (Harviainen & Frank 2016). However, barebacks are an active subculture of swingers. A subculture comes into being when people develop contact with each other and identify common interests and beliefs (Kean, 2018). The range of tools to connect through online culture allows for promotional websites for clubs, members only connecting sites and chat rooms (Frobish & Griffiths, 2013). The internet allows for anonymity, in turn developing a space to communicate intimate requests without fear of judgment (Walker, 2014). Engaging in sex outside primary relationships is typically not accepted in mainstream society due to its contradiction of cultural scripts (Ruzansky & Harrison, 2019). Swingers online can meet with others who deny this precept (Serina,

Hall, Ciambrone, & Phua, 2013). Less defined, however, is whether certain behavior within the lifestyle, like bareback sex, is considered acceptable to the group overall (Kimberly, 2016).

Multiple researchers focused on swingers reported that sex without condoms within swinger culture is a long-standing occurrence (Bentzen & Traeen, 2013; Fang, 1976; Frobish & Griffiths, 2013). There is an overall uncertainty regarding the percentage of swingers who identify as bareback and have sex without condoms as preference (Frank, 2018). Ground rules are necessary for interactions in sexual relationships, and condom use, or nonuse is a basic sexual ground rule (Kimberly, 2016). Determination of preferences is individual, but can be aligned with a subgroup, and condom use is derived from these rules (Weitzman et al., 2019). Groups can have some level of cohesion but also groups who come together for swinging are typically newly acquainted and have set the rules in unique ways (Lehmiller, 2015). Some swingers identify with firm rules related to condom use (Frank, 2018). Some swingers establish preferences by identifying as bareback in web profiles (Frobish & Griffiths, 2013). There are significantly inconsistent references to safe sex and condoms in online profiles which suggests several options. Perhaps swingers proceed from the perspective that safe sex is non-negotiable therefore condoms do not warrant specific mention (Serina et al., 2013). Another consideration is that it is possible that swingers are less likely to practice safer sex than the general population and will determine their use of condoms based on each encounter (Frobish & Griffiths, 2013).

Decisions regarding sexual behavior and particularly sexual risk behavior such as condom use have important consequences for health (Rendina, 2015). Even with health risks present, condom use can mean concerns about diminished sexual pleasure for some, while for others it provides feelings of safety and reassurance (Ellis, Homish, Parks, Collins, & Kiviniemi, 2013). Negotiations for sexual parameters can be conducted via technology, resulting in ease in setting limits (McKie, Levere & Humphreys, 2016). Research is mixed in results related to seeking sex partners online as a marker of risky sexual behavior, or if seeking sex online itself increases a person's risk of exposure to persons with STI (McKie et al., 2016). Larger studies where STI related outcomes are recognized are needed (Gravningen, Aicken, Schirmer, & Mercer, 2015).

Self-disclosure of sexual desires and rules occurs in couples with higher overall communication skills and who view sexual communication more positively (Kimberly & Hans, 2015). Event hosts select attendees and set rules to meet social and sexual desires (Harviainen & Frank, 2016). Internet site users utilize customized profiles to negotiate boundaries and establish credibility to attract others on swinger social media. Predominant themes in swinger profiles are statements that denote goodwill, demonstration of physical attractiveness, and mental stability (Serina et al., 2013). Additional commentary often focuses on sexual skill, sense of humor, and hygiene, with profiles where swingers assert themselves as clean and free of disease (Frobish & Griffiths, 2013). Sexual encounters at lifestyle events like clubs and conventions require more in person negotiation since condom use is typically expected (Harviainen & Frank, 2016). One study reported that a bareback swinger is likely to pass on having sex with a

condom in group setting due to negative beliefs related to condom use (Kimberly & Hans 2015).

Frobish and Griffiths (2013) reported that some swingers who bareback have shared that they prefer having frequent STI testing to practicing safe sex. This was attributed by participants to the knowledge that STI can be transmitted through hands, fingers, sex toys and oral sex, not solely through penetrative sex. This group reported that unless everything is protected in the way that a condom protects a penis, that sex is never completely safe (Frobish & Griffiths, 2013). Risk is typically addressed through sexual behavior changes, but Frank (2018) considered that the most efficient management of STI for some swingers is through regular testing and treatment. This is much like the current model utilized in the adult film industry, otherwise known as porn (Moors, 2018).

Swingers who bareback and risk-taking. Research indicates an optimistic attitude among some swingers despite the high-risk nature of their sexual activity, even though they reported fear of contracting STI (Bentzen & Traeen, 2013). Rules regarding condom use preference can streamline interactions and support the sense of sexual freedom desired by swingers (Harviainen & Frank, 2016). Rates of testing among people who engage in collective sex are reported as high (Moors, 2018). Untested swingers in this subpopulation identified to be at higher risk can benefit from outside motivation to get tested (Platteau et al., 2017). One study identified the primary reason that swingers stopped their engagement in the lifestyle as fears of risk to their health, and notes that if swingers believed they were putting their health at risk, that they report that they would cease swinging (Vaillancourt & Few-Demo, 2014).

One predictor of health behavior is attitude towards risk. Attitudes toward condom use are the consistent predictor of actual condom use (Senn et al., 2014). The sexual scripts of swingers are not commonly studied or known (Jenks, 2014; Moors, 2017). Group specific scripts in the sexual socialization process teach individuals socially valid sexual scripts (Kean, 2018). Sexual scripts are defined as group and context-specific sets of norms for socially acceptable roles and behavior which serve to direct social interaction (Baumgartner, 2017). A sexual script defines acceptable norms for sexual situations (Carson, 2017). The contents and elements of swinger scripts are commonly shared among swingers, but also gradually shaped to fit individual preferences related to what specifically personally arouses a person (Cornwell & Schneider, 2017).

There is much that remains unknown about factors that predict sexual risk-taking behaviors (Mullen et al., 2009). It is posited that those engaging in sexual risk behaviors also engage in risk behaviors elsewhere in their lives (Frank, 2018). In the literature on other high-risk groups like men who have sex with men, there is evidence that venues where sex partners meet have a role in the spread of STI (Niekamp et al., 2013). Inconsistent use of condoms when sexual partners meet is also related to drug and alcohol use, adding risk factors for STI transmission (Platteau et al., 2017).

People recognize that condoms reduce transmission risk, however sexual behavior is more heavily influenced by relationship dynamics than by perception of STI risk (Haddad et al., 2018). Cognitive science demonstrates that behaviors interpreted as intentional actions consist of socially learned behavior, which is automatic behavior (Rendina, 2015). Behavior that is automatic is executed through associative and affective

thinking, otherwise known as habit. Habit can originate from following the behavior of what a person believes is the likely and common behavior of others (Lewis et al., 2014). Understanding individual behavior and the role of social influence has implications for collective sex environments. Sexual risk-taking differs from other health risk behaviors, because in most instances, sex occurs between multiple persons (Glasman et al., 2014). When two or more individuals are involved, social influence is a factor (Hansson, Fridlund, Stenqvist, Britton, & Liljeros, 2018).

Health Decision-Making

To understand how to increase condom use and reduce STI in any population, developing knowledge of sexual behaviors and scripts is essential (Bentzen & Traeen, 2013). Selection of sexual partners is not a completely rational decision, where someone navigates all possible outcomes along with the risk associated with potential partners: there are assessments of a potential partner that may focus on attractiveness and ignore risk altogether (Glasman et al., 2014). Perceptions of attractiveness can directly influence condom use intention (Eleftheriou, Bullock, Graham, Stone, & Ingham, 2015). It is not certain which aspects inform the decision that a partner is low or high risk. How risk is assessed is relative to personality type and level of sensation-seeking behavior (Henderson et al., 2005).

Sparling and Cramer (2015) noted that exposure to STI can be attributed to faulty methods that people utilize to make decisions about sexual partners and situations. Condom use may not be a simple decision related to risk, but rather the outcome of a negotiation of observed risk factors that may or may not be accurate and completely

arbitrary (Fridlund et al., 2014). Perceived risk of STI from a potential partner, intention to use a condom, and level of relationship commitment are linked to condom use for heterosexual adults at increased risk for STI (Agnew et al., 2017). This can explain why condom decisions may be made differently in different situations. Assumptions about the cleanliness or assumed number of partners can play a role, even when these assumptions have a chance of being incorrect (Kimberly & Hans 2015). This group is less likely to use condoms, placing them at a high risk for STI (Frank, 2018). Sensation seekers were noted to view potential partners more positively and were more likely to have unprotected sex, as confirmation bias may cause them to view potential partners as less risky and are less likely to believe that they would contract STI (Henderson et al., 2005).

Individuals with multiple partners are at a higher risk for STI, and place their future sex partners at risk, so it is very important to understand the predictors of condom use (Senn et al., 2014). When decision making related to sex is studied, interventions to mediate risk and promote condom use address primarily cognitive and social factors. It is known, however, that positive and negative feelings about health behaviors strongly motivate behavior choices (Shimp et al., 2015). Affective associations, which are the emotions connected to behaviors have an important connection to health-related behavior. Affective factors are not typically the focus of study or targeted by researchers (Chrysikou & Thompson, 2016). Affective associations are an important part of sexual behavior whereas cognitive beliefs, or beliefs based on known facts, have a more limited impact (Ellis et al., 2013).

Much of the literature defaults to cognitive antecedents of behavior as predictive. Sexual decision-making is proposed in some studies to be the result of affective and cognitive processes operating together (Rendina, 2015). Both cognitive factors and affective associations are at play when making sexual health related decisions, like deciding to have unprotected sex (Ellis et al., 2013). Cognitively most people are aware of negative consequences like STI and are completely aware of the effectiveness of condoms in preventing STI (Nydegger et al., 2017). However, individuals develop affective, or emotional associations with condom use that can predict the behavior of deciding to use a condom (Shimp et al., 2015).

Affectively based ideas can be the stronger predictor of behavior, overriding cognitive knowledge (Ellis et al., 2018). Implementation intention develops into a behavioral intention, and these intentions tend to be concrete and make a person more likely to act in a certain way, repeatedly (Hönl, Meissner, & Wulf, 2017). Intention to use a condom was tested in one study (Nydegger et al., 2017) where the authors measured condom use again after one year. The data remained stable, in that those who did not use condoms were likely to still not be using them one year later. The authors determined that behavioral intention to use a condom or not is a good predictor of future condom use. Decision making models used in literature related to sexual behavior rely heavily on cost-benefit analysis (Rendina, 2015). The decision-making process is connected to events where a personal choice is made, but in sexual decision making, consideration for between-persons choices must be made (Kean, 2018). When examining sexual behavior, it is important to consider behavior to be the result of interactions between individual,

interpersonal, and environmental-specific characteristics (Lewis et al., 2014). People may have variability in their behavior related to adaptations made to specific persons and environments (Rendina, 2015).

Health Belief Model

This study is grounded in the HBM which addresses the knowledge, opinions, and actions of a person in relationship to health and disease prevention (Agnew et al., 2017). The HBM is a longstanding and respected model in research related to STI prevention (Champion & Skinner, 2008). The HBM posits that beliefs about risk for a disease or health problem and perceptions of the benefits of acting to avoid it influence actions, and therefore, perceptions and attitudes impact their health-related decision making (Montanaro & Bryan, 2014). Predictions of the HBM include a perception of susceptibility to and severity of a negative health outcome as well as an evaluation of barriers to action, as well as consideration of the benefits of acting to prevent the negative outcome (Champion & Skinner, 2008).

Exploring the choice to have high-risk sex with multiple partners based on the HBM framework can provide an understanding of how sex-related health decisions are made (Montanaro & Bryan, 2014). Understanding how swingers view risk of STIs in sexual situations and the attitudes that affect how they make decisions related to risk underlies the research question in this study. Another strength of the model is that it has implications for intervention design, making testable predictions related to the payoff of changing behaviors and the impact of doing so (Darteh et al., 2016).

Prevention

Next to recommending abstinence, suggesting monogamy is utilized as a primary prevention strategy in sexual health prevention efforts (Lehmiller, 2015). Stigma can result for those on the fringes of what is considered acceptable or mainstream (Stevenson, Keogh, Smith, & West, 2018). If someone suspects that a healthcare provider will stigmatize them for having an STI, it is less likely that they will pursue treatment (Conley et al., 2015). There is a lack of available data on sexual healthcare seeking behaviors, (Mapp et al., 2017), and even less data related to swingers specifically. One study showed that about half of the swingers who attended sex clubs in Canada reported that they did not test for STI (Mercer, 2017). It is also likely that when swingers do seek testing or medical care that they are not identified as such (Spauwen et al., 2015). Very few healthcare environments have a protocol to identify swingers (Dukers-Muijrers et al., 2017). Kimberly and Hans (2015) concluded that swingers are an invisible part of the STI clinic population. The authors noted that it is reported that they do not wish to share with healthcare personnel that they are engaging in extradyadic sexual activity due to feared stigma.

There are guidelines for prevention and control of STI, developed in 2009 by a group of staff members at the CDC (2017) in collaboration with STI experts. They developed strategies, which included education and counseling for those at risk, to promote changes in sexual behaviors and use of prevention services, identification of symptomatic and asymptomatic persons who are not likely to seek treatment, effective diagnosis, treatment and counseling of those infected, evaluation, treatment, and

counseling of sex partners, and pre-exposure vaccination where appropriate (CDC, 2017). Prevention plays a key role in the magnitude of the spread of infectious disease (WHO, 2018). An effective prevention intervention could reduce the spread of STI by effectively informing persons at risk about the likely results of their risk behavior (Darteh et al., 2016). Data related to lifestyle behavior and specific risk factors is essential to guiding prevention efforts (U.S. DHHS, 2015). Developing more impactful STI prevention efforts, informed by an understanding of sexual health beliefs and attitudes will create more effective public health efforts, creating social change through reduced rates of STI.

Health Promotion

Places where collective sex occurs have long been maligned in the name of morality and their violation of social norms related to sex (Frank, 2018). In private settings where people have collective sex, boundaries are often less defined, requiring more direct and personal engagement from those involved. Private settings, as a result, have different rules and expectations than the club setting, where safe sex suggestions may be posted (Bentzen & Traeen, 2013). Effective prevention must be customized to each setting to impact sexual risk behaviors, recognizing that there are multiple influences potentially determining condom use decisions (Haddad et al., 2018). The relationship between environment and sexual risk-taking behavior can lead to infinite variations of such interventions, as different environments have idiosyncratic features (Frobish & Griffiths, 2013). Analyzing the environments and situations where swingers meet and where they have encounters can expose situational influences on behavior,

therefore considering the characteristics of each setting and subsequent influence on how decisions about sex are made (Frank, 2018).

Those involved in CNM are generally not recognized as a specific, individual group in healthcare environments (Spauwen et al., 2015). With the growing number of persons involved in swinging, healthcare providers cannot make assumptions about monogamy when treating sexually active persons (Lehmiller, 2015). It is important that sexual healthcare providers routinely ask about sexual partners in the contest of CNM in order to identify and appropriately care for this population (Mercer, 2017). Without protocols to identify this group, the provision of tailored service is precluded. Care specially tailored to a population will benefit both the person served and will benefit overall public health (Gravningen et al, 2015). With swingers, tailoring treatment would include extragenital STI testing due to more extensive and varied sexual practices (Dukers-Muijrers et al., 2017). Targeted tracing of networks is important to address typical risk behavior with multiple concurrent sexual partners when STI is diagnosed. With guidelines to identify and treat swingers, there is a missed, largely hidden target group for appropriate STI care (Dukers-Muijrers et al., 2017). Innovative methods like interactive websites could provide tailored sexual health advice. STI testing services linked to online care may increase access to stigma free testing and treatment (Gravningen et al., 2015).

Knowledge about patterns of homophily in sexual groups can be useful in the development of intervention strategies (Neikamp et al., 2013). Population-specific variables like negative attitude toward condom use are important to consider in the

successful implementation of interventions (Pitpitan et al., 2016). Mainstream society may still perceive swinging as a negative behavior that is not conducive to healthful and ethical living (Wilt et al., 2017). Stigma has negative effects on health behaviors, and the ability to openly discuss risk without stigma towards risk creates change (Nydegger et al., 2017). Stigmatizing sex or STI likely leads to increased transmission of STI as people are prevented by stigma from entering treatment (Conley et al., 2013). People experience conflict between the cultural norms about typical sex and their own sexual behaviors. This conflict, compounded by stigma, must be understood in STI treatment planning (Brandon, 2016). Stigma discourages improved health behaviors and can lead to poorer health outcomes (Conley et al., 2013).

Research Related to Swingers

Much of the research on swingers was initially completed in the1970s, with limited contemporary study examining present attitudes and empirical data collections related to this group (Brewster et al., 2017). Existing research focuses heavily on relationship factors, and CNM among LGBTQ persons with exploration mostly focused on men who identify as gay (Wilt et al., 2017). This lack of literature reinforces the stigma that extradyadic relationships are rare, unusual, or abnormal (Brewster et al., 2017). Findings related to low use of condoms in this group indicate that additional study is warranted to focus on the role of swingers who do not use condoms and STI risk (Kimberly & Hans, 2015). There is a need for greater awareness of diverse relationship structures, and a need for the incorporation of related content into educational programming and prevention efforts (Levine et al., 2018).

Challenges to Swinger Research

Limitations include Kimberly's (2016) observation that researchers who attempt to learn about the swinging community face challenges due to the group's emphasis on privacy, causing the swinging lifestyle to be rarely seen by social researchers. Harviainen and Frank (2016) noted that cultural contexts as related to taboo sexual issues must be understood in depth by the researcher to access the hidden society that is to be explored, and that sexual activity considered taboo occurs in secured environments with barriers to entry. Researchers face challenges due to the group's emphasis on privacy: therefore, researchers need to build trust to gain access to developing an understanding of these unique social scripts (Kimberly, 2016).

Across studies, results consistently demonstrated a stigma surrounding CNM, and a halo effect related to monogamy (Conley et al., 2013). Participants in a study may be concerned about lost social status if they are outed as swingers, since this group does not typically share their identity with family, coworkers or friends who do not participate in the lifestyle. This level of secrecy around their identity as swingers can make finding research subjects difficult (Wilt et al., 2017). Recruitment strategies may tend toward snowball studies that garner participation through networks of connected swingers (Rubel & Bogaert, 2015; Rubin et al., 2014). Generating valid samples could depend on recruiting participants involved in multiple networks rather than selecting participants from a large single social network (Cornwell & Schneider, 2017).

Places where swinger sexual activity occurs are typically secured with multiple barriers to entry, such as door policies at clubs, membership requirements for conventions

and vetting processes for private parties, as well as rules about minimal participation of attendees (Harviainen & Frank, 2016). The nature of group sex environments requires that a researcher develop an understanding of the mores of the community and be able to appropriately relate to the community members while maintaining awareness of ethical boundaries (Kimberly, 2016). Survey fatigue can happen when the time to complete an interview infringes on the subject's opportunity to participate in the activity at an event (Mullen et al., 2009). Alcohol and drug use can be present in swinger scenarios, and care to not administer interviews to visibly intoxicated persons must be given (Kimberly, 2016). In addition, humans are likely to be inaccurate sources of information when reporting on their own sexual behavior (Cankardas & Tosun, 2016).

Social stigma surrounding CNM may deter people from participating in scholarly pursuits addressing this sexual minority group (Haupert et al., 2017). Swinging may be avoided by researchers due to the sensitive nature of non-traditional sexual behavior and the societal perception of some sexual behaviors as taboo. One researcher noted that research on subjects that may prove contrary to achieving status and acceptance may not be chosen. Wilt et al. (2017) suggested that uninformed researchers may believe swinging to be so rare that further study is unwarranted. Haupert et al. (2017) believed that presumptions about monogamy as the ideal can influence who is included or left out of social science research. Belief that monogamy is normal and that other conventions are therefore deviant prevents development of an understanding of nonnormative sexual practices (Brewster et al., 2017).

Societal views surrounding relationship patterns, however, appear to be shifting as nontraditional relationships like those found in individuals practicing CNM become more prevalent (Brewster et al., 2017). More United States data on diverse sexual behaviors and practices are needed to help clinicians, educators, policy makers and the public develop and understanding and acceptance of the range of human sexual expression (Herbenick et al., 2017). Because that range is ever-evolving, research and education are the gateways for recognizing sexual behaviors that go against traditional norms (Kimberly, 2016). Exploring and developing a discussion about human sexuality in its myriad forms can facilitate a sexual minority's ability to be recognized and better represented. This can also develop a wider range of understanding of what constitutes a valid relationship (Brewster et al., 2017). Research could elucidate accurate population numbers and population characteristics and could be effective in urging wider acceptance of CNM (Haupert et al., 2017).

Conclusion

Many individuals hold the belief that sexual expression is an individualized affirmation of self-knowledge and self-expression (Edgar, 2006). CNM can be viewed as part of the normal range of human sexuality, not as a symptom of a psychological or relationship dysfunction (Rubel & Bogaert, 2015). Changing beliefs about sex create an opportunity for people to consider sexual practices infrequently engaged in due to suppressive sociocultural norms. Some of these sexual practices have always been part of the human sexual experience, but the evolution of sex diversity tolerance like making

same sex marriage legal, and the overall development of equal rights for persons who are in sexual minority groups, is bringing them into the light (Wilt et al., 2017).

In a comprehensive review of the literature, Rubel and Bogaert (2015) noted that individuals in monogamous and CNM partnerships reported similar relationship quality and satisfaction, as well as lateral psychological well-being. Responses from swingers in empirical study indicated a high rate of overall life satisfaction beyond their sex life (Wilt et al., 2017). Nevertheless, sex with multiple partners has implications for swinger's everyday lives that cannot be ignored, most notably the risk of STI (Harviainen & Frank, 2016).

STI is an increasing public health problem on a large scale, despite its highly preventable nature (WHO, 2018). Unprotected sex with multiple partners is a high-risk health situation, leading to the spread of infection that can cause health problems and even death (Conley et al., 2015). This study explored the attitudes and beliefs that influenced people to have sex without engaging in preventative behavior, even when the perception of some level of risk for STI was present. Exploring swingers in the context of their elevated STI risk is an opportunity to develop increased knowledge about why STI is spread when the use of condoms for protection was an option. Understanding how people view exposure to STI in high-risk situations will inform more effective and targeted prevention efforts and public health programs.

Chapter 3: Research Method

Introduction

This study took place in the New Jersey/Philadelphia metropolitan area of the United States. The research design was developed from the problem statement. Qualitative methods of data collection were utilized, with information obtained through individual face-to-face interviews. The attitudes, knowledge, and beliefs of the participants were explored by utilizing a questionnaire. Qualitative analysis of collected data uncovered a subjective viewpoint of this group related to STI. Chapter 3 presents the methodology utilized to discover the beliefs about STI held by swingers who do not use condoms.

Research Design and Rationale

Qualitative research is used to collect data from people involved in a phenomenon, utilizing perspectives to derive meanings. Generic qualitative research illuminates individual experience by exploring viewpoints to identify patterns in these experiences (Jamali, 2018). This strategy allows for details to emerge through inquiry and first person expression and explanation (Ellis, 2016). Further, generic qualitative studies are used to investigate reports of a person's subjective reflections on their experiences and expands what previous knowledge may show by providing more fully descriptive information (Percy, Kostere, & Kostere, 2015). A generic qualitative study is an examination into how people construct worlds from meanings attributed to experiences (Kahlke, 2014),

Further inquiry was warranted on the individual experiences related to attitudes and beliefs about STI in the high-risk sexual network of swingers who bareback. I collected information on the beliefs of this group related to risk. I explored a specific lived experiences and answered the research question "What are the beliefs and attitudes that influence swingers' decisions to engage in unprotected sex with multiple partners despite the high potential for STI contraction?"

Role of Researcher

Qualitative researchers understand that research findings are developed as an interpretive process and are subjective (Reiners, 2012). As a qualitative researcher, I was aware of my integral part in the process that can affect the results because the role of researcher in qualitative research is the primary instrument and participatory (Clark & Vealé, 2018). Additionally, I am an experienced mental health counselor with an extensive work history with clients in the areas of sexual and relationship health. I also have experience in providing support and guidance for couples engaged in CNM. This was helpful, as I have developed interviewing skills through my work experience. However, my role in this study was exclusively as a researcher; there was no therapeutic element provided to the participants as they engaged in the research process. In preparation for potential emotional discomfort or distress experienced by participants, there were available resources to seek support to address concerns. Every effort was made to provide a safe and comfortable emotional experience for participants.

Participants had concerns related to my motivation as the researcher and inherent mistrust related to the purpose of the research (Stevenson, Keogh, Smith, & West, 2018).

Participation was rewarded with a $25 gift card to thank participants for their time, as a reward can be helpful to entice participation from those who may not otherwise believe that such an effort is worth the time investment. Rewards are an important consideration for participants' interests in taking part in research, and incentives can impart to a subject that a researcher appreciates their input and values their time and stories (Stevenson et al., 2018). The decision to participate in research can also be driven by the benefits perceived by subjects (Kelly, Margolis, McCormack, LeBaron, & Chowdhury, 2017).

Methodology

Participants

Qualitative methods were utilized for this research, as in-depth interviews were conducted with participants to explore the beliefs of a small sample. Eighteen individuals were selected and interviewed. Sample size can best be determined by asserting a broad range based on similar research, as the characteristics of collected data cannot be known at the onset (Blaikie, 2018). Researchers have recommended a sample size for qualitative study as ranging from three to 20 subjects (Sim, Saunders, Waterfield, & Kingstone, 2018) or between six and 20 individuals (Ellis, 2016).

Participation was voluntary through a purposeful sample. Individuals who experienced the phenomenon related to the research question were selected (Ellis, 2016). Candidates were recruited through a gatekeeper from multiple events scheduled for swingers to pursue swinging connections and engage in swinger sex. Solicitation for participants were made directly to the gatekeeper who organized group events. Group members for events were invited by the gatekeeper from swinger specific websites and

from attendance at previous events. Participants were a purposeful sample, determined by their ability to meet the criteria of being a swinger who has sex with multiple partners and does not typically use condoms during sexual activity.

Population and Sampling

Due to an increased interest in peer-reviewed qualitative research, it is important to make qualitative methods as robust and defensible as possible (Borreani, Miccinesi, Brunelli, & Lina, 2004). Six to 20 participants can be appropriate to develop significant data for analysis (Sim et al., 2018). Larger sample sizes could always add something new, but if the sample is too large, data becomes repetitive and superfluous (Mason, 2010). In interview studies, little information collected after interviewing 20 subjects is new information (Green & Thorogood, 2009). In some qualitative studies as few as 10 subjects were needed to reliably establish consensus (Atran, Medin, & Ross, 2005).

The sample size for this study was 18 individuals. The pilot study consisted of two participants, plus 16 participants, for a total of 18 completed questionnaires. Recruitment can be difficult due to a subject's potential questions related to the motivation and even the qualifications of a researcher, which can be amplified with socially stigmatized groups (Stevenson et al., 2018). Thus, multiple events where swingers connected were sourced to ensure that a diversity within swingers was explored and that the goal number of subjects was reached. An attempt was made to have comparatively equal numbers of men and women to maximize the ability to capture a broad view incorporating both men's and women's perspectives. Efforts were also made to include swingers who were of multiple sexual orientations.

The skill of the interviewer can affect the quality of data and achieving saturation (Morse, 2008). Additionally, sample size in qualitative studies should be determined based on reaching the point where new information does not add significantly to the overall data (Mason, 2010). Larger sample size past saturation does not necessarily lead to more useful information (Green & Thorogood, 2009). The point of saturation can be a difficult point to identify (Mason, 2010). But this study met the goal number of 18 subjects, who were interviewed in a consistent manner and provided rich data. Abductive logic can be utilized to discover the meanings and concepts that subjects experience; this can involve both inductive and deductive data (Kelly et al., 2016). The goal was to collect descriptions and translate these to scientific explanations (Blaikie, 2018). Inductive analysis is data driven, with open collection of data and without the goal of fitting data into preexisting categories (Percy et al., 2015).

Data Collection: Instrument

Qualitative studies involve interviews to collect first person experiences and descriptions (Sumskis & Moxham, 2017). I developed a structured questionnaire to collect data from participants through interviews. The instrument was created with the goal of answering the research question and develop an understanding of the beliefs and attitudes that influence swingers' decisions to engage in unprotected sex with multiple partners despite the high potential for STI contraction. The instrument collected data based on the six components of the HBM, the theoretical basis of the study. Areas of inquiry on the instrument included data collection regarding the perceived severity of STI, the perceived susceptibility to STI, the benefits and costs of acting to prevent STI,

and data related to the individuals' confidence in acting, or perceived self-efficacy related to STI prevention. The study interview questions were divided into six question groups. Each one of the questions corresponds to the six components of the HBM. Questions included *yes* or *no* answers, and some questions required participants to share their views by explaining their attitudes, knowledge, and beliefs. Table 1 demonstrates the correlation of the HBM precepts to the interview questions on the study questionnaire.

Table 1

Health Belief Model Applied to the Attitudes and Beliefs About STIs

Concept of health belief model	Description	Interview question
Perceived Susceptibility	Belief about the likelihood that someone would contract a disease.	Do you know anyone in the lifestyle who has contracted an STI?
		Do you ask potential partners about ST history of testing?
		Do you believe it is likely that you would contract an STI?
Perceived severity	Belief about the severity of the disease	Do you know what an STI is?
		Do you know the impact of an STI on health?
		Are you aware of the symptoms of STIs?
Perceived benefits	Belief that an advised action is beneficial to health	How frequently are you tested for STIs?
		When was the last time you were tested for STIs?
		Do you believe that you can prevent an STI by using condoms?
Perceived barriers	Belief about the costs of an advised action	Is there a negative/undesired effect of using condoms?
Cues to action	External events that encourage an advised action	Have you ever had sex using a condom?
		Would you use a condom is a partner suggested it?
		Would you use condoms if they were readily available onsite?
Self-efficacy	Belief about readiness, interest, or confidence to take action	Do you believe that using condoms limits access to sexual partners in the lifestyle?
		What could make you use condoms in every sexual encounter?

Data were collected through structured interviews, allowing for probing questions to gather as much information as possible. Questions were asked in the same order in every interview. A pilot study was conducted with two participants. These two persons are identified as initial contributors to the study and were interviewed first to determine the approximate length of interviews, invite feedback on the process, and to ensure content validity of the instrument. Arain, Campbell, & Lancaster (2010) note that pilot studies garner relevant data, with the limitation only that the sample size of the pilot study is too small to stand alone. Data collected in the pilot study is utilized in the aggregate study, and these two participants are included in the total number of 18 subjects referred to throughout the study. Therefore, the total number of participants and subsequent collection of data reflects the 18 total interviewees.

Data Collection: Technique

Collection of data took place during a period of five weeks. Data were collected in a private office, where interviewees were scheduled for interviews prior to their attendance at a swinger event. Participants completed the interview in a private space where they were encouraged to freely provide answers, alone with the researcher. In arranging interviews, consideration for provision of total privacy was made where the interviewee and interviewer were unheard and unobserved. Kahlke (2014) noted that generic qualitative study must minimize influence to obtain broad insight of the person's lived experience. The completion time for the interview process was consistently less than 15 minutes per participant.

Data Organization and Data Analysis

There was extensive note taking from the researcher. Data were collected as uniformly as possible in order to create lateral data for simplicity in data coding. Data come directly from words in qualitative research, so thematic analysis requires observing patterns of ideas even if they are presented in verbally different ways (Clark & Vealé, 2018).

Open coding was utilized to analyze the data and note themes. Coding is the transitional process between the collection of data and the analysis of that data (Clark & Vealé, 2018). This enabled the information to be placed into common categories. Once data were coded, sorting of patterns and themes occurred to identify categories in the data. Percy, Kostere & Kostere (2014) noted that generic qualitative study requires that data patterns be synthesized in order to interpret meanings and find implications for the research questions. Themes were identified from the coding and sorting process (Clark & Vealé, 2018). Emergent themes were noted.

Trustworthiness

Reliability, Credibility, Transferability Dependability, Confirmability and Validity

The initial pilot study of two participants ensured the content validity of the instrument. Saturation was not be considered, as interviews were scheduled until all 18 interviews were completed. Consistently administering the questionnaire in the same manner each time increased reliability. Credibility was defined as conducting full and complete interviews consistently to develop confidence in the truth of the findings. Greater credibility was enhanced by fostering a sense of privacy, and in security and

complete confidentiality to predispose participants to increase trust and facilitate disclosure, improving the richness of the data and the value of the study (Petrova, Dewing, & Camilleri, 2016).

Transferability, or the ability of findings to have applicability in other contexts may be limited. Transferability implies that sufficient contextual data would apply in other settings (Sumskis & Moxham, 2017). This is a very specific subgroup of a sexual network; however little data currently represents the attitudes and beliefs of this group related to STI and condom use, so transferability is unknown.

Dependability means that the findings are consistent and could be repeated (Sumskis & Moxham, 2017). This was addressed in the study by uniformity in conducting interviews by utilizing the questionnaire consistently. Confirmability, or the degree of neutrality of findings of a study, means that findings will be shaped by participants and not by the bias of the researcher (Sumskis & Moxham, 2017). Confirmability was ensured by collecting the views of participants, recorded as data, with no bias from myself as the researcher included in the data.

Descriptive validity means that data is completely collected and then accurately presented in the findings. Clark and Vealé (2018) suggest maintaining validity by verifying the accuracy of transcription of data from source to record and by ensuring the integrity of the definitions of the codes used to prevent shift. Conclusions must accurately reflect what the participant has said in the data. An accurate account of the formative data is the foundation of a valid study. Subsequent to data collection, notes taken during

interviews were compared to data analysis transcriptions in order to confirm accurate data collection.

Member checking is useful for gaining participant approval for using quotations, information verification, and participant review of data collected (Thomas, 2017). In this study, member checking consisted of summarizing or paraphrasing the information received from a participant to ensure that what was heard or written down was concise, but also correctly recorded and complete. This was done during the interviews for questions involving descriptive responses beyond yes or no answers. Member checking following data collection was deemed inappropriate for this study, due to limiting contact to one episode with the participants in order to respect privacy and confidentiality.

An audit trail was established as a qualitative strategy to establish the confirmability of the research study's findings. Establishing confirmability shows that the findings are based on participants' responses rather than researcher preconception or bias. The audit trail describes how data is collected and analyzed. The final study includes information about the coding process, descriptions of how individual codes developed into themes, and rationale for how codes formed the basis of a theme. The audit trail, presented in the findings, demonstrates that the analysis follows a logical path based on data collected from participants.

Ethical Procedures

In qualitative study, the researcher has multiple roles: researchers evaluate, observe, and interpret (Sanjari et al., 2014). Qualitative research can pose ethical challenges for researchers; and ethical researchers fully contemplate their role as the

primary instrument as well as the impact of the research process on the lives of the participants (Dickson-Swift, James, Kippen, & Liamputtong, 2007). This includes sensitivity to conflicts of interest as well as respect for participant dignity and privacy (Sobočan, Bertotti, & Strom-Gottfried, 2018).

Approval from the Institutional Review Board was secured before the data was collected the IRB approval number is 11-26-19-0080230.

Participants were protected by shielding their identities and the researcher went to great lengths to protect their privacy. Only first name and last initial and state of residence were collected as primary identifiers. Participants were able to use pseudonyms rather than actual names if they chose to do so. Interviews were held privately to protect the interviewees' privacy during the process. Participation was completely voluntary, and participants were only contacted one time prior to the interview meeting. Participants could withdraw at any time from the interview process or during the actual interview. Interviewer contact information was provided for future questions or concerns, and for participants to learn more about the study's outcome should they care to do so.

Participants signed appropriate consent documents before taking part in interviews. Sanjari et al. (2014) noted that informed consent is of importance to clarify to participants how data will be collected and utilized. Researchers have the responsibility of protecting participants from potentially detrimental consequences that could affect them as a result of their participation (Dickson-Swift et al., 2007). Participant identifying information was stored separately from data collected to ensure confidentiality. Interview

data collected was stored in a double-locked and secured location to protect the identity of participants.

Qualitative researchers collect individual experiences through data collection, then attempt to understand those experiences, and categorize the themes, in order to record a comprehensive description (Ngozwana, 2018). Ethical researchers engage in careful and appropriate observation to gain knowledge while respecting privacy and dignity and avoiding misrepresentation (Sanjari et al., 2014).

Summary

Chapter 3 described the research design for this qualitative research project. Data was collected and later transcribed from interviews with 18 persons who were identified as participants. Subjects were encouraged to participate based on an incentive and with complete assurances that their confidentiality would be maintained. Full and open participation in these interviews provided rich data through open disclosure of the participants' beliefs. Data were analyzed using a coding process to identify themes within the answers to a questionnaire administered verbally to participants.

Chapter 4: Results

Introduction

Qualitative methods were utilized for structured, individual, face-to-face interviews exploring the experiences of the participants. A questionnaire was used to ask participants to describe attitudes and beliefs about STI. This chapter documents the procedures utilized for data collection in the study. The themes detected in the data are also described as well as the overall findings of the study. Integrating all the individual textual descriptions into a group of universal descriptions of this group was the goal. In this process, there is a recognition of themes that account for the emergence of a phenomenon.

Data Collection

Collection of data took place during a period of 5 weeks in January of 2020. First a pilot study was completed with two subjects. These two participants were invited to complete the interviews then provide feedback on the interview questions and the participation experience. The interviews were first held in the planned procedure and timed. These lasted 10 and 12 minutes respectively, which was within the expected time frame of 15 minutes per interview. Both subjects declined to be audio recorded, citing privacy concerns. The pilot subjects were then asked to report their experience of the interview space, their privacy, and the questionnaire. Both subjects reported the interview space to be private and comfortable. Both subjects reported that they felt that their anonymity was protected by the process and only objected to the optional recording of the interview. They both reported that answering the questions was neither difficult nor

uncomfortable. They both agreed that recognizing their effort with the $25 incentive was appropriate for the time they invested. From the pilot study, it was determined that audio recording could disrupt the sense of security felt by interviewees related to privacy and anonymity. Note taking during the interviews in the pilot study was thus an appropriate and comprehensive way to collect data. The subsequent interviews of the 16 participants in the current study were not audio recorded. Data from the pilot study are included in the study data.

Subjects were identified with the assistance from a gatekeeper who had no group affiliation. He was an individual active in the lifestyle who followed his interest in swinging by hosting, planning, and participating in small group events. He was an organizer of group gatherings where swingers met. He recruited participants, chose venues, and facilitated events. These events were open to swingers of varying interests and sexual orientations and were not specific to swingers who bareback. It was known, however, that many of the attendees with whom he was familiar did not use condoms consistently as practice.

As the facilitator, the gatekeeper sent invitations to known attendees of previous events. In addition, he invited people with whom he connected on swinger websites to attend events, which were held primarily in private homes or hotel suites. He provided those attending the events with the recruitment flyer regarding the study. The flyer provided information on the study and invited event attendees to participate in the study. Potential participants contacted needed to do nothing if they were not interested in

participating, but interested participants reached out to me and selected a time slot for their interview to occur.

Interview dates coincided with events and were held prior to the start of events, with times conducive for attendees to participate in the interview then attend the event after. There were scheduled breaks in time between couples and individuals attending interviews to protect the privacy of those who chose to participate. This time allowed for participants to move through the office and to their vehicle without being seen by other participants. In addition, the office location was closed to outside individuals, so participants did not see any other persons during the process. The gatekeeper had no knowledge of who chose to participate or not.

Participants were scheduled on five dates, which were Friday and Saturday evenings. There were 23 subjects scheduled, with a total of 18 completed interviews and five no shows. This included the pilot study with two interviews for a total of 18 completed interviews. The unit of participation was individuals; however, couples were scheduled at adjacent times for their convenience. Members of couples were interviewed individually. Participants completed the interview in a private space where they were encouraged to freely provide answers alone with me. Consideration for provision of total privacy was made, as we were unheard and unobserved. Interviewees were provided with the consent document, and it was verbally reviewed with them prior to signing. They also received a copy of the document. They were invited to ask questions prior to the start of the interview and again at the end of the interview. The completion time for the interview process was consistently 15 minutes or fewer per participant.

Data Analysis

The goal of the data analysis process was to develop a composite textual description from the total of 18 interviews. The process of data analysis was completed in multiple steps to generate an overall meaning from the data. Data analysis developed from my vantage point following reflection on the collected data. Inductive analyses are data driven, as there are no preexisting codes or theme-related categories. Themes synthesized into a composite synthesis from which meanings and implications related to the research question could be interpreted.

First, interview data were transferred from the completed questionnaire records to data tables. Data tables were created for each question to record the complete data for that question individually. Then each data table (for each question) was double checked for accuracy in transferal from the written questionnaire notes to the appropriate data table. Then the totals of the data were tallied in questions where *yes* or *no* answers were provided. Additional data collected as text were then hand coded for key words. These key words and concepts were tallied from their occurrence in the raw data collected in the responses. Then patterns and themes were noted. Further analysis deducted consistencies in patterns and themes in the data. The final step was an intuitive integration of the composite textual and structural descriptions into a unified statement of the essence of the experience of the phenomenon.

Findings

The interview questionnaire was divided into two sections. The first section collected demographic information and further details about each participant's

experiences as a swinger. This included gender, age, years of experience in the lifestyle, sexual orientation, partner status, condom use, average number of monthly sexual partners, and the primary methods for connecting to other swingers. Results are noted in Tables 2-3.

Table 2

Sample Demographics and Other Factors

Characteristics of Participants	Category	*N*
Gender	Male	10
	Female	8
Age range	30-39	3
	40-49	3
	50-59	8
	60+	4
Years in lifestyle	Less than 1 year	4
	1-2 years	3
	2-5 years	3
	5-10 years	4
	10-20 years	4
Sexual orientation: males	Heterosexual	7
	Bisexual	3
Sexual orientation: females	Heterosexual	0
	Bisexual	8
Partner status	Married	8
	Committed/unmarried	5
	Single	5

The average number of monthly partners was lower for males in the study, with most participants stating that they engaged with zero to two partners in a month. One third of male participants reported three to five partners a month, and one male participant reported six to 10 partners per month. The average number of monthly partners was higher for females in the study, with most participants stating that they engaged with three to five partners in a month. One female participant reported zero to two partners per month, and one female participant reported six to 10 partners a month.

Additionally, most participants, 14 out of 18, reported their primary connecting method as swinger websites. Three participants reported that swinger clubs or venues were their primary meeting place for connecting to partners. One participant reported that other swingers were how they most frequently connected to others. Most participants utilized multiple methods to connect to others in the lifestyle. See Table 3 for data on condom use.

Table 3

Condom Use of Participants

Gender	Occasionally uses condoms	Rarely uses condoms	Never uses condoms
Male	6	1	3
Female	3	4	1

The second part of the questionnaire consisted of a structured set of interview questionnaire divided into six groups. Each one of the question groups, numbered one through six, correspond to the six components of the HBM, the theoretical basis of the study. Areas of inquiry on the instrument included data collection regarding the perceived severity of STI, the perceived susceptibility to STI, the benefits and costs of acting to prevent STI, and data related to the individuals' confidence in acting, or perceived self-efficacy related to STI prevention. Questions included yes or no answers, and some questions required participants to share their views by explaining their knowledge and beliefs.

Perceived Susceptibility to Sexually Transmitted Infections

One out of 18 participants knew of someone who had contracted STI while in the lifestyle. The participant indicated that a person they knew had contracted HIV and left the lifestyle as a result. One hundred percent of the participants indicated that they did not discuss STI status or STI testing with sexual partners. Most participants (77.78%) believed that they were not likely to contract STI while participating in the lifestyle. Of the four participants who reported that they believed they may be at risk for STI contraction, they reported the likelihood of contracting STI as 50%, 25%, 10% and 5%. Participants offered a positive bias toward other persons in the lifestyle related to STI. Participants stated related to condom use: "I never would every time with swingers as they are usually safe." Another participant stated "I would never use one (a condom) every single time for any reason. Swingers are not usually an STD problem." Another stated: "if I was worried about diseases (I would wear a condom) but I feel safe with other people who swing." Table 4 illustrates responses related to participants' perceptions about the susceptibility to STI.

Table 4

Perceived Susceptibility to STIs

Question	Category	*N*	Percentage
Do you know anyone in the lifestyle who has contracted an STI?	Yes	1	5.56
	No	17	94.44
Do you ask potential partners about STIs?	Yes	0	0
	No	18	100
Do you believe that it is likely that you would contract an STI?	Yes	4	22.22
	No	14	77.78

Perceived Severity of Sexually Transmitted Infections

One hundred percent of participants were able to identify or describe in some way what STI was. Two thirds (66.67%) of participants were able to describe in some way the impact of STI on health. Two thirds (66.67%) of participants agreed that they knew the symptoms of STI. Participant responses consistently reflected overall accurate knowledge of STI. All reflected that they knew these conditions were transmitted through sexual activity. Some provided more detail to include disease names, methods of transmission, that they are contagious in nature, and some described the severity of symptoms. Frequency of the most prominent themes in those responses is noted in Table 5.

Table 5

Perceived Severity of STIs?

Responses to what is a sexually transmitted infection/disease?	
Caught from an infected person	12
Caught through sexual contact	12
Caught through body fluids	8
Caught through unprotected sex	3
Mentioned STI by name	
HIV/AIDS	8
Herpes	7
Gonorrhea	3
HPV	2
Chlamydia	1
Hepatitis	1
Trichomoniasis	1
Syphilis	1
Responses to what is the impact of STIs on health?	
Death	11
Pain/discomfort/symptoms	11
Need for medical treatment	5
Infertility	5
Less access to sex due to contagion	4
Lifelong illness/incurable	4
Curable disease	2
Cancer	2
Stigma	2

Perceived Benefits of Taking Action to Prevent Sexually Transmitted Infections

Most participants were not regularly testing for STI. One third of participants had never been tested for STI. Three out of 18 participants reported annual testing for STI. All were female and reported that they were tested at their annual gynecological wellness exam. One third of participants believed that they could prevent STI by using a condom, two thirds did not. Table 6 illustrates the perceived benefits to acting by the participants.

Table 6

Perceived Benefits of Taking Action to Prevent STIs

Question	Category	*N*	Percentage
How frequently are you tested for STIs?	Annually	3	16.7
	When infection suspected	9	50
	Never	6	33.3
When were you last tested for an STI?	Within 6 months	1	6
	Within 1 year	2	11
	Within 2 years	4	22
	More than 2 years ago	5	28
	Never	6	33
Do you believe that you can prevent an STI by using condoms?	Yes	6	33.3
	No	12	66.7

Perceived Barriers to Taking Action to Prevent Sexually Transmitted Infections

Seventeen out of 18 participants reported that there was a negative or undesired effect to using a condom. Participant responses were mostly related to one of two areas: asking someone to use a condom implies distrust, and using a condom impacts the feeling of sex in a negative way. Responses related to fear of intimating distrust included:

- “Looks like you think someone has a disease.”
- “Implies distrust of a person’s health.”
- “Says I don’t think you are clean.”

Additionally, a female participant stated related to condoms that "men don't want to wear them." Another female stated "men don't like to wear them so I don't like to ask. I want my partner to feel good." Participant statements and descriptions related to using condoms were:

- "Cumbersome"
- "Have to have a lot of them and change them constantly at group events."
- "Tastes terrible"
- "Prevents a woman's access to body fluids during male orgasm."
- "Interferes with the flow of sexual excitement"
- "Gets in the way of the flow of things"
- "Numbs down full effect of oral sex"

Cues to Take Action to Prevent Sexually Transmitted Infections

One hundred percent of participants reported that they have used condoms in past sexual experiences. One hundred percent would not use condoms simply because they were on hand or easily accessed on site at an event.

Self-Efficacy

One third of participants believed that using condoms as regular practice would limit access to partners in the lifestyle. Two thirds believed it would not. Participants were asked in an interview question: what would make them use condoms in every sexual encounter? Two thirds of participants noted that they would use a condom at a partner's request or requirement. Themes noted in responses are in Table 7. Participants responses included:

- “I would never use one every single time for any reason.”
- “If a man insisted on condoms I would never object out of respect.”
- “If a woman or her partner insists, I do.”
- “When someone asks me to, I will comply.”
- “If the man requested or required condoms, I would use them. Otherwise I never would.”
- “I would only do it every single time if the girl asked me to.”
- “I probably never would all the time, but I do when someone wants to.”
- “If it is required by a specific party or a venue has rules about it, I would always obey that.”
- “If I feared disease for some reason, I would ask him to wear one.”
- “If it is someone I am not totally sure about like a single girl who sleeps with a lot of people, I might. But not every time with every person, that would not happen.”
- “If I had an STD I would.”

Table 7

Self-Efficacy: Readiness, Interest, or Ability to Take Action to Prevent STIs

Responses	*N*
If a partner wanted to use a condom	7
If a partner requires it to have sex	5
I would never in every instance	4
If I suspected someone has STI	3
I feel safe with swingers	3
If I had an STI	2

Summary

Chapter 4 presented the results of this study exploring the attitudes and beliefs about STI held by swingers who do not use condoms. Qualitative methods of data collection were utilized, with information obtained through individual face-to-face interviews utilizing a questionnaire to ask participants to describe attitudes and beliefs about STI. The data reflects the beliefs and attitudes of 18 individuals who identify as swingers. Even though all have used condoms before, they only occasionally, rarely or never use them as practice. The data indicated that they understood what STI was and its implications for health. They cited many reasons for not using condoms, despite the evidence that established that they largely believed that STI is passed through sexual contact, and that condoms can prevent STI.

Chapter 5: Discussion

Introduction

The purpose of this study was to examine the beliefs and attitudes that influence swingers' decisions to engage in unprotected sex with multiple partners despite the high potential for STI contraction. This chapter explains the findings of the study. The integrated individual textual descriptions are shared and interpreted here.

Interpretation of Findings

The research question in the study was "What are the beliefs and attitudes that influence swingers who bareback to engage in unprotected sex with multiple partners despite the high potential for STI contraction?" The questionnaire was categorized into six sections reflecting the precepts of the HBM, the theoretical framework for the study. Exploring the choice to have unprotected sex with multiple partners while examining both the cognitive and affective components of this decision provides an understanding of how sex-related health decisions may be made. Understanding the beliefs that swingers have related to STI risk in sexual situations and the attitudes that affect how they make decisions related to that risk defined the research question in this study.

The first part of the interview tool, or questionnaire, collected demographic information and history related to participant swinging activity. Ten males and eight females participated. The second part contained six sections, each reflecting one of the six precepts of the HBM, with two to five questions in each section. The questions consisted of both *yes* or *no* answers as well as questions where participants were asked to

answer with their specific thoughts, knowledge, and beliefs. Each section's findings are shared in the following sections and organized by the six HBM precepts.

Perceived Susceptibility to Sexually Transmitted Infection

The series of questions related to perceived susceptibility helped investigate beliefs about the likelihood that a participant in the lifestyle would contract a STI. All the participants indicated that they did not discuss STI status or testing with sexual partners. Most participants believed that they were not likely to contract STI while participating in the lifestyle. Participants also indicated that asking a partner to use a condom would indicate lack of trust or suspicion about their health. Researchers have noted this as well, reporting that concerns about entering a sexual situation increases the perceived importance of addressing a potential partner's perceptions about themselves and the relationship (Sparling & Cramer, 2019).

The probability that a person will change health behaviors to avoid a consequence depends on how serious the perceived consequences will be. The findings indicate that overall, this group does not believe that there is significant risk for contracting STI. This justifies their lack of condom use or inconsistent condom use; people are not inclined to change health behaviors unless they believe that they are at risk. Other research has shown similar results where participants with multiple new partners and no use of condoms in a recent 6-month period did not presently consider themselves at risk for STI (Guleria, Faber, & Hansen, 2018).

Perceived Severity of Sexually Transmitted Infection

All the participants were able to correctly identify or describe in some way what STI was. Two thirds of participants were able to accurately describe in some way the impact of STI on health. There was a clear trend in the knowledge of STI: overall, participants knew what it was and knew that it was a significant threat to health. In addition, most identified death as a potential primary outcome of STI. Fearing death as a possible consequence, however, was not significant to initiate positive health behaviors related to sex. Motivational systems involve knowledge of consequences to hedonic behavior, but the individual does not always consider the undesired outcome as a primary factor in decision making (Baumeister & Leary, 1995). Thus, the participants may value the pleasure-seeking aspects of swinging more than they fear the repercussions of unprotected sex. Additionally, group sex events are pleasure seeking environments with high risk, and a similar study showed that participants averaged more than one sex partner with whom they had unprotected sex at the last event they attended, suggesting that transmission of STI to multiple partners at one event is likely (Friedman et al., 2008). Even when an advised action is beneficial to health, that may not be significant motivation to engage in it when giving up something that they enjoy is required.

Perceived Benefits of Taking Action to Prevent Sexually Transmitted Infection

Most participants are not regularly tested for STI, including one third of participants who have never been tested for STI. Three respondents who were tested annually were female; all three reported that they were tested at their annual

gynecological wellness exam. This indicated that participants were generally not going out of their way to specifically pursue testing regularly for STI.

People are more unrealistically optimistic about themselves than about unknown people and similarly optimistic about people they are close to or desire to be close to (Baumeister & Leary, 1995). This is a cognitive process where people erroneously believe that negative events are less likely to happen to themselves or to those with whom they get close in relationships (Baumeister & Leary, 1995). These beliefs impact the informal norms of how a group behaves. For instance, one third of participants believed that they could prevent STI by using a condom, whereas the majority, two thirds, did not. This presented significant evidence that this group does not concur with the information that shows that many STIs can be prevented using condoms and that condom use is associated with statistically significant protection from STI (Holmes & Weaver, 2004; Stover et al., 2017). Informal norms of prevention in a group reflect values and how people react to disease (Carson, 2017). People with positive attitudes toward condom use engage in condom usage negotiation and consistent condom use (Rodrigues, Lopes & Conley, 2019). Informal norms are predictive of preventative behavior, but why some norms discount preventative behavior is unclear.

Despite a lack of clarity regarding norms, aattitudes toward using condoms have been associated with intentions and predicted condom use behavior consistently (Montanaro & Bryan, 2014). Safe sex behaviors are motivated by individual factors, but also by contextual influences as well (Rodrigues, Lopes, & Conley, 2019). The belief about the benefits of an advised action would be low if a person does not believe that the

action is truly effective, and their belief becomes evident in this group's subsequent behavior. People will not change health behaviors when they think that it is hard to do so or that the action indicated might be of no value.

Perceived Barriers to Taking Action to Prevent Sexually Transmitted Infection

Seventeen out of 18 participants reported that there was a negative or undesired effect to using a condom. There is a sensation seeking attitude of swingers consistently documented in the literature as a defining characteristic (Conley et al., 2018; Edgar, 2016; Frank, 2018). Balancing caution with sexual satisfaction may result in this group choosing pleasure over precaution. Cues to action are external events that encourage an advised action. This could include onsite accessibility to condoms (all participants denied this would be a motivator), or venue requirements that condoms are utilized. Partners who require condom use are consistently reported in the study findings as a motivator for condom use. External motivators appear to only be a factor if they are inflexible and required for sexual activity to proceed.

Cues to Take Action to Prevent Sexually Transmitted Infection

All participants have used condoms at one time during sex and all reported that they would use a condom if a partner requested it. However, they all stated that they would not use condoms simply because they were on hand or easily accessed onsite, meaning they are making the decision to not use condoms unless they are required to by a partner, though one participant noted that they would use condoms if a venue required condom use. Others reported that they would use condoms if they were infected with STI. Otherwise they report no other motivation to use condoms. The goal to develop a sexual

relationship may compete with the desire to avoid the risks associated with unprotected sex (Sparling & Cramer, 2019). Further, sexual venues are diverse, which leads to questions about the effectiveness and practicality of safer sex intervention in collective sex environments (Frank, 2018).

Self-Efficacy

One third of participants believed that using condoms as regular practice would limit access to partners in the lifestyle, and two thirds believed that it would not. Participants were asked what would make them use condoms in every sexual encounter. Two thirds of participants noted that they would use a condom at a partner's request or requirement. This reiterated that pleasure-seeking is primary for this group. This also affirmed that participants only used condoms when required to do so by another person who will not otherwise engage in sex.

From the findings, those engaging in swinger sex had low levels of concern for STI and a higher concern for relational and pleasure related issues. Reasons for not using condoms related to relationship concerns could include fear of the partner's reaction, fear that asking to use a condom could lead to partner distrust, and fear that suggesting a condom may lead to the loss of the encounter. Farrington, Bell, and DiBacco (2016) had similar findings in their research. This finding also relates to self-efficacy, which in sexual health decision making relates to beliefs about readiness, interest, ability, or confidence to act. A person's belief in their ability to make a change and still receive a benefit is key.

Another factor present in the findings was the tendency of men to dictate condom use decisions. Women must negotiate condom use with their male partners. Men can decide to use condoms during sex, or not, and women would then have to concur on their decision related to condom use. Findings indicate in this study that women can defer condom use decisions to men out of concern for the loss of male pleasure, or to please a partner. Kukla (2018) noted that healthy sexual negotiations directed by women are sexual invitations that set up protective frameworks and safe exit conditions. Women may have to advocate for condom use with a partner, in order to protect themselves from STI, even if a male partner has no desire to use a condom (Peasant et al., 2019).

Literature on condom use suggests that engaging in unprotected sex may convey closeness, trust, or the perception of not being infected (Gause, Brown, Weige, & Northern, 2018). It could be suggested that people may engage in unprotected sex in order to avoid conveying a negative message by suggesting condom use. Not using a condom could serve as communication of trust and suggesting condom use can convey the opposite. Addressing communication skills related to condom use negotiation would be helpful as part of prevention, eliminating fears related to the negative messages in suggesting condoms be used.

Prevention strategies still tend to rely on cognitive behavioral change models that emphasize the role of using knowledge to affect motivation and intention. Traditional intervention focuses on the decision maker's progress to higher states of readiness and their capacity to engage in positive health behavior based on knowledge about risk and consequences. Frasca et al., (2012) noted that prevention in sexual health focuses on the

concept that vulnerability perception level motivates precautions like condom use. The authors observed that traditional health promotion activities like preventive screenings and risk information provision may be less effective with sexual health efforts because of the strong emotions associated with sex like desire and arousal, and also the latency period of STI, which makes symptoms not always apparent or connected with sex (Frasca et al., 2012).

Intention is a strong predictor of behavior (Lewis et al., 2014). Sensation-seeking persons are often involved in non-traditional sexual practices (McKie et al., 2016). This is described as the drive to experience new and varied sensations and experiences, compounded by the willingness of the seeker to accept risks to achieve these sensations (Henderson et al., 2005). Sexual activity is pleasure focused, thought of in the affective and emotional realm. As evidenced in the findings, the cognitive self of a swinger knows the risk, on some level, of STI. When accepting full responsibility for the potential consequences, but not acting to avoid that consequence, a swinger would experience cognitive dissonance. The social and emotional environment of swingers who bareback is pleasure focused. Cognitive dissonance impacts that arousal in a negative manner. Cooper (2019) noted that experiencing cognitive dissonance is unpleasant, and there is significant motivation present to avoid that feeling. Bareback swingers do not perceive a real risk of STI, because they are more focused on the emotional gratification of pleasure seeking through sex. Therefore, they only use condoms in instances where if they do not use a condom, there will be no sex.

Limitations

It appears that the demographics of the participants in the study are consistent with previous studies that point to common characteristics of swingers. Swingers are middle aged, Caucasian, married or partnered, have sex with multiple partners as practice, and tend to connect primarily via the internet. The demographics of the study participants reflect these characteristics. Therefore, it can be stated that the demographics of the participants in this study reflect the previously established demographics for the population. However, this study does not reflect all swingers in the population. These were attendees of private events in hotels and homes. It is known that swingers also populate swinger specific clubs, vacation destinations, and interest specific parties. It is documented through the literature that condom rules can differ in specific venues, with clubs and conventions more likely to suggest or mandate condom use (Harvianen & Frank, 2016; Kimberly, 2016). Also, it must be considered that people do not always clearly or honestly fully self- report on sex and sexual health behavior (Brewster et al., 2017). Uninvestigated elements also included actual instances of having contracted STI and how this affected condom behavior.

People are faced with health decisions through the lifespan. Swingers are faced with impactful sexual health decisions every time they have sexual relations with another person or group of persons. Carpenter and Niedenthal (2018) described the experience of emotion as reflective of inputs from the sympathetic and parasympathetic nervous system and from the mind. When a health decision involves choices related to sexual factors, the ability to balance emotions and logic, cognitive and affective, is critical to making good

decisions. Health decisions can be consequential and difficult, and sexual health decisions are particularly fraught with emotion. Sexual health decisions involve risk assessment, which encompasses both cognitive and affective factors. The ability to balance cognitive and affective factors in sexual decision making could lead to health decisions with better outcomes. Challenges to making sexual health decisions are due to a variety of factors, including confirmation bias, forecasting errors, the influence that sexual desire and pleasure seeking have on decision-making, faulty cost-benefit analyses and susceptibility deception from others.

Recommendations

Researchers studying non-traditional, outlying groups like swingers have used theoretical views based on heteronormative experience (Kimberly, 2018). Although swingers are an expanding population, there is scarce research on their sexual behaviors, health behaviors, and overall demographics. For continued research, there are many facets to this population that could be explored. Longitudinal studies that measured actual rates of STI contraction would be useful and informative to public health. Studies that measure sexual health and condom behavior across various swinger occupied venues could provide information about the spread of STI in this sexual network. Sexual network examination could also provide important information about where in the Lifestyle the highest STI rate of transmission exists. Effective prevention would have to consider the way that sexual health decisions are made. For prevention efforts, it can be noted that cognitive versus affective factors, as well as the resulting cognitive dissonance must be considered.

Milhausen et al., (2018) noted that condom use decreased with level of relationship commitment, whereas ratings of pleasure increased. Swingers, by the nature of their activity are focused on seeking pleasure through the activities of the lifestyle. Pleasure as an outcome goal should be given more attention by researchers who study condom use (Graham, 2012). Swinger events, in the spirit of pleasure-seeking, are often accompanied by alcohol use (Frank, 2018). Substance use before sexual decision making could affect condom negotiation strategies. Limited research has examined how alcohol use before sexual activity influences condom negotiation strategies (Peasant et al., 2019). Low condom usage in this group, as well as noted alcohol use at events elicits further questions related to the role of alcohol in condom negotiation communication.

Implications

The findings of this study highlight that the swinger population, although covert, exists, and that they engage in risky sexual health behaviors. As part of a sexual network, there are indications that STI could spread quickly among this group. Prevention efforts would benefit this group; however, these would have to consider the cognitive dissonance that exists, evidenced by their sexual health behaviors. Prevention would need to include consideration for both cognitive and affective domains. Understanding that the dynamic involved with decision-making is not always relevant to education and experiences, but rather with beliefs and feelings.

The HBM addresses the knowledge, opinions and actions of a person in their consideration of health and disease. This study explores the health behavior of condom use in this population in this context. Current research in health behavior must consider

how people make decisions about their health. Examining both cognitive and affective processes to expose cognitive dissonance in decision making can illuminate health behaviors in a clearer way. This study demonstrates that even when adults cognitively understand a health risk, they make decisions largely based on feelings and desires.

It was reflected in the research that swingers are part of an older group of sexually active people, and this matches the age range of the participants in this study. Older adults are engaging in sexually risky behaviors; and they are also not getting STI testing, likely because they are not having sexual health discussions with healthcare providers due to their age (Syme, 2017). Approximately 11% of new HIV infections in the United States are in adults 50 years old and older (CDC, 2015).

Improved communication related to condom use would be an important facet of sexual health communication, as findings indicate that swingers are having unprotected sex and do not appear to be discussing testing or STI history. Gause et al., (2018) reported that prevention efforts that address communication with potential sexual partners can improve engagement in positive health behaviors, reducing risk for STI.

Creating systems of care and prevention must be prepared to address the complexity of sexual experiences, respecting the differences present outside of heteronormativity. Gruskin and Kismodi (2020) noted that moving past pathologizing non heteronormative views of sex could create affirming attention to overall sexual rights and sexual health.

Conclusions

STI is a modern epidemic with significant economic and health impact (CDC, 2017). Condom use reduces STI, but many people choose to accept risk and have sex without condoms (Young, Marks, Zaikman, & Zeiber, 2017). Research indicates that swingers are a group with a high risk of developing STI due to sexual health behaviors that include inconsistent condom use (Platteau, van Lankveld, Ooms, & Florence, 2017).

Generic qualitative study was utilized in this work due to the largely unknown nature of this group and the unknown nature of their beliefs. Kahlke (2014) noted that the tendency toward generic qualitative study is well suited to conducting research in an area where few studies are available. The author noted that knowledge can be developed about an unknown group only through examination of the person who subjectively experiences life in that group. Swingers in this study were able to openly share their beliefs about their decisions related to condom use and STI.

How individuals pursue sexual pleasure brings into play larger social issues and important health issues. Gruskin & Kismodi (2020) noted that how people enjoy and obtain sex has implications for public health programming and health care. In addition, there are larger implications for how people establish relationships, life fulfilled lives, and stay health mentally and physically.

The study explored the beliefs and attitudes of this subgroup, swingers who bareback. Key findings include that the pleasure-seeking nature of this group precludes consistent condom use. Participants noted consistent views that they did not fear STI, and that using condoms was detrimental to their sexual experience. They are aware of the

implications of STI, including symptoms requiring medical treatment, stigma, and even that death can result. They only use condoms when a partner requires them to: not because they believe that it protects them from STI or that they are likely to contract STI. Study findings could inform prevention efforts by noting this cognitive dissonance and addressing both cognitive and affective factors in decision-making.

In addition, the study points to the need for further exploration in the area of swingers and CNM as a growing and prevalent sexual identification. This study also highlights the need for a prevention intervention for swingers who bareback, as they are placing themselves at risk for STI. These results could support the initiation of efforts related to social change, in that a difference of approach to proposing positive health behaviors could be considered. Making positive health decisions leads to positive health behaviors and safer sexual behavior. Positive health decisions must involve a mediation of and consideration for both cognitive and affective factors. Simply presenting the facts about a health issue does not suffice. This group of participants were overall clear on the facts of STI contraction and implications. However, they chose to engage in negative heath behaviors regardless. This cognitive dissonance is significant and demonstrates the power of the affective, the emotional, the pleasure-seeking side of how we make decisions about sexual health and risk. Addressing cognitive dissonance in health prevention could create more effective intervention and create social change by improving health decision making and subsequent health behaviors.

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Appendix: Questionnaire Utilized for Interviews

STUDY QUESTIONNAIRE DEMOGRAPHIC DATA:

PARTICIPANT CODE

GENDER

☐ *Male* ☐ *Female* ☐ *Non-Binary*

AGE

☐ *18-21* ☐ *22-29* ☐ *30-39* ☐ *40-49* ☐ *50-59* ☐ *60+years*

YEARS IN THE LIFESTYLE

☐ *Less than 1year* ☐ *1-2* ☐ *2-5* ☐ *5-10* ☐ *10-20* ☐ *20+years*

SEXUAL ORIENTATION

☐ *Heterosexual* ☐ *Bisexual* ☐ *Homosexual* ☐ *Other*

PARTNER STATUS

☐ *Married* ☐ *Committed Unmarried* ☐ *Single* ☐ *Other*

CONDOM USE

☐ *Never* ☐ *Always*

☐ *Sometimes SELECT:* ☐ *Frequently* ☐ *Occasionally* ☐ *Rarely*

AVERAGE NUMBER OF MONTHLY PARTNERS

☐ *0-2* ☐ *3-5* ☐ *6-10* ☐ *11-20* ☐ *21+*

CONNECTING METHOD (HOW FIRST TIME PARTNERS MEET)

RATE IN ORDER OF FREQUENCY:

_____ *Swinger Websites*

_____*Private Parties*

_____*Swinger-specific Club/Venue*

_____*Swinger-specific Convention/Travel Group*

_____*Referral from other swingers*

_____*Other:*_____

1. PERCEIVED SUSCEPTIBILITY *(BELIEF THAT YOU WILL CONTRACT A DISEASE)*
1A. Do you know anyone in the Lifestyle that has contracted STI? (Yes/No)
1B. Do you ask potential sexual partners about STI history or testing? (Yes/No/Sometimes)
1B2. (If Sometimes is the answer to 1B) In what cases would you ask? (Describe)
1C. Do you believe it is likely that you would contract STI? (Yes/No)
1C2. (If Yes to 1C) Rate (1-100% chance) believed lifetime likelihood of contracting STI.
2. PERCEIVED SEVERITY *(BELIEF THAT THE DISEASE IS SEVERE IN NATURE)*
2A. What is a Sexually Transmitted Infection? (Describe)
2B. Do you know the impact of STI on health? (Yes/No)
2C. Are you aware of the symptoms of STI? (Yes/No)
3. PERCEIVED BENEFITS *(BELIEF THAT TAKING ACTION IS BENEFICIAL TO HEALTH)*
3A. How frequently are you tested for STI? ☐monthly ☐annually ☐when infection is suspected ☐never ☐other____
3B. When was the last time you were tested for STI? ☐within 1month ☐within 6 months ☐within 1 year ☐within 2 years ☐2+ years ago ☐never
3C. Do you believe that you can prevent STI by using condoms? (Yes/No)

4. PERCEIVED BARRIERS *(BELIEF ABOUT THE COST OF ADVISED ACTION)*
4A. Is there a negative/undesired effect related to using a condom? (Yes/No)
4A2. (If Yes to 4A) Describe negative/undesired effect(s) related to condom use. (Describe)
5. CUES TO ACTION *(CUES TO TAKE ACTION)*
5A. Have you ever had sex using a condom? (Yes/No)
5B. Would you use a condom if a partner requested it? (Yes/No)
5C. Would you use condoms if they were readily available (on site/free)? (Yes/No)
6. SELF-EFFICACY *(CONFIDENCE TO TAKE ACTION)*
6A. Do you believe that using condoms limits access to sexual partners in the Lifestyle?(Yes/No)
6B. What could make you use condoms in every sexual encounter? (Describe)