

EXPERIENCES OF STIGMA DURING SEXUAL HEALTHCARE VISITS: A
QUALITATIVE STUDY OF NON-MONOGAMOUS WOMEN

by

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ABSTRACT

Access to health care services is critical to both personal health outcomes and health equity within a community. While non-monogamous behavior is widespread, stigma surrounding consensual non-monogamy can create barriers to health care access. This research outlines the experiences of non-monogamous women during sexual health care visits, how class acts to modify those experiences, the barriers to health care access that they encounter, and the adaptive strategies they employ. The sample for this research was 23 consensually non-monogamous women. Participants were contacted through online support groups, message boards, and snowball sampling. In-depth interviews about their sexual health care experiences were conducted. Interviews were recorded, transcribed, and analyzed for themes related to the intersection of non-monogamy and health care experiences.

The interactions between health care professionals and non-monogamous women, whether or not those women disclose their non-monogamous status, were often perceived as stigmatizing. Increased class status, both of participant and of provider, was described as increasing experiences of stigma and barriers to care. The information provided by this research may be used to better understand, and thus improve, the barriers health care access experienced by non-monogamous women. Suggestions given by the participants for improving their health care access and decreasing experiences of stigma are included.

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CHAPTER 1: INTRODUCTION

The term “compulsory monogamy” has been used to describe the deeply ingrained social expectation of sexual exclusivity within a dyadic relationship. Monogamy is overwhelmingly viewed as both a socially normative and desirable behavior (Willey 2014). Monogamy itself can be said to be hegemonic (Anderson 2010). Non-monogamy, in contrast, is severely stigmatized even among groups that express a desire to avoid monogamous commitment (Barker and Landridge 2010; Conley et al 2013).

Before the eighteenth century monogamy existed primarily within marriages arranged as way to transfer economic capital. Female non-monogamy was seen as a threat to this transfer of capital, and the loss of exclusive access to a woman’s body viewed as loss of property. The social institution of compulsory monogamy is thus tied to the control of female bodies, labor, and behavior in support of patriarchal capitalism (Kipnis 2003). Women's bodily autonomy in non-monogamy can be seen as a socially disruptive forces that challenge the capitalist structure of Western society (Anderson 2010; Kipnis 2003; McPheeters 1999).

The nature of monogamy as a controlling force influencing female labor, and the stigma that acts to support this force, is present in both sex work stigma and general whore stigma that impacts all non-monogamous women. Sex work is a stigmatizing activity, when sex or work by themselves are not, in part because it violates the social expectation of compulsory monogamy (Abrahamson, Pinkerton, and Huppin 2003). Whore stigma shames female sex workers for transgressing gender norms by demanding money for services, being knowledgeable about sex, dressing to draw sexual attention, and exchanging sex for power or financial gain (Pheterson 1993). Whore stigma does not just impact women that are sex workers; it also works to control

the behavior of non-sex worker women, as they must avoid a range of behaviors in addition to actual sex work that might serve to label them as whores.

Violating the accepted social script of compulsory monogamy, especially for women, creates stigma that can act as a barrier to health care access (Barth et al. 2002; Lichtenstein 2003). Much of the prior research on non-monogamous women and their health care experiences has focused on those that are non-monogamous occupationally. Both street based and high end escort sex workers have been widely represented in popular media. Located between these two, the average indoor sex worker is a largely invisible presence. Succinctly, "There is a neglected group of women, proportionately more of them off-street workers from middle class backgrounds, who exercise conscious choice in turning to sex work" (Scambler 1997:113). There has been minimal qualitative research done on sex work in the US, and noticeably missing are qualitative research studies addressing the health care experiences of indoor sex workers in the post-internet age. Technological advances have made advertising for clients an activity easily done online. This has factored into the increase in indoor sex workers, yet their unique experiences have so far been unaddressed (Flowers 1998). Working in indoor locations is associated with an increase in educational level compared to street based sex workers (Jeal and Salisbury 2007). On the surface this would seem to be beneficial, as increases in class level, generally indicated by increasing level of educational attainment, have in previous research on the general population been associated with encountering fewer barriers to health care services (Allin 2006). However, when gender, increase in educational attainment, and the stigmatized occupation of sex work intersect, these increases in educational attainment and the presumed increase in class that accompanies them are associated with an increase in barriers to health care services (Lazarus et. al 2012). This reversal of the benefit generally provided by an increase in

class level is possibly due to the different social situations of female sex workers with a higher class status. For these women there may be an increase in the level of occupational stigma experienced, and this may act as a barrier to health care access.

Similar to indoor sex workers, non-monogamous women who identify as polyamorous are more likely to occupy a class status that is middle to upper-middle (Sheff 2005; 2006). With the shared experiences of whore stigma and class position it is reasonable to look at the health care experiences of both indoor sex workers and self-identified polyamorous women, as the legality and rationale for their non-monogamy can be understood as a less defining characteristic than their violation of compulsory monogamy and female sexual scripts. This research looks at the perspectives of both indoor sex workers and polyamorous women on their experiences of stigma during sexual health care visits.

The purpose of this research is to examine non-monogamous women's perceptions of their sexual health care interactions. While all health care interactions carry the potential to be stigmatizing for non-monogamous women, the nature of their sexual identity dictates that sexual health care services are accessed more frequently and carry a greater stigmatizing potential (Phillips and Benoit 2005). The questions this research seeks to answer are what, specifically, those interactions look like from the perspective of non-monogamous women and what impact class has on those experiences.

CHAPTER 2: THEORETICAL FRAMEWORK

Stigma

Stigma is understood to be "an attribute that is deeply discrediting...an undesirable difference...a spoiled identity" (Goffman 1963:3). In some of the oldest sociological discussions of stigma, prostitution is used as a classic example of spoiled identity (Goffman 1963). Enacted stigma can be viewed as the consequences of having a spoiled identity. It refers to the manifestations of stigma; social avoidance, devaluation, rejection, and structural and interpersonal discrimination are all examples of enacted stigma (Link and Phelan 2001). Laws against sex work that punish the sex worker but not the client, and the banning of sex workers from entering the U.S. even when traveling specifically to attend sex worker conferences, are prime examples of structural discrimination. Because sex work is so highly stigmatized in modern Western society, people that engage in it experience the difficulties of their occupation, which are many, along with the added difficulties of enacted stigma. Having sex without pay does not generate the stigma that having sex for pay does. Using the body to perform other physical work that involves interaction with another's body for pay - for example massage, home health care services, and boxing - does not carry with it the stigma attached to sex work. The intersection of these two generally non-stigmatized activities, having sex and using the body to perform paid work, transform two previously unremarkable activities into an activity that generates profound social stigma (Ericsson 1980).

Research on those in polyamorous communities has shown that social repercussions due to stigma, such as job loss or rejection from family members, occur in the presence of non-monogamy, or relationship agreements which allow for multiple partners, even without the

added stigma of sex work (Sheff 2005). Monogamous relationships are rated more favorably than non-monogamous relationships, and a belief in monogamy as more ethical and less risky than non-monogamy act to increase stigma assigned to those in consensually non-monogamous relationships such as polyamory (Anderson 2010; Conley, Moors, Matsick, and Ziegler 2013). The relatively recent legalization of gay marriage has been met with religious leaders warning that multi-partner marriages would be next, and comparing the desirability of this to bestiality and child abuse. That polyamory is used as a political point to discourage the legalization of gay marriage reflects its highly stigmatized status. Consensual non-monogamy is viewed as even more stigmatizing an activity than cheating even though it does not involve the breaking of relationship commitments. Cheating, although involving both deception and the violation of agreements, at least carries with it the superficial attempt at monogamy (Anderson 2010). This elevation of cheating over consensual non-monogamy illustrates the pervasiveness of compulsory monogamy is and the seriousness of the stigma attached to non-monogamy, particularly polyamory (McPheeters 1999).

Having a stigmatized identity can impact a person even in the absence of any enacted stigma. Felt stigma refers to the stigmatized person's internalized feelings of shame relating to their stigmatized identity. These feelings can cause the stigmatized person to perceive situations as stigmatizing even when no active discrimination is occurring. This altered perception can cause changes to the stigmatized person's behavior (Kinsler et. al 2007). While enacted stigma requires others to be aware of the stigmatized person's spoiled identity, felt stigma only requires that the stigmatized person be aware. The difference between being outed as having a stigmatized identity and being privately aware of your own stigma is referred to as having a discredited versus a discreditable identity (Goffman 1963). In order to avoid changing from

discreditable to discredited, and the possible increase in enacted stigma that may then occur, sex workers often conceal their occupation from their health care providers. Young (2014) found that polyamorous individuals use the stigma management strategy defined by Goffman (1963) as “passing,” which involves presenting as monogamous in order to conceal their discreditable status and avoid being subjected to enacted stigma.

Conception of Risk

Sex work, like many occupations, involves risk. In the U.S. these risks include increased rates of STIs, physical violence, and risk of arrest to name only a few (Kurtz et. al 2005). The conceptualization of risk is not, however, a straightforward assessment of numerical odds. Risk is constructed in ways that are individually relative (Sanders 2004). Because an individual's perceived ability to cope with the outcome of a potential risk influences how that potential risk is ranked, the way a sex worker ranks a certain risk may be very different than how a health care worker ranks a certain risk.

Non-monogamy is generally viewed by society as riskier than monogamy (Conley et al. 2013). Monogamous relationships are seen as healthier, more meaningful, and benefit from the “halo effect” that possessing a socially desirable trait imparts (Conley et al. 2013). A halo effect occurs when a person that possesses a socially desired attribute, like thinness for women or muscular appearance for men, is then seen as possessing other positive qualities having nothing to do with the original attribute, e.g., intelligence, kindness (Nisbett and Wilson 1977). So polyamorous women are seen as having unhealthy, riskier, and less meaningful sex than their monogamous counterparts, regardless of the safety protocols they may use or the meaning they attach to their sexual encounters (Conley et al. 2013).

The concept of risk itself is gendered. Attitudes towards people that engage in risk taking behaviors are often influenced less by the behavior itself than by the gender of the person engaging in it. "Dominant notions of femininity tend to represent the careful avoidance of danger...they are more often portrayed as the passive victims of risk than as active risk takers" (Lupton 1999:161). Women that reject the norms of feminine behavior in regard to risk taking are seen as immoral and not deserving of community support or protection (Stanko 1996:51). As Chan and Rigakos (2002) point out:

What constitutes risky behavior is filtered through a masculine lens that conditions what we identify and define as 'risky'. Moreover, when women do take exceptional risks, the tendency is to conflate women's exceptional risk taking with 'amorality' as in the case of promiscuity. (P. 743)

Risk taking is also influenced by power dynamics; the choice to engage in a particular behavior, even if made without coercion, is influenced by a person's location within the social power structure (Sanders 2004). Risk taking, both action and the conceptualization, by non-monogamous women is influenced by gendered risk taking expectations and their location in societal power structures.

Based on these two theoretical frameworks, it would seem reasonable to think that non-monogamous women would have their sexual identity and behavior categorized as "risky" by their sexual health care providers. Other behaviors now considered risky, such as being overweight or participating in extreme sports, have their associated stigma compounded when performed by women (Toothman 2013). This combination of gender, a behavior considered "risky," and a stigmatized identity may be problematic for women during sexual health care visits where both their behavior and identity are a core reasons for seeking care (eg. STI testing).

CHAPTER 3: LITERATURE REVIEW

Defining Sex Work

The term "sex work" refers to a widely diverse range of occupations that are considered to be part of the sex industry. Stripping, posing for nude pictures, performing in pornographic videos, phone sex, web cam modeling, performing direct sexual acts on a client, and Professional Domination offering BDSM fetish scenes all fall under the umbrella term of "sex work" (Cohan et. al 2006). Sex work and sex worker, as used in this research, will refer specifically to engaging in direct sexual activity with another person in exchange for money or goods. More specifically, the sex work referred to here are all voluntary exchanges and occur outside of established relationships such as marriage or informal "sugar daddy" arrangements. While economic pressures influence the decision to begin sex work for most sex workers, clear distinctions are made between sex work and human trafficking (Groves et. al 2008; Jeal and Salisbury 2007).

While a technical definition of sex work provides necessary clarity, evaluating the meanings attached to this term, and similarly applied terms like whore and prostitute, is an essential part of defining sex work and understanding the stigma experienced by sex workers. Prostitute is defined as "A woman who is devoted, or (usually) who offers, her body to indiscriminate sexual intercourse, esp. for hire: a common harlot" (*Oxford English Dictionary* 1989:673). Prostitute is also a verb, defined as "to prostitute oneself is to sell one's honor for base gain or to put one's abilities to infamous use" (*Oxford English Dictionary* 1989:673). The term prostitute does not simply convey the definition that a prostitute is someone that has sex for money. This word has a gendered definition; while sex workers can be of any gender, the

definition of prostitute carries within it the image of a female actor. Combining the noun and the verb use of prostitute highlights the weight of sexual and gender standards that the term prostitute conveys. As Pheterson (1993) explains, "A prostitute then becomes one who sells her honor by offering to hire her body for base gain or for an unworthy doing, specifically sexual intercourse" (Pheterson 1993:39). Sexual acts become synonymous with female honor, and the definition of prostitution itself contains the stigma associated with the activity. The use of the term "indiscriminate" as a modifier for sexual intercourse further defines the circumstances under which exchanging sex for money is considered prostitution. Exchanging sex for money is not prostitution, and thus does not impugn the honor of the person (always presumed to be female), if it is not indiscriminate. Similarly, having sex within an exclusive sexual relationship immediately before a shopping trip is not prostitution even though the act of sex may be understood to lead to compensation. This exchange avoids transgressing gender norms, and the resultant Whore Stigma attached to these transgressions, as the woman performing the sexual activity is limiting sexual access to one man and is not directly negotiating to be compensated for her labor. When referring to the exchange of sexual activities for money or goods the term "sex work" is used by the majority of sex researchers and sex worker advocacy groups. It is used to intentionally reduce the negative connotations of prostitute or whore, and also to associate sex work with other service industries.

Defining Polyamory

Polyamory, like sex work, is a form of consensual non-monogamy, but focused on interpersonal relationships as opposed to sex work's occupational focus. The concept of "polyamory" has been used to refer to a variety of different theoretical objects in the academic

and popular literature on the subject (Barker and Langdrige 2010; Haritaworn et al. 2006; Klesse 2006; McLean 2004; Ritchie and Barker 2006; Strassberg 2003). For the purposes of this paper, "polyamory," or "poly," is a noun referring to the practice of an individual engaging in multiple committed, romantic relationships with other individuals, with the full knowledge and consent of all of the individuals involved; "polyamorous" is the adjective form of polyamory (Barker and Langdrige 2010; Haritaworn et al. 2006; Klesse 2006; Ve Ard and Veaux 2005). Individuals engaged in polyamory often identify themselves as polyamorous as a kind of "relationship orientation," roughly analogous to kinds of sexual orientation (Ve Ard and Veaux 2005). Polyamory emphasizes a focus on multiple concurrent romantic and sexual relationships with fully informed and consenting relationship partners, in comparison to other forms of consensual non-monogamy, such as swinging or hooking up, which have a focus on primarily sexual, non-romantic relationships (Young 2014).

Polyamorous relationships can be described in terms of their size, openness, geographic density, and configuration. The size of a polyamorous relationship refers to the number of people currently connected to one another through committed, consensual romantic and sexual relationships. Although the average size of a polyamorous relationship is unknown, they can range from two individuals in a dyad open to new partners, to any number of individuals connected through a chain of relationships (Barker and Langdrige 2010). The openness of a polyamorous relationship refers to the willingness of polyamorous individuals in a relationship to initiate new relationships with outside individuals. While monogamy would not be a constraint, a polyamorous individual might limit themselves from adding more partners due to constraints placed on their time and resources by preexisting relationships, work, childrearing and other obligations (Barker and Langdrige 2010; Ve Ard and Veaux 2005). One common term used in

reference to the openness of a polyamorous relationship is "polyfidelity," a type of relationship which closely resembles a monogamous married family with more people (Strassberg 2003). In a polyfidelous relationship, the number of relationship members is set at a certain number, and all of the members commit to not leaving the relationship or adding new members as long as the polyfidelous relationship exists - theoretically, until death do they part (2003).

Geographic density refers to how close members of a polyamorous relationship live to one another. Finally, the configuration of a polyamorous relationship refers to the pattern of dyadic relationships between individual members of a polyamorous relationship. This includes individuals' gender identity and sexual orientation, individual relationships with other members, and relationships to the group itself.

On Street vs. Indoor Sex Workers

While the definition "exchanging sex for money or goods" may apply to all sex workers discussed in this research, sex workers as a whole are not a homogenous group (Jeal and Salisbury 2007). Prior research makes clear distinctions between the lives of street based and indoor sex workers (Jeal and Salisbury 2007; Cohan et. al 2006). Street based sex workers are much more likely to deal with issues of homelessness, drug addiction, poverty, and violence than are indoor based sex workers. These differences are not merely due to the environment in which they work. Street based sex workers are more likely to report childhood abuse, enter into sex work at an earlier age, and have a lower educational level than indoor sex workers (Jeal and Salisbury 2007). These factors precede street based sex work, and are indicators of the substantively different life experiences of street based sex workers. Indoor sex workers, whether in a brothel, massage parlor, or private residence, are more likely to use condoms with clients,

more likely to seek health care services in general and sexual health care services in particular (Jeal and Salisbury 2007). They are less likely to have children, but more likely to have those children at home with them, and more likely to report that they are in sex work due to childcare and financial issues stemming from being a single parent (Jeal and Salisbury 2007).

Although indoor sex workers can reasonably be considered as occupying a higher class status than street based sex workers, they are less likely to have told their health care provider about their occupation (Jeal and Salisbury 2007). Withholding information about the nature of their work increases the chances of receiving non-stigmatizing care, but limits the topics that sex workers can consult with their health care provider about. This causes health issues related to sex work to go unaddressed (Phillips and Benoit 2005). Issues of musculoskeletal strain, urinary tract infections, sleep schedule difficulties due to working nights, and emotional strain are all mentioned as health issues sex workers felt were needs they were unable to discuss with their health care provider due to occupational stigma (Phillips and Benoit 2005). For indoor sex workers, having a higher class status does not provide greater access to health care resources, but instead acts as a barrier to receiving care (Lazarus et. al 2012).

Legal vs. Quasi-Legal vs. Illegal Sex Work

The legal status of sex work varies country by country, and often even within counties. From state licensed brothels that require sex worker registration and frequent STI screenings, to the simple decriminalization of sex work if done indoors, legal or quasi-legal status allows sex workers the ability to engage in sex work without fear of arrest. Legal or quasi-legal status does not, however, confer protection from the social stigma associated with sex work (Groves et. al 2008; Nguyen et. al 2008). In qualitative interviews with female sex workers in Victoria,

Australia, where sex work is both legal and regulated, concerns about anonymity were expressed by over half of the participants (Groves et. al 2008). The main rationales given for this concern were that, if their anonymity was breached, family members would reject them and society would view them negatively.

In those places where sex work is illegal, the occupational stigma associated with sex work is compounded by the stigma associated with criminal activity. Sex workers are also viewed as inherently "Bad Mothers" (Park 2011), and if discovered to be a sex worker can have their children taken away by the state even in the absence of abuse or neglect (Sanders 2004). Legal repercussions that relegate sex workers to the edges of society increase negative health outcomes and experiences of violence (Day and Ward 2007). In all three variations of legal environment, sex workers consistently report that fear of stigma motivates them to conceal their sex work from health care providers (Nguyen et. al 2008; Groves et. al 2008; Kurtz et. al 2005).

Legality of Polyamorous Relationships

In the contemporary United States, there exists no legal recognition of polyamorous, multi-partner relationships (Ashbee 2007; Strassberg 2003). Heterosexual dyads (and, in a growing number of jurisdictions, homosexual dyads) may enter into a legal marriage with all the rights and privileges thereunto, but additional partners are denied this benefit due to anti-polygamy laws (Lehr 1999; Strassberg 2003). As such, multi-partner polyamorous relationships often exist in a certain grey area akin to that of homosexual dyads in the United States - different legal rights and privileges are extended in different areas, or most commonly, no legal rights and privileges outside of those granted to married dyads within a larger polyamorous relationship. In addition, occupancy limits on residences in some jurisdictions within the United States limit the

number of unrelated individuals that can legally share the same domicile, thus limiting the ability of multi-partner relationships to share the same domestic space (Strassberg 2003). There are also no laws prohibiting discrimination on the basis of "relationship orientation" or participation in polyamorous relationships, meaning polyamorous individuals have no legal recourse to fight discriminatory behavior (Emens 2004).

Sex Work as Work

"Prostitution is only a *particular* expression of the universal prostitution of the worker..." (Marx 1974:125). Sex work, no matter the legal or moral status it occupies, does involve actual work. How people that engage in this work should be viewed, and the amount of agency ascribed to them, is intensely debated by feminist theorists (Shimizu 2007). Sex workers have been traditionally described as submissive victims preyed upon by pimps and their own drug addiction, or as predatory deviants (Maher 2000; Shimizu 2007). In addition to divergent views on sex workers, there are a multitude of feminist theories regarding the nature of sex work itself. Some view all sex work, no matter how voluntary, as coercive sexual abuse operating within a patriarchal system of oppression (Barry 1979; Jeffereys 2009). Others view sex work as a legitimate occupation, and even consider the legalization of sex work to be an essential part of ending the sexual double standard (Kempadoo 1998). Those that espouse this second viewpoint point to the lack of consistency between laws against pornography and laws against sex work. They argue that these variations in legal status allow "white males to sell women's bodies, but do not allow women to sell their bodies themselves" (Anderson 1984:14). One of the most influential supporters of sex work as a valid occupational choice emerged in the U.S. in the 1970's. COYOTE, or "Call Off Your Old Tired Ethics", was founded in San Francisco in 1973 as

a prostitutes' rights organization, and has since grown to an international organization. Framing prostitution as a worker's rights issue, COYOTE was instrumental in bringing about both legal and conceptual changes that have occurred in regard to sex work in the U.S. (Jenness 1990).

Dolores French, sex worker and president of Florida COYOTE, makes this argument clearly:

A woman has the right to sell sexual services just as much as she has the right to sell her brains to a law firm where she works as a lawyer, or to sell her creative work to a museum when she works as an artist, or to sell her image to a photographer when she works as a model or to sell her body when she works as a ballerina. Since most people can have sex without going to jail, there is no reason except old fashioned prudery to make sex for money illegal. (Henkin 1988:3).

In shifting the conversation about sex work to a focus on worker's rights, COYOTE and other advocacy organizations point out that the illegal nature of sex work denies sex workers legal protections afforded to other occupations (Jenness 1990). Sex workers that have worked collectively have a dramatic decrease in their risk of STIs, yet due to the illegal status of sex work in the U.S. collective sex work is often more easily stopped than individual sex work (Cohan et. al 2006). Health insurance and workplace safety issues are not things that can be negotiated for without the ability for sex workers to take collective action. Working in a delegitimized occupation excludes sex workers from conversations about occupational injuries. This exclusion mandates that injuries incurred be viewed as the result of risk taking, instead of the result of participation in the labor force. This distinction acts to further stigmatize sex workers, and serves as another barrier to health care access.

Occupational Stigma as a Barrier to Care

Occupational sex work stigma, defined as "hiding occupational sex work status from family, friends, and/or home community" is associated with encountering barriers to health care access for street based sex workers (Lazarus et. al 2012). This remains true regardless of differences in demographics, drug use, and homelessness. The St. James Infirmary in San Francisco, CA, founded in 1999 to provide free medical care to sex workers in the area, provides a unique venue from which to view the impact of occupational sex work stigma. Staffed primarily by former or current sex workers, its mission is to provide nonjudgmental care for sex workers. Studies done at St. James indicate that 70% of sex workers seen in their clinic had never before disclosed their occupation to a health care provider (Cohan et. al 2006). Reasons given for nondisclosure were negative past experiences as a result of disclosure, fear of disapproval, and embarrassment. This high rate of nondisclosure indicates that occupational sex worker stigma is a prevalent barrier to care for sex workers.

Canadian sex workers that reported using a regular general practitioner (GP) for their health needs were less likely to disclose their occupation to their provider than sex workers that primarily used STI clinics or emergency services (Nguyen et. al 2008; Jeal and Salisbury 2007). Many stated that the long standing relationship with their GP, sometimes occurring over the span of decades, acted as an impediment to disclosing their sex work (Nguyen et. al 2008). Some of these same women reported that they visited STI clinics for more anonymous care regarding their sexual health needs, using their GP for regular health care.

Having regular access to a GP is made much easier by Canada's universal health care policy; class is less of a factor in access. In the U.S., regular access to a GP is associated with higher class status. Therefore, U.S. sex workers that use a GP as their primary health care source

are likely to be of a higher class status, and that means they are likely indoor sex workers. For sex workers, an increase in class means an increase in occupational stigma during health care interactions (Lazarus et. al 2012), and this combined with the reluctance to disclose their occupation to a long standing GP may serve to situate indoor sex workers in a particularly disadvantaged position in regard to health care access.

Social Stigma as a Barrier to Care

Although polyamorous individuals don't experience occupational stigma in the way that sex workers do, they still experience social stigma as a barriers to health care access. Monogamy acts as a hegemonic force in U.S. society, establishing life-long monogamy as natural and superior to all forms of non-monogamy from cheating and hook-up culture to polyamorous relationships (Anderson 2010). The cultural hegemony of monogamy means that non-monogamy is stigmatized throughout society - even by non-monogamous individuals themselves, who may experience guilt and shame as a result, or even manage their stigmatized identity by continuing to identify as monogamous despite non-monogamous behavior (Young 2014). As well, previous research on polyamorous relationships specifically has identified several costs of the stigma of polyamory, including potential loss of employment, loss of custody of children, institutionalization, and being ostracized by friends, family, and social groups (Pallotta-Chiarolli 2010; Sheff 2005; 2010).

Previous research has found that polyamorous individuals tend to be privileged individuals, i.e., mostly white, college-educated, and middle- to upper-class professionals (Sheff 2005; 2006). These systemic advantages can provide "a social and financial safety net to rely on should the polyamorous relationship be unsuccessful or the identity undesirable," effectively

insulating polyamorous individuals from many of the effects of whore stigma (Young 2014:11). However, not all polyamorous individuals are privileged along race and class lines, and even those that are so privileged experience stigma as a result of their non-compliance with the standards of hegemonic monogamy. Previous research has found that this stigma and its effects tend to be stronger for polyamorous women than for polyamorous men due to the same whore stigma experienced by women sex workers and, indeed, all women in society (Klesse 2010; McLean 2004; Ritchie and Barker 2007; Sheff 2005; 2006).

Care Provider: Intentional and Unintentional Stigmatization

Sex worker experiences with health care providers can be categorized as directly or indirectly stigmatizing. In Canada, where sex-work is quasi-legal, sex workers reported experiencing directly stigmatizing behaviors such as being dropped as a patient as a result of disclosing sex work, and shaming experiences in emergency care situations that are in any way associated with sex work (Phillips and Benoit 2005). Victim blaming, and the reminder that they are in violation of gender norms surrounding female risk taking, is expressed in a 19-year old massage parlor sex worker's emergency room experience: "at the hospital they didn't respect me at all. It was like 'oh, you're a prostitute [and] what did you expect' and other negative things were said to me" (Phillips and Benoit 2005:94).

Unintentional stigmatization, defined as behaviors of health care professionals that were well intentioned, generally center around differences between how sex workers and health care professionals conceptualize risk (Phillips and Benoit 2005). Health care providers are more likely to view sex work as a risk activity such as smoking rather than as a labor activity (Sanders 2004). They are also more likely to focus on potential physical risks. This can result in

paternalistic lectures on occupational choice and repetition of STI risks as a main focus of health care interaction (Phillips and Benoit 2005). Indoor sex workers, while aware of physical risks, focus more on the potential emotional risks of their occupation (Sanders 2004). Being discovered, or having the separation of public and private lives breached, is ranked by indoor sex workers as a higher perceived risk than physical harm. A violent encounter can be recovered from, while being outed as a sex worker would do permanent harm to personal relationships. With indoor sex workers more likely to consistently use condoms, STIs are something that is seen as generally controllable (Sanders 2004). It is also a risk that is only present during their work. The risk of discovery is constant, and continues even after permanently leaving sex work.

UN/AIDS (2002/2009) has identified access to non-judgmental health care services as a critical part of HIV prevention in sex workers (Rekart 2005). Female sex workers with positive self-image have an increased ability to insist on client condom use (Ngo et. al 2007). The shaming that sex workers often experience during sexual health care visits reduces positive self-image and is counterproductive to decreasing sex worker STIs. Reducing risk is the goal of many health care professionals' interactions with sex workers. Ironically, the fact that sex workers experience of these interactions as stigmatizing can result in increased health risks.

Slut Shaming as Health Care

The relationship between non-monogamous stigma and health care access has been well established, but it has not been well defined. The specific stigmatizing experiences of indoor sex workers and polyamorous women at the point of sexual health care access have not been examined in the U.S. Their unique location at the intersection of a stigmatized expression of female sexuality and an increased class status has been only briefly researched. The specific

manifestation of stigma surrounding sexual health care visits, and how the intersection of their stigmatized identity and class impacts their sexual health care, is the focus of this research.

CHAPTER 4: METHODS

This qualitative study explored non-monogamous women's perceptions of stigma during sexual health care visits through the use of in-depth interviews with 23 self-identified consensually non-monogamous women aged 22 to 55. Interviews were primarily conducted over the phone to provide as much anonymity as possible, and the interview schedule was semi-structured. I asked where and how participants got their sexual health care needs met, what factors influenced their selection of providers, if they were able to disclose their non-monogamous status, and what their overall experiences were like during these interactions. These interviews were then analyzed using grounded theory and feminist standpoint research as described by Charmaz (2006), Smith (1992), Suddaby (2006), and Thompson (1992). Transcribed interviews were analyzed using a two-step coding process. Initial coding involved themeing data and emotion coding as described by Saldana (2013). This was followed by focused coding wherein identified themes were sorted into larger, more sociologically connected categories.

Grounded Theory and Feminist Standpoint

I chose grounded theory as the analytic approach for this research because it is best suited to understanding how people construct meaning from their lived experiences (Suddaby 2006). Glaser and Strauss (1967) described grounded theory as an inductive process where data are collected and analyzed reciprocally, using each analysis to inform the next data collection. Grounded theory shares common features with feminist standpoint research. Both place importance on researcher reflexivity, value the voices of individual participants, and

acknowledge the impossibility of truly objective research (Thompson 1992). Despite their similarities, feminist standpoint research differs importantly as to political agenda (Lindsey 1997). There is a focus on women's experiences of patriarchal oppression and on women as an important knowledge source for their own realities (Thompson 1992). A distinction is made between research on women versus research for women. The latter is aimed at enhancing the lives of women, not just describing them (Thompson 1992).

In addition to ordinary ethical concerns present in all research on humans, feminist standpoint research carries with it additional ethical considerations for the objectification of research participants. In order to avoid treating the women participating in my study as objects, and instead to take a feminist standpoint perspective that treats them as informed and empowered individuals, I both summarized what I thought the participant had meant during the interview and discussed emerging themes with participants at the close of the interview. Seeking feedback on the research process is a way to deconstruct the power structure inherent in the researcher-participant relationship, and to make space for the voices of participants in constructing the analysis of their own experiences (Thompson 1992).

Agenda

As Suddaby (2006) points out, grounded theory does not require a researcher to come into a project with no prior knowledge of the field in question. Not only is this impossible, but Glaser and Strauss (1967) state that using preexisting, or substantive, theory to provide and initial direction for the formulation of categories is both desirable and often necessary. I acknowledge my own previous research into the sexual health care experiences of consensually non-monogamous women led to the creation of the initial lenses of stigma, risk, and class that I

have defined in my Theoretical Framework. As a woman in the US, and as a sociologist, I expected to see some form of stigma surrounding the health care experiences of my participants. I did not know what form that would take or what significance would be assigned to it by the participants, and I was careful to continuously reflect on my own subjectivity throughout the data collection and analysis process. Based on my prior research I was aware that risk and class might be present as factors in participants' encounters with health care professionals, but was uncertain as to whether they would be at all and if so what they would look like or what impact they would have on the overall encounters. By continuously acknowledging my awareness and expectations I worked to mitigate the influence of my own subjective perspective on the data. The question outline was crafted using open ended questions that used a neutral tone and did not mention stigma, risk, or class to avoid the creation of themes within the data based on my own expectations.

In addition to prior awareness of possible substantive theories related to the research, I also acknowledge that my personal perspective on sex work and non-monogamy is that they are not deviant activities, and that they should be legalized and viewed as morally neutral. I was drawn to research on women's sexual health care experiences, non-monogamous women in particular, with a desire to illuminate these experiences and positively contribute to the dialogue on women's sexuality and health. Holding a political position on the liberation of female sexuality is consistent with feminist standpoint research; acknowledging it as part of reflexive efforts to minimize subjective impact on data is consistent with both feminist standpoint and grounded theory processes.

Sampling

Because sex workers and CNM women are both sensitive (Lee 1993) and a hard-to-reach populations (Spren & Zwaagstra 1994; Watters & Biernacki 1989), targeted and snowball sampling was used (Watters and Biernacki 1989). Websites that sex workers use to advertise for clients were initially used to locate participants. Contact was made through the email or phone number listed in their ads. The following websites were used: Backpage.com, Eros.com, theeroticreview.com, and cityvibe.com. General postings on these sites seeking participants were also done. As sex work is illegal, contacting participants online added an additional layer of anonymity (Benoit et. al 2005).

Recruiting efforts on the above mentioned websites were minimally effective. I also contacted sex worker support groups located on Fetlife.com and asked the group moderators for permission to post a request for participants. This was met with mixed success, and at one point involved defending the concept of qualitative research in an online forum. Subsequently, outreach and support sites such as sexworkersproject.org and Facebook groups devoted to sex workers rights were contacted. This was much more successful and resulted in several referrals that completed interviews. COYOTE, as a sex workers rights group, has often acted in concert with researchers seeking to further understand or improve the lives of sex workers. I contacted one of their advocates that managed a Facebook group to request help in securing study participants. Teaming up with Community Partner Organization of this sort has been found to be beneficial when researching hard to reach populations in general and sex workers in particular (Benoit et. al 2005). Several of my initial contacts were met with understandable suspicion and a requirement that I both explain my perspective on legalization and show the question outline for my interview. After several back and forth emails my status as a researcher that held a sex

positive, pro-legalization stance was accepted by three of the groups that I contacted and referrals were made to possible participants.

Finding non-monogamous women that self-identified as polyamorous was a good bit easier than finding self-identified indoor sex workers, at least in terms of being accepted as a non-threatening and competent researcher. Using both Facebook groups and personal contacts, I sent out requests for participants. This generated multiple responses in a rather timely fashion.

At the end of each interview I asked if the participant might possibly know anyone else that would be interested in participating. Many interviews ended with a direct referral and shared email or phone number of a possible new participant.

Data Collection

I have a current CITI-certification and all interviews, transcription, and data analysis were completed by me. The research protocol used was IRB approved. Once individuals agreed to participate, an interview time was scheduled. For participants that had been contacted via email the Informed Consent was emailed to them prior to the interview. For those participants that did not want to be contacted via email the Informed Consent was read to them prior to the beginning of the interview. Semi-structured interviews were conducted with participants over the course of 12 months, and ranged from 17 minutes to 90 minutes, with most lasting approximately half an hour. After verbally obtaining participant consent, a Sony IC recorder was turned on and the interviews were recorded. Completed interviews were later transcribed verbatim.

After beginning each interview with the question “Where do you go to get your health care needs met?” I continued the interview process by either asking follow up questions or

continuing down the interview question outline. The nature of the replies to each question sometimes meant that a question farther down the outline ended up being answered early on in the interview. When this happened I made a point to mention the question when it came up in sequence, noted that we had already discussed things related to this, and asked if there was anything the participant thought important to add. In this way I allowed the conversation to maintain a natural flow but also confirmed that each question on the outline was formally presented.

Subsequent questions asked about their last visit to a sexual health care facility, what factors impact selection of health care providers, and whether or not they are able to disclose their non-monogamous status. After the first few interviews I added a question about paperwork to the question outline. Multiple respondents had mentioned that being asked to write down number of sexual partners, either past or current, was perceived as stigmatizing, so that question became part of the process for the additional participants. Immediately after each interview I summarized my impressions of the interview for use during future coding.

I did not ask participants whether or not they participated in sex work. The presence of an online ad offering sexual services for compensation was considered a strong enough rationale for me to categorize them as sex workers. While most of them brought it up using the clearly defined words “sex work,” I avoided having it as part of the question outline. By avoiding requiring participants to admit to an illegal activity, I attempted to provide an additional layer of participant safety. No participants, whether non-monogamous in just their personal lives or in both personal and work, were asked for their names. During the transcription process I replaced all personally identifying data with a generic filler word (eg. NAME, CITY) during the transcription process. All participants were reminded that they could stop the interview

process at any time during the interview, and that no personally identifying information would be used in the final research write up. Participants were assigned pseudonyms that were then attached to their data, and care was taken to provide generic descriptions of their life circumstances in order to avoid any possibility of identification. Unless somehow important to the framing of their quotes, participants' statuses as either a sex worker, polyamorous, or both, were not noted. While initial expectations were that the experiences of each group would be possibly be distinct, as analysis preceded it became clear that the commonality of non-monogamous stigma was a unifying thread in the participant accounts. The legality of their sexual behaviors, while serving to add an additional layer of concern for some women, did not in itself distinguish the accounts so labels were left off unless relevant to the context of the quote.

Sample

All participants were aged 18 years or older. In total 23 self-identified consensually non-monogamous women were interviewed. Of these women, 14 identified as current sex workers, and 9 identified as currently polyamorous. All together, participants had a combined 255.5 years of experience being non-monogamous, ranging from 1 year to 38 years of experience, with a mean of 11.10 years. Participants ranged in age from 22 years old to 55 years old, with a mean of 34 years old. Responding to questions about their race or ethnicity, 21 participants identified as white, 1 as African American, and 1 as Hispanic/Latino. While marital status was not a question asked on the demographic section of the interview schedule, many respondents indicated either marital or relationship status during the interview process; 8 participants indicated they were currently married, 8 indicated they were currently single, 3 indicated they were currently divorced, and 4 did not make any indication. Like marital status, questions about children were

not part of the demographic section of the interview schedule, however many respondents brought up the fact that they either had or did not have children; 12 indicated that they had children, 4 explicitly indicated that they did not, and 7 made no indication either way. All but one of the 23 participants had completed some level of post high school education, and that one participant had completed their GED. Of the rest, 5 were current undergrads, 5 had completed some college, 3 had completed certification programs at technical colleges, 5 had completed a Bachelor's degree, 1 was currently in graduate school, and 1 held a PhD. All participants were living in the United States at the time of the interview.

Data Analysis

Transcribed interview transcripts were coded for themes using Dedoose, a secure online platform for qualitative analysis similar in features to NVivo. Analysis began immediately after the first interview to allow for emergent themes to influence the addition of questions to future interviews. In order to continuously practice reflexivity I made use of memo writing both after each interview was completed and after initial coding was finished for each interview.

In analyzing the interview data I used a “distillation of key ideas” instead of line by line coding (Stern 2007:118). I chose this approach after reading through the first transcript and coming to the realization that so many of the responses were dependent on larger amounts of surrounding conversational context. Additionally, normal speech patterns of placeholder sounds, laughter, and repeated false starts to words frequently made individual lines nonsensical when viewed alone. By using larger chunks of data I was able to maintain context during comparison of data from one interview with another. Using multiple codes per selected short chunk of text

allowed me to retain vital pre and post code framework without losing the specificity generated by line by line coding.

My initial coding used both themeing data, where I created a short phrase to capture the meaning of the description, and emotion coding, where I coded participants' feelings (Saldana 2013). An example of a code created by themeing data is "avoiding providers with religious affiliation," while an example of a code created using emotion coding is "Feeling – Anxious." As emotions and perceptions of outside judgment are such vital parts of describing a stigmatizing experience I felt it necessary to provide a specific focus on emotions themselves.

As the research process progressed I repeated the cyclical process of interviewing, discussing the data as I understood it at that point with the participant, transcribing the interview, memoing, and doing initial coding. Once several interviews were complete I was able to begin my second stage of coding using focused coding. Focused coding is used to identify frequent and significant codes and group these codes together categorically (Saldana 2013). As part of the constant comparison process described by Glaser and Strauss (1967), I engaged in both gathering new interviews, initial coding, and focused coding simultaneously for much of the data collection process. I used the newly emerging themes brought to light during the focused coding process to generate new, more accurate codes for subsequent transcripts, and also returned to previously analyzed transcripts to reinterpret initial codes. Although numerous themes were identified during focused coding, this paper focuses on three of the most relevant ones to the feminist standpoint taken in designing and analyzing this study. Those selected themes involve stigma, class, and risk. Stigma and class are addressed in their own results chapters, while the theme of risk informs the discussion of the results.

CHAPTER 5: STIGMA

Testing

For the non-monogamous women in this study, STI testing stands as a focal point of interaction around which stigmatizing experiences and adaptive strategies to manage those experiences occur. Because of this, describing participants' experiences with the STI testing process is an important prerequisite to understanding their overall experiences of stigma. Desire for STI testing often means individuals must weigh the consequences of disclosing their discreditable status against the consequences of being denied access to testing. Requests for STI testing were often described as a challenging gauntlet requiring justification and eliciting increased provider scrutiny. If no sufficient justification is provided, participants reported that requests for testing were often simply denied. Nearly all participants stated a personal belief in the importance of frequent STI testing, particularly in relation to their non-monogamous status. Whether STI testing was important, or whether or not they had ever been tested, was not a question ever initiated by me. STI testing was overwhelmingly described by participants as a responsible, ethical behavior choice. Constructed as such, accessing STI testing carried a significant emotional importance.

Amanda, 26 years old and married, described an interaction with her private practice gynecologist where she requested STI testing and was met with what many other women in the study describe as “pushback” in response to this request:

She was the one who most gave me a quizzical look when I asked, “I would like to get STI testing.” She just looked at me and was like, “Oh, but didn't you have

him? I'm sure you had the OB/GYN [perform testing] when you had him.” Mind you, he was four years old, so even if he would have been my kid... I just don't get it.

Being asked “Why?” in a way that could not be adequately answered without disclosing their non-monogamous status was frequently a frustrating experience. Amanda, the participant mentioned above, described her experience of being asked “Why?” and being unable to answer it in a way that resulting in her accessing STI testing:

I felt like I was hiding something. I felt like I was in a Catch-22, where I was trying to get something without giving away information that I needed to, that I had to, even though I didn't feel like I needed to. I felt like getting tested for that is something that should be... I really felt that it was going to be as easy as just asking for it. So I was a little puzzled, and then I was put on the spot, and then, like, uuuugh, just coming up with, it was so uncomfortable, I just felt so frustrated. And then when I left I really felt like “Well, what do I do now?” I felt like I have to go elsewhere, I felt like I have to go find Planned Parenthood or something. I have to find, this is something I have to find somewhere else, it's the feeling that I got. It just doesn't seem to be something that I can say without some kind of like shock value coming from it, or only disclosing things that maybe I'm not comfortable with in order to have that available to me. Or to go somewhere that operates on a completely, you know, on a harm reduction standpoint where they're excited about giving it to you. So that was, I was really frustrated with

that. And I didn't, I felt like I lost some of the faith that I had in my healthcare and how it was being handled.

A provider responding with “Why?” in response to a request for STI testing was framed as different from a line of medical inquiry into whether or not they had symptoms that prompted the testing request. Instead of being seen as a medically relevant question, the “Why?” was viewed by participants as evidence that a provider saw STI testing requests as an indicator of deviant behavior that required explanation. Asking “Why?” was frequently seen as the provider attempting to “figure out” what risky or deviant behavior precipitated the request.

I usually go for testing every fifteen days to a month, and obviously for a regular healthcare provider they're questioning you and saying “Well why do you need to come in and get tested so much? What are you doing so bad?”... if you want to just make sure. (Cassandra)

So it was very much like furrowed eyebrows. Like, questioning “Why, why do you need that?” There was definitely a feeling of what they were thinking, and the kind of gears that switched in their heads when I asked to be tested for that. Like, “What does that mean?”... They were trying to figure it out what it was that I was doing that was risky and destructive that required me to get tested, even though I didn't have symptoms... There was like, “Well why?” It was like, “Well, if you're, this is the picture that we have of you and what...” It seemed like they were trying to guess what kind of risky behavior I was engaging in, like there had to be a kind

of deeply, like, destructiveness attached to that. Like, are you just sleeping with random people every night and not using protection? Are you sharing needles with intravenous drug users? That's how I felt, I felt very much like "WHY?" Like, "Why do you need that?" (Amanda)

There is well established association in the medical literature between an individual's number of sexual partners and the benefit they receive from regular STI testing - an association known in lay society as well. This linking of what, for women, is a non gender-normative number of partners with a justification for STI testing may also create an inverse association - that women requesting STI testing are then assumed to have a large number of sexual partners. Because of this inverse association, women that seek STI testing are possibly seen as engaging in transgressive sexual behavior simply because of their desire for testing.

Although STI testing was a large source of stigmatizing interactions for the overwhelming majority of non-monogamous women interviewed for this research, not all participants viewed testing this way. Donna, a 24 year old adult film actress, noted that while her experiences were overwhelmingly positive they were also likely outside the norm.

Well the one reason why I go to the STD clinic that I go to is because they're really, really welcoming for people in the business. You know the, the same women have been running the clinic for 20 years, so they know the business and they know the issues that we have, and so they're kind of our therapists as well and we really love them there...my interaction with doctors, I think is a little bit different, because even though both of us are doing something, me and an escort,

both of us are doing something that's kind of frowned upon by society, I think that people who escort get treated significantly worse than I do. From what I've heard, and from what I understand, my personal experiences have been kind of abnormally positive.

By engaging in a form of sex work that is legal where she lives, and using an STI clinic that specifically caters to adult film stars, her experience of stigma is mitigated. There is no decision to disclose, as non-monogamous status is a given due to the testing certification form that must be filled out by providers. There is also no presentation of "Why?" in response to a testing request. Testing is mandatory in order to continue working, and this clinic is one that specifically issues STI certification to those in the adult film industry.

Disclosure

If participants can't convince their providers to grant them access to STI testing based solely on their desire for testing, they are faced with a choice. They can either find another provider or disclose some reason that the provider will take as valid justification for STI testing. Finding another provider involves all of the regular day-to-day hassle of making any doctor appointment, along with the added concern that this new provider will yet again decline to perform testing. Insurance may not cover another well visit, and scheduling conflicts may create gaps in time longer than personal testing frequency preferences. For those in polyamorous networks with pre-sexual contact testing policies this lack of access to testing may inhibit the

development of new relationships. All of these reasons and more act as motivating forces when participants are faced with a situation where they must disclose some justification for testing.

Some participants report fabricating a reason that they feel the provider will accept. Claiming to have a cheating boyfriend, or saying that they “date a lot of people” without directly stating how many or under what circumstances, were both reported as strategies used by participants. A drawback to this strategy, however, is that participants risk being caught in a lie if they use the same story later or don’t remember the story they told accurately. Additionally, if participants see the same provider for long periods of time, a story of a “cheating boyfriend” starts to look suspicious when repeated enough times. For those participants that choose to disclose their non-monogamous status in order to access STI testing, this disclosure is a tradeoff that reveals their discredited identity but opens doors to healthcare. Regan shared her analysis of that disclosure in exchange for testing tradeoff:

When I've said that I want regular testing they've always been like "Well why?" is the immediate answer, or immediate question. And I say 'Because I want to know I don't have these diseases', this seems obvious to me. And they're like "Well what, have you had activity you think you've been exposed?" I'm like, "No, I've had safe sex, I've followed the, you know, gloves and condoms, but I just like to be sure." And they're like "Well, how many people are you having sex with that you're concerned about this?" And if the number is two or more they're like "Oh, ok, that's why you need the testing." I've actually had more people be like "Oh, ok, that justifies it." Like "That makes sense, you're a whore, ok, I get it, you need the testing." Not even negative about it, they're just "Oh, you're a slut, gotcha,

sluts get tested, ok, cool." But it's like you have to justify that you're slutty enough to deserve to get tested.

The decision to disclose was not strictly limited to situations that called for justification of STI testing. 15 out of the 23 women reported ever having disclosed their non-monogamous status to any health care provider, whether a sexual health specialist, primary care doctor, or therapist. Multiple women reported viewing disclosure, or the ability to disclose, as a vital part of their relationship with a health care provider.

...if I was working today I would definitely be open with my health care professional. I don't think that they would be able to give me the care that I need without that information. (Elizabeth)

I feel like if I'm going to get decent care from a doctor I need to be honest with them. Who more should you be honest with, besides your partners, than your doctor? (Natasha)

So I very much had the expectation that you do not lie to your health care providers because you might have something that you're doing that they need to know... And it is in my best interest to have my health care providers know that I am non-monogamous. (Faith)

Even for those participants that placed high importance on disclosure, there were multiple factors that influenced when and to whom they would disclose. Urgency of medical need was a consideration for whether or not to disclose, as disclosure was seen as a possible barrier that might delay care in a time sensitive situation. Relevancy of the provider's field was also a consideration. Providers in a sexual health related field were seen as more important targets of possible disclosure than providers that dealt with more general aspects of overall healthcare. Participants' willingness and ability to handle the potential consequences of disclosing served to influence a case-by-case style of disclosure risk assessment. Past negative experiences when disclosing non-monogamous status to providers - either the participants own experiences or those they had heard of from others - reinforced expectations of future negativity in response to disclosure and decreased willingness to be honest with providers. Even when participants stated that their willingness to disclose was low or nonexistent, they still expressed a desire for an ideal situation where they would be able to disclose without experiencing consequences they viewed as negative.

Felt Stigma

Felt, or perceived, stigma refers to the internalized feelings of shame relating to having a stigmatized identity. The presence of frequent and consistent themes in the participants' interviews relating to feelings of shame, fear of judgment, feeling out of the norm, and fear of discovery all seem to indicate that participants in these scenarios were experiencing felt stigma (Goffman 1963). Fear of judgment was a very commonly expressed emotional state surrounding sexual health care interactions.

I would walk into the clinics and I would be like "Oh my god, they're going to judge me, they're all looking at me right now, they know I'm a whore. (Gwen)

Just fear to go in the first place because, you know. Fear to tell people the truth because they're going to judge. (Pamela)

Yeah, well, it's difficult because you run a risk of that person... I guess of feeling judged by that person. (Harley)

Felt stigma influences decision making and behavior even in the absence of any tangible enacted stigma. Prior research supports the idea that stigma can act as a barrier to sexual health care access (Lichtenstein 2003). While feeling judged, fear of discovery, and other very negative feelings surrounded sexual health care experiences for a large number of participants, none of these were presented as significant enough impediments to STI testing to warrant forgoing testing altogether. For women in this study, felt stigma seemed to only influence their decisions to disclose their non-monogamous status to their providers - not their decision to receive care in the first place. Selina, a 23 year old undergrad, explicitly used the word 'stigmatized' to describe how she thinks her provider views her non-monogamous behavior:

Because I already feel stigmatized about it, I feel like the answer they want is "I have this many partners" or "I have this one partner" and this is how frequently I have sex...I feel like they want that straight answer, but I've never been able to actually have an open dialogue with my health care providers because I know the

answer that they want, and the answer that I have is not the answer that they want.

So I don't actually talk about it that much, because I allow the societal stigma of it to carry into my own private conversations.

Fear of being reported to law enforcement, fear of being flagged on their health insurance as “promiscuous” for having accessed STI testing too frequently, and fear that disclosure would negatively impact their children were all mentioned as concerns related to participants’ experiences of felt stigma.

Intake paperwork presented during sexual health care visits was also described as a source of felt stigma, specifically sections that asked about number of partners, sexual practices, or established monogamous partnering as the standard. Here is what Jean, a 49 year old with children, and Inara, a 30 year old married woman with children, describe as their perception of negatively worded intake forms:

They actually had something on the form like, "Have you slept with," I think it says "with more than ten people, or under eight?" You know, crazy-- there's not actually numbers there. [laughing] And you check one part of the number, and they really don't realize that it's offensive ... (Jean)

Or the forms that ask all these questions in a, “Have you done anything stupid?” sort of way. Which kind of make you feel like I don't want to tell you if you're going to phrase it in a fashion that's...”So, have you had unprotected sex with anybody in the last year?” Well, yeah, I've been doing that since my kids were

born because that was the point of the tubal. But the way it's phrased is just, "So that we can talk to you about how contraception functions." ...As opposed to "Are you using contraception, do you want us to talk to you about it?" As opposed to putting it in your hands... (Inara)

Conversely, paperwork could also act to decrease experiences of felt stigma. Intake forms that indicated provider awareness of non-monogamy were seen as reassuring. They, along with other visual cues provided in decorations (eg. pictures of non-heteronormative families) were seen as a pre-encounter demonstration of a provider's acceptance of non-monogamy. For example:

... when you go to Planned Parenthood and you see the form, you're like "Oh, well this is a place where I'm not going to get judged or yelled at or whatever, it's going to be fine, I'll be ok here"...their form is "What pronouns would you like us to use?" And I'm 'I could say anything here and nobody would care.' You can tell by the form..., And your partner, parentheses, 's', closed parentheses. Right, so you guys have heard everything. There's nothing I can say in this room that's going to weird you out, great. (Inara)

Enacted Stigma

Enacted stigma, the manifestation of stigma that arises in response to having a discredited identity, includes but is not limited to structural and interpersonal discrimination (Link and Phelan 2001). For the non-monogamous women in this study, expressions of enacted stigma

during sexual health care visits ranged from relatively mild and non-confrontational (e.g. provider facial expressions - “old Catholic nun face,” “snooty sneering”), to severe and directly challenging (e.g. told not to come back, lectures about behavior, denial of medical care). Even the relatively milder forms of enacted stigma were still capable of changing participant behavior in regard to future disclosure of their non-monogamous status.

I can't remember exactly what she told me, but the look she used. I remember her tone was just very...and even though I'd used stuff like, I think I used the word sex worker; it's usually what I use. But she, in a very dry tone of voice, referred to me as a prostitute from then on out...and basically just kind of treating me like, I don't know, like I was trash, basically. So since then I haven't. (Vanessa)

Lectures about non-monogamous behavior were experienced by both sex workers and polyamorous women. While most focused on the perceived risks of non-monogamy, some took the form of repeated questioning related to lifestyle choice. Cassandra, 22 with one child, described being questioned about her choice to work in adult films each time she went into her provider's office. This questioning took place every 15 days to one month over the course of a full year:

I was seeing this nurse practitioner that always rubbed me the wrong way...she'd ask me every single time "Are you sure you're okay doing what you're doing? No one's forcing you to do this? This is what you really like to do?" She kept on asking all these questions to the point I'd hate stepping into that office every 15

[days] to a month. It got the point where I had to change that doctor because I felt like I couldn't handle even seeing her, to be questioned like that every time when she knows, when I'm looking her dead straight in the face, [saying] that I love what I do, and she can't grasp it... she's like "You're sure? You're sure you're going down the right path? You really like what you're doing?" She'd just keep on asking me as if she's not hearing what I'm saying. It would make me so mad because by the end of the exam, 20 minutes, 30 minutes later, she'd be asking the same god-damned questions over and over, even though I'm right in front of her face, saying it straight in her eyes... I hated every time I had to go into that office. It's like every single appointment would be the same, one after another after another. So the disbelief and the questions, over and over.

Compared to these direct lectures about the inappropriateness or unsafe nature of participants' non-monogamy (often without asking what safety standards participants already had in place), questioning that was invasive and irrelevant to receiving sexual health care appears relatively banal. Several polyamorous women described being asked things such as "Well don't you get jealous?" and "Do they know about each other?" after disclosing that they had multiple committed relationships. These types of questions were seen as arising from provider curiosity rather than due to medical necessity. This type of invasive, irrelevant, curiosity-based questioning was described in particular detail by Beatrice, a 27 year old married sex worker that also self-identifies as polyamorous:

Because a lot of my work is fetish work people kind of drop the doctor-patient relationship to go, "Oh, so what is that like? Are you beating up guys all the time?" That kind of prurient question thing. I'm like, 'You're not even pretending like this is relevant to the care you're giving me. This is 'I have met a circus freak so let me ask them what the circus is like'... I've never met a doctor who has asked me questions about my work and asked "Is it all right if I ask you about the intimate details of your sex life that aren't, you know, [medically relevant]." It seems to be pretty consistently considered fair game. The 'You're an animal at the zoo and I want to ask about your cheetah spots' is definitely the most [common]. I've had doctors ask "So, what do you wear? You must have really cool clothes!" In that sense I would say that talking to doctors is very much like just talking to any new people about my job...obviously it's more inappropriate when it's a doctor.

Even when questions viewed as invasive and irrelevant are seen as well intended, the very existence of a need for questions served as a reminder that non-monogamy was outside of the norm for that particular provider asking the questions. Six of the nine polyamorous participants mentioned their frustration at having to introduce a provider to new concepts. That they were required to educate their medical providers was described as a positive opportunity that was nonetheless a burden.

I have had an OB, she was like "Oh, really! Tell me more so that way I can be sensitive to it if I come up in the future." She was like "I want to know what this

word is. Poly what?" and took it as a learning experience, which was great, but also not my job...I don't really feel like I need to get on the polyamory education soap box when I go in for a pap smear. (Regan)

I either get to be the person who gets to have this discussion with you for apparently the first time ever, or I can just not, and hope that we don't ever have anything specific to this that we ever have to talk about. (Inara)

At the opposite end of the spectrum from questioning that is merely invasive and irrelevant lies direct denial of medical care. This was the most blatant and aggressive form of enacted stigma described by women in this study. Denial of care experiences occurred both as a rejection of the participant as a patient entirely, and as a refusal of health care services, both directly ascribed to participants' non-monogamy. One polyamorous participant reported being told that their non-monogamy made them not a "good fit" for the office. Cassandra shared that her gynecologist office of five years responded to her new adult film work and related STI testing requests by saying "You don't have to come here so much," and telling her to go to a STD clinic or Planned Parenthood instead.

Participants' non-monogamous status was described by providers as either a directly causal safety issue that necessitated refusal of health care, or as an indicator of personal circumstances that were not stable enough to qualify for the desired medical care. An example of the latter is described by Beatrice, the 27 year old married sex worker with a BA who is also polyamorous:

I don't personally want to have children, ever, so I had asked about more permanent contraception. The doctor basically at that point sort of stonewalled me and said "Well, you know, we don't like to do permanent procedures on people who haven't already had children because they might change their mind, and particularly with people who are in..." what was the, because there were such a particular phrase he used, "chaotic life circumstances."

Beatrice has a thriving business as Dominatrix, a completed four year degree, and a marriage partner that also practices non-monogamy. These seemingly valid indicators of rational decision making and stability were eclipsed by the stigma of associated with Beatrice's non-monogamous status.

Refusal of care that cited non-monogamy as a directly causal safety issue happened even when - and sometimes because - participants described their sexual safety practices. Faith, a 28 year old polyamorous, married undergrad, presented a highly detailed description of refusal of care:

When I got my IUD inserted I had a conversation with an MD. We had cleared it all and I was very blunt. "I am non-monogamous, and I know that that is one of the risk factors for getting an IUD inserted, that it can increase my risk for pelvic inflammatory disease, or for catching an STI, or this various host of things. You should know this about the practices: we use condoms and barriers, we're only fluid bonded within this particular group, and everybody gets STI screens every six months both within my quad and then any outside partners. That's actually

one of the prices of admission into having sexual contact within the circle.” And the doc okay’d me to get my copper IUD. So I show up the day that I’m supposed to have my copper IUD inserted and she’s got an APN [advanced practice nurse] who’s assisting her...She hands me this questionnaire to fill out, and it’s the same questionnaire that I’d filled out earlier when talking with the MD about my options, and I check off the part that says I’m non-monogamous. She comes back in and she’s like “Well, I don’t think you’re going to be getting a copper IUD today, because you’ve said that you sleep around, and that is unacceptable. That makes you too high risk for this and I’m not putting it in.” And I’m there in my fucking little paper gown with my panties off, and this woman is berating me because I’ve clearly lied to her and the doctor, and she’s just not going to participate in this. And I was stunned. I absolutely did not expect this, because I had cleared it, and I looked at her and I said “Well, you might want to go back and talk with the doc, because this is a conversation I’ve already had.” She said “No, I’m shutting this down today. This is unacceptable.”

The provider in Faith’s health care encounter directly referenced her non-monogamous status as being “too high risk” for the previously scheduled medical care. Describing Faith’s sexual practices as “sleeping around” instead of a more neutral “because you have more than one partner” would seem to indicate the provider’s personal value judgment being communicated along with their professional assessment of medical risk. Viewing non-monogamy as inherently risky was also present in Inara’s refusal of care experience:

My physician, who had been very pro the hysterectomy that I was supposed to get up unto this point, when he discovered that I had a partner other than my legal spouse all the sudden was like "Yeah, I don't think that you're a candidate for this procedure any further." So we've been having an issue, because he thinks that by getting a hysterectomy I'm going to use that somehow as a form of birth control, and that that would be "encouraging risky sexual behavior in someone who is not in a monogamous relationship." That's what he's said before, because I asked him why this is no longer something that he was suggesting that I get done. He had suggested I take time off of work and do this as soon as possible because of other health factors. He said that when he'd suggested it he thought that I was in a monogamous relationship...Since I was not in one, and since I wasn't using condoms and I was relying on the fact that I had a tubal and I am in a closed poly relationship, but it's still a poly relationship, that's how I was planning on not getting STDs. That wasn't as a reliable of a plan, and so he didn't feel that this was now as easily recommended as a procedure. So it was either going to be more discussion, or I should consider doing something else, or if I wanted to have a monogamous relationship for a year and a half that then we could do it again.

[Interviewer: So, just so I understand correctly, his theory was that your hysterectomy was you wanting that so that you could have unprotected sex, even though you have a tubal?]

Yes, that was his theory. Oh, well, it was going to lead to being even less careful than I was being already. Right. I'm not sure how you can be less pregnant than one already is but, less pregnant, apparently, was going to be also less careful.

The experiences of enacted stigma reported by women in this study align with previous research on women's experiences in sexual health care settings. Women in the UK that were interviewed about their experiences during STI screenings reported that providers had accused them of promiscuity and even shouted at them (Dixon-Woods et al. 2001). Lichtenstein (2003) found that staff at public health clinics described women seeking STI treatment as "good" based on factors such as whether or not they had a steady partner, seemed embarrassed to be seen in the clinic, and presented themselves "like ladies" (p. 2438). Women were alternatively described as "bad" if they pursued men instead of being pursued, did not show shame at being in an STI clinic, or joked about their sexual exploits (p. 2439). Men that utilized the health clinic were not divided into "good" and "bad" by the staff, and their STI screening requests were seen as a display of "machismo" (Lichtenstein 2003; p 2439). Neither of these studies focused on women that were non-monogamous, or had disclosed non-monogamy. That they experienced enacted stigma simply from seeking STI care illustrates the pervasiveness of gendered behavior expectations that define "good" female sexuality.

Adaptive Strategies

Felt and enacted stigma created barriers to health care for non-monogamous women. A barrier to health care as described here is anything that makes a health care encounter more difficult for the participant. Nearly all women in this study related adaptive strategies they employed to manage the effects of stigma and reduce barriers to their health care.

The adaptive strategies employed by participants can be generally placed into one of two categories. The first of these is identity management, or “passing,” a stigma management strategy described by Goffman (1963) as managing information about a stigmatized identity in order for it to remain hidden. The second is establishing ultimatums, a stigma management strategy outlined by Young (2014). Establishing ultimatums requires that family members, or in this case medical professionals, accept the stigmatized identity in order to continue the relationship.

Examples of identity management strategies employed by participants include lying about having a cheating partner, dressing conservatively, going outside of their insurance, low-balling their number of partners, paying cash, seeing multiple providers simultaneously, redirecting questions, and using Any Lab Test Now style clinics for STI testing. All of these help participants avoid transitioning from a discreditable to a discredited identity (Goffman 1963).

I find when I go to Connecticut or Massachusetts I don't even have to show ID if I have \$300, and I can put any name on the form I want. (Jean)

And since my last visit was always so recent, I would low ball it and be like "Oh, five." (Gwen)

They don't do my testing for VD and everything else because nobody should get tested that often in the real world, and I don't want them to know. (Moirra)

Examples of establishing ultimatums include the obvious ones of ending provider relationships and seeking less judgmental providers. Related to these were prescreening, either by directly calling the provider's office or by using selection criteria that were seen as enhancing the likelihood of a provider responding positively to non-monogamy. Avoiding providers with religious affiliations, and looking for providers that did their residency in a liberal areas of the country, are both examples of this more passive type of prescreening.

For many participants, adaptive strategies were used for more than simply mitigating experiences of stigma. When providers declined participants' requests for STI testing even after disclosure of their non-monogamous status, strategies such as going to a different provider were used as a consumer strategy that allowed participants to purchase the health care they wanted elsewhere. Going to a different provider often involved operating outside of insurance coverage, and thus required paying cash. Using these adaptive strategies to seek out and acquire health care was not presented as a way to manage experiences of stigma but as a reflection of the participant's determination to acquire the health care services she wanted. Inara, a 30 year old married woman with children, talked about her experience being denied testing for HPV despite having disclosed her non-monogamous status and her recent possible exposure:

I was like "Ok, we, we had a person who was in and out of my significant other's life who had a positive HPV test"...And they were like "Yeah, no, you don't need that." And I'm like "Here's why I do, because I know that this person has had a positive test result, and she's sleeping with this person, and I have also slept with this person, and I want to make sure that this is not a thing that has been passed through." And they were like "Yeah, no, you still don't need it." And I was like

“I’m pretty sure that’s actually how tests work. That’s when you go and do that, if not beforehand. Please?” And they were like “Nope, you don’t need it.”...And I was like ‘Ok, fine.’ So it was just, there wasn’t any way to access it through my regular provider...And so I called Planned Parenthood, and we had this moment where my insurance, it’s vaguely Catholic in nature, and they wouldn’t pay for me to so much as get an exam done at Planned Parenthood because they have quote ‘real doctors.’ So I had to go to Planned Parenthood and pay for it out of pocket there.

One adaptive strategy used by participants did not fit as cleanly into either identity management or establishing ultimatums. Deliberately seeking out health care providers that served low income clientele, even when a participant had private insurance or the ability to pay cash at a private provider, was repeatedly employed as an adaptive strategy. Regan described feeling “not out of the norm” as one of the primary reasons for using this strategy:

...if I had a voucher where I could go anywhere, I think I would avoid the uppermost tier of offices and areas because I think that I would get treated worse. I think if I went to a place that catered to college kids, and ‘the youths’, that I would at least just be overlooked as just another slutty coed, and that wouldn’t raise as much of a flag as when it’s a bunch of prudish, married women popping out babies. When you’re like “I mean, I have two boyfriends” that’s a lot more noticeable than in a sea of baby daddies and slutty coeds, air quotes. What’s another type of promiscuity?

This management strategy minimizes the impact of stigma by choosing a setting in which the non-monogamous participant's discreditable identity is just one of many similarly stigmatized identities. This is different than Goffman's (1963) description of seeking an in-group of others with similarly stigmatized identities, as there is no secessionist ideology expressed. Non-monogamy is described as more normative for younger, single, less financially stable women. By receiving health care in a lower class setting than she would normally occupy Regan avoids "raising flags" related to her non-monogamy.

CHAPTER 6: CLASS

To be honest the worst treatment I've had was at the hoity, rich, white ladies in the suburbs clinic. The poor people clinics, they're too busy to really be terrible at you. (Regan)

Despite not having any initial questions in the interview guide relating to class, Beatrice – the second participant to be interviewed – volunteered her belief that her class position disqualified her from certain health care assistance: “I think...if I'd had more difficulties they would've been able to be more helpful.” She found herself in need of urgent health care services, and after contacting a sex worker advocacy group she was referred to facilities whose focus was on street based sex workers. Cassandra, the third participant to be interviewed, mentioned that she used Planned Parenthood – despite having a private doctor and health insurance – during a time when she was struggling with housing, in order to avoid the judgment that she thought her private provider would show if told about her housing struggles. In total 14 of the 23 women interviewed explicitly mentioned class as a factor that impacted their sexual health care, and the vast majority discussed adaptive strategies that reflected an awareness of class-based standards for sexual behavior.

Provider Class

Nearly half of the participants made clear mention of provider class and the impact it had on how non-monogamy was viewed. Upscale providers were perceived as being more likely to be uncomfortable with non-monogamy. When defining the term “upscale” this referred to private

practice physicians or midwives in contrast to places that were public or non-profit health centers.

Those places tend to be harder to deal with, and I don't know if it's because the perception is you aren't the norm and it's who they choose not to have as their clients. I don't know if there is a judgment, but every provider who you deal with is a person, and every person has fundamental beliefs, and unfortunately the reality is the majority of the people in the United States have negative connotations associated with us in some respect or another. What that says is your odds of walking into a doctor, especially a higher end one, somebody who hasn't signed on to treat people like us, quote unquote, the odds of that person being non-judgmental and giving you the same health care that they would give to someone else is much less than walking into a free clinic. (Moir)

In contrast, non-monogamy was viewed as something that did not violate the behavioral norms for people seeking care at public health units or Planned Parenthood locations. This was sometimes seen as a result of the assumed deviance of the lower class, and that individuals who were presumed to frequent free and low cost health care services would be in that lower class category.

I felt less judged going to the Health Department because they were more apt at dealing with people [pause] of my status, you know. What I'm trying to say is the

stigma of that...They deal more with people like me, and drug addicts, and prostitutes... (Katherine)

More frequently, a health care provider's choice to work in a public or non-profit location was seen as evidence of that provider's expectation of engaging with non-normative practices. The overwhelming majority of participants mentioned Planned Parenthood or county health units as places that, while inconvenient due to long waiting periods and crowded facilities, were places that they could more frequently expect positive health care interactions. Participants were more likely to disclose their non-monogamous status to providers at these types of facilities, and were more likely to see these locations as reliable sources of non-judgmental sexual health care services. Both were described as "harm reduction" focused, and this focus was seen as taking prominence in relation to whatever personal opinions providers might hold as to non-monogamy.

Are used to seeking it? Or are used, or...have internalized that it's normal for the people that they might treat to have those lifestyle choices or those lifestyle experiences. Even if they don't encounter it all the time, they're like, "Oh, well you know I work at the Planned Parenthood downtown clinic, I'm going to see those people off the streets. The salt of the earth people." Even if they never encounter them they have that script in their mind. (Regan)

If you go in to a free clinic they've signed on to this whole idea that they're probably going to be treating prostitutes. They're probably going to be treating drug addicts...They're going to be treating people at a lower socio-economic end

that are on the fringe of society, and so they're all on board and they don't seem to have a problem with how, whoever you are or however you present. (Moira)

... They're working there because they chose to work there and to help the public, you know, I always felt I got better treated and less judged going there.

(Katherine)

When participants did have negative experiences at public or non-profit health sexual health care facilities – something that was uncommon among the women interviewed – they ascribed this negative experience to the individual health care provider instead of the class of the facility at which the provider worked. Negative experiences that took place at public and non-profit facilities were often presented as surprising, and contrasted with participants' expectations of how providers at these locations would view sexual health practices in general and non-monogamy specifically. Vanessa, 31, shared her surprise at experiencing what she considered a stigmatizing reaction to disclosing her occupation to a provider at Planned Parenthood:

I did once at Planned Parenthood... I can't remember exactly what she told me, but the look she used. I remember her tone was just like very...even though I'd used stuff like... I think I used the word sex worker, it's usually what I use. But she's like, in a very dry tone of voice, referred to me as a prostitute from then on out. Well I thought she was, I mean I just assumed, Planned Parenthood is pretty liberal and they'd dealt with people of all, they work with all sorts of different people, like of all different social classes. Mostly not the really upper class, but

you know what I mean. They should be used to things that really go on in the world... But she just like acted like it was kind of repulsive, so. Which surprised me. I was just “whoa.”

Overall, participants repeated positive to glowing descriptions of their experiences at Planned Parenthood and to a lesser degree public health units. One aspect in particular that was a source of comfort was the lowered frequency with which they had to introduce providers at these locations to the concept of consensual non-monogamy. Private doctors, in contrast, were repeatedly described as not understanding non-monogamy. As Natasha said, “I use Planned Parenthood because regular doctors and gynecologists don't understand polyamorists.” Having to introduce a provider to concepts, even when that provider is open to and interested in learning about consensual non-monogamy, is seen as a reminder that a participant’s non-monogamous status is outside the norm for that provider.

I don't feel great when I'm going to see a professional and I feel like I'm educating them. Even when it is, understandably, about a fringe lifestyle, technically. I want to have that trust in my doctor that they're, if they deal with sexuality on a daily basis, like a gynecologist is, you'd think maybe at one point in their entire twenty-five years as a doctor they Googled 'non-monogamy' just to see what was out there or something, I don't know. I shouldn't be the first one exposing them to the concept of sexually safe non-monogamy. Even if, taking the politics and the morals and the ethics about it, just the concept should not be totally foreign to

them that people can practice safe sex with more than one married, white, heterosexual couple. (Regan)

Participant Class

Middle class appearance was something that many participants employed as a stigma management strategy that let them more easily “pass,” particularly when accessing STI related health services. Things like dressing conservatively, wearing minimal makeup, and appearing well put together were all mentioned as passing strategies. These management strategies could backfire, however, as middle class appearance also served to increase norm-violation during disclosure of stigmatized identity. Having received sexual health care as an openly non-monogamous woman in a variety of socioeconomic settings, Regan concluded that appearing to be of a higher class status resulted in more stigmatizing health care interactions. Here she shares her perspective on participant class and her experience disclosing non-monogamy in higher class health care facilities:

I think poor people are assumed to be slutty, so when a poor person comes in and is talking about ethical non-monogamy in a way that is just categorized as slutty, it's not a surprise because you're poor.

[Interviewer: Do you feel that some of the judgment is because of the surprise?]

Yeah, as far as the uptight white ladies, definitely. They're just like, “Oh, you're admitting to that thing that we all did with our husbands when they were on business trips, but now we're not going to talk about it.” Maybe I touched a nerve

that way, I don't know. But yeah, there was definitely much of, there was a propriety element, definitely. There was a class element of propriety I sensed.

In contrast, Beatrice described how appearing educated and economically privileged served to deter provider judgment about her non-monogamous status:

I certainly come off as someone who is reasonably economically privileged even if I'm seeing these doctors in circumstances that suggest that that's not the case. You know, kind of obviously college educated. So I think things like that cut off some of the, this is obviously inference on my part, but things like that cut off some of the more basic judgmental moments.

Participant class was mentioned regularly, but seemed to operate differently in different settings. Appearing middle class in middle to upper class settings seemed to make most sexual health care interactions more difficult. Presenting as educated and relatively economically stable when accessing public or non-profit based health care seemed to preempt some forms of enacted stigma. This is perhaps due to non-monogamy being seen as a violation of class norms. One participant volunteered this as her perspective on why accessing sexual health care was when presenting as lower class was a less stigmatizing experience:

I think that, like I said before, there are a lot more cultural scripts for poor people to have non-monogamy or promiscuity than there are for rich people. Rich people, you can cheat. You've got one option, you can cheat. Or you can be a swinger on the DL

[down low]. Those are your two options, and no one talks about the second option. But if you're poor, well poor people get knocked up by one another all the time, and swap partners because they're, they're too uneducated to get married, or they're all just young and just sleeping with each other anyway. So there's a lot more tropes and social scripts for promiscuity in low income. (Regan)

Access issues caused by increased class were also shared by a few of the women. Beatrice, the second participant and the first to bring up how her class status impacted her sexual health care, talked about how her middle class economic status disqualified her for certain types of aid. Moira gave a nuanced explanation of what it was like to move from lower to middle class status as a sex worker and the shift in health care access that came with that rise in status:

More of my medical encounters were actually when I was younger because there were more options. As I moved out of that realm of the street work and the lower end, you have to become more and more class conscious and people aren't as friendly in those areas... When you're going into Planned Parenthood and you're on the street and you have nothing, you know they're looking at you like "Oh, let's help this person" and that's their niche in life to be there. Once you get medical insurance, like somebody gets married and has a husband or has medical insurance or they have it through another job, now all the sudden you're put into this other realm of health care. For those people, you aren't the norm.

Along with an increase in class status comes the desire to protect the things that often accompany that status. Moving into middle class status doesn't mean they have the same access to middle class health care services. Even when economically they can afford the health care privileges associated with middle class status, their stigmatized identity creates strain when using those facilities. It puts them in a position of being outside the norm for their socioeconomic status, and reduces their ability to have full disclosure and non-judgmental health care during sexual health care visits.

If you have nothing to lose you're going to tell people, you're going to find somebody who's going to help you, it doesn't matter. You bounce from place to place because there is no center, there is no home, there is no nothing. Once you get a home and you get a family, or you get something that you want to protect, now you have something to lose. So an attack from anybody becomes much more than something that emotionally you're going to feel. It becomes something that can jeopardize your life... That middle class that sort of moves out of that, now you're in that problem where you can't drop millions of dollars on health care but at the same rate you need it and you, there's really no place for you, you know, no place to belong and no place to be safe. It makes it a little hard. (Moir)

“But you’re married”

Married participants frequently mentioned that their marital status acted as a barrier to health care access. Due to the general social expectation that marriage implies monogamy, non-monogamous behavior within a marriage – especially for women – is seen as compounding the

originally deviant non-monogamous behavior (Cherlin 2008). Marriage is also associated with a higher socioeconomic status, and as such the violation of expected marital behavior is also a violation of middle class norms (Kipnis 2003).

Social expectations of marital monogamy were most frequently expressed during sexual health care visits by providers referencing a participant's marital status in response to requests for STI testing. On occasion these expectations were expressed as direct calls to the presumed authority of a participant's husband to influence her sexual behavior. Beatrice recounts how her health care provider expressed concern about her husband's feelings in regard to her non-monogamy work before sharing the results of her STI testing:

I'm married, although we're non-monogamous. And that was on the little questionnaire as well so I had listed that. And the doctor got, it had started with the doctor going "Oh, so how does your husband feel about this?" I'm like, we, we're fine. Huh [laugh]. I want to make sure that I'm reporting accurately. And he's like, "Don't you feel that you're putting him in danger?" And I said, well, not especially. Obviously we talk about these things, but it's not any, there's, there's not anything different between the fact that we date other people and the fact that I'm a sex worker. And he was like "Well, what do you, do you not have sex with people?" At that point I tried to change the subject. You know, "Can we talk about my test results?" Because I'm very nervy about STIs, it's something, I guess it's a joke, germaphobic sex worker. But it's something that causes me a lot of anxiety, and that's something that goes back way before any experience in the sex industry. So I was like, "You're holding my test results in your hands, can we

actually talk about whether not I have any diseases, instead of how my spouse feels about the possibility that I might have diseases?"

Marriage was most frequently described by participants as a barrier to STI testing. By revealing their marital status, something that often has to be done if covered by the health insurance of a spouse, participants faced increased challenges when accessing sexual health care services. As monogamy was a standard provider assumption for married individuals, asking for STI testing was seen as a flag for non-normative behavior on the part of one spouse or another. While the participant could lie and say they suspected their spouse of being unfaithful, this was only seen as a valid strategy with providers that would not be seen regularly in order to avoid mixing up what lies they had told in order to get STI testing. Disclosing non-monogamous status to health care providers was made more difficult by being married, as it indicated not only violation of compulsory monogamy but also violation of normative standards of marital behavior. Many married women in this study were unable to convince a health care provider to perform STI testing without disclosing their non-monogamous status:

"Well, but you're married"... I've gotten that. Like, "But, you're married, why do you want to get tested?" kind of thing. (Amanda)

When I was still with my husband and I would go for my annual exams, I would ask for a standard STI panel. The nurse would always ask me why I wanted it done. Then the doctor would ask me why again, say "Aren't you married?"...They thought that just because I was married meant that I shouldn't

be exposed to any STIs. They obviously thought I was cheating or doing something illicit. Then I'd have to explain that I was in an open marriage, etc. I felt like they were looking down on me because I didn't fit in with their standard of 'norm.'... They asked why I wanted the tests done every year so I figured I'd just tell them the truth. I wasn't ashamed of what I was doing. In a way, it felt really good to just be honest and not feel like I needed to hide it. But I also felt like I was being judged. They didn't say anything back to make me think that. But the fact that they asked at all is what upset me. What if I had a husband who cheated on me and I wanted to be tested for that? That's no more their business than the fact that I had an open marriage. (Lorna)

Marriage was described as a barrier to good sexual health care due to the implication that marital status meant low risk behavior. For Faith, disclosing her non-monogamous status is even more important because of the fact that she is married. She feels that her sexual health care provider would be more likely to write off symptoms of an STI as a yeast or urinary tract infection because of her marital status and the assumption of monogamy that it implies. In order to feel that her sexual health care provider is going to be as alert to possible, Faith not only discloses her non-monogamous status but prescreens for offices that indicate they understand how her non-monogamy will impact their diagnostic process:

Because they look at me and I'm, you know, a middle class, white female who's legally married, I look like I'm low risk. But I know I'm not. And they have to know that, too, if they're going to provide me with good health care.

It's not only STI requests from non-monogamous married women that act as flags for non-normative behaviors. Birth control requests from within married couples can also act as indicators of non-monogamy. Inara, a 30 year old married woman with small children at home, describes the health care interactions that took place after her husband underwent a vasectomy at the family practice office that tends to both her, her spouse, and their children's medical needs. The reasons for her husband's vasectomy were repeatedly questioned by health care providers in the office due to the fact that Inara had a tubal ligation after the birth of her and her husband's second child. Despite explaining directly to multiple providers within the office their joint decision to have a vasectomy as an added layer of security after having two medically fragile children, Inara still experiences what she views as suspicious and repeated questioning as to her husband's motivations for this medical procedure. Here she describes one of her interactions with the doctor that performed her husband's vasectomy:

... there's this pause, and he looks at my son, and he goes "He's your last child, right?" And I'm like "Yes, you know god willing." And he goes "I was...you, you had a tubal when he was born, didn't you?" And I was like "I did, yeah." And he goes "It seems odd, this many years after that, that his father would have a sterilization procedure as well."

In another instance, an office nurse suggests "confidential" STI testing as an add-on to her regular blood work, something that hadn't been offered during any visit prior to the vasectomy.

And then there's the pause, looks at the two sets of paperwork, mine and my husbands, and then asks me if I want to have an STI screen as well. And I can't tell if it's, it definitely feels like 'This looks like he's up to no good.'...She goes “You could, you could do that, too, while you're, I mean it's like one other vial of blood, if you want to come in and do that while you are doing this. And that's, that's totally confidential, if you wanted to do that.” And I was like “I know he had it, it was a discussion he had. He did this, he came home and I made him soup.”

Most notably, Inara mentions the pamphlets send home with her significant other after he was the one to take her children to one of their multiple checkups at this family health care office:

... they send home pamphlets on how vasectomies function and on tubal ligation and on STIs when my other significant other took the kids to a doctor appointment. He took the kids to the appointment, and they sent back paperwork with him, for us to read... he's well aware. He thinks this whole thing is hysterical...it's probably been 30 visits [during a 6 month period, counting all family members office visits], and out of them half of them at least have had this moment of “So....why this is the thing?”

CHAPTER 7: DISCUSSION

Present in the participants' interviews was a paternalistic view of women's health – either brought to or inculcated in health care providers by the medical institutions in which they receive training and perform their work – that does not see women's agency as a valid part of their health care experiences. Medicine is an institution of social control, and acts as an arm of the patriarchy to police the bodies and sexuality of women (Morgan 1998). That policing becomes stricter as they rise in class level.

Women who actively chose non-monogamy, particularly those that did so without outside forces such as economic necessity to act as a rationale for their decision making, violated both gendered risk-taking norms and norms of proper feminine sexual behavior (Sheff 2005).

Women who choose to be non-monogamous are seen as engaging in what Laurendeau (2008) calls voluntary risk behaviors. Risk itself is a gendered concept. Speaking of gendered risk, Robertson (2006), in his research on the gendered health views of men, said “‘Risk’ in this sense is not about probability, the chance of an event happening, but is integrated, woven, into the gendered fabric of society's expectations” (P. 181). They may not necessarily view their actions as risk taking, and indeed may outline detailed safety protocols and the enhanced communication of consensual non-monogamy as providing greater safety than monogamous relationships.

However, since non-monogamy is viewed as inherently more risky than monogamy, they are still seen by society as engaging in a voluntary risk taking behavior. Risk taking in women, especially women that are also mothers, is viewed as particularly irresponsible. Donnelly (2004) uses the differing media responses to the deaths of two high profile mountaineers to illustrate this

point. While both of the individuals in question left behind minor children, only the woman's death resulted in media outlets describing her choice to engage in a risky activity as abandoning her children. Ideas of what constitutes responsible behavior are gendered; motherhood is central to ideas of femininity, and non-monogamy is seen as violating the requirements of "responsible" motherhood (Palmer 2004). Sexuality and motherhood are generally seen as mutually exclusive; because of this, women that are non-monogamous after having children engage in a trifecta of norm violation – those of compulsory monogamy, gendered risk taking, and "good" maternal behavior (Friedman, Weinberg, and Pines 1998; Montemurro and Siefken 2012). Female non-monogamy is a violation of both patriarchal control of women's bodies and a rejection of their expected societal duty to avoid risk as either current or future mothers. Women's bodies are viewed as both the property of men, and as the property of society as whole (Kipnis 2008). Female non-monogamy is seen as using property that does not belong to them in a way that risks community resources and for reasons that are both invalid and deviant – those of their own personal sexual pleasure.

The view of voluntary risk taking by women can be ameliorated by removing some of the "voluntary" aspect associated with the risk taking activity. When health care providers perceived sex work to be for survival reasons, as opposed to occurring under circumstances where it is seen as a more deliberate choice, the "voluntary" aspect of the perceived risk taking was diminished. As Pamela says: "Well then they can feel SORRY for you... Or, or put you in some, they can relate to how to deal with that in their head." In discussing her voluntary participation in sex work, despite having other career options, Pamela shared the following story:

I was walking down the street in full latex (laughter), handing out these flyers, you know, about what we were doing. And this woman..., she looks it over and she realizes what it is, and she looks at me and she goes "But, but, wouldn't you do something different if you could?" And I said to her "Well, how is it that you think I can't do something different? Because I'll have you know that I am very qualified to do any of a number of different vocations, and very capable and able, and yet I choose to do what I do because I really like it." And her brain was, she was just sitting there like with her mouth dropped open like 'Aaahhhha' [croaking noise]. It's like, you know, that really blew my mind. I was like wow, she really thinks, had a construct that there's no way anybody would ever WANT to do this!

By occupying a position as a middle class, educated, sex worker, Pamela's participation in non-monogamy is both more voluntary and more deviant. Women that engage in "serial monogamy" – one sexual partner at a time but in sequence – may have as many or more sexual partners when compared to polyamorous women. However, because this can be seen an involuntary circumstance during their attempt at monogamous partnering, serially monogamous women are not seen as engaging in the "voluntary" part of voluntary risk taking. Deliberately choosing to be non-monogamous, either for economic or relationship reasons, is declaring a voluntary participation in a risk taking activity.

Maintaining "health" and avoiding health risks is viewed as morally responsible behavior. Men contend with the dual messages of avoiding health risks being morally responsible behavior, yet seeking out risk taking activities being a necessary part of their masculine identity (Peterson and Lupton 1996). Because of this dual messaging male risk taking

is more readily excused and does not conflict with their gender identity. Crawford (1994) argues that maintaining “health” is also part of maintaining middle class identity. As with any identity construction, defining the ‘other’ – in this case the “unhealthy” or “sexually deviant” – acts to reaffirm the boundaries of identity.

For women in this study class, both of health care provider and of participant, impacted access to sexual health care. While an increase in class is generally associated with an increase in access to health care, for non-monogamous women their personal increase in class resulted in having their stigmatized non-monogamous identity exacerbated. The performance of gender is inextricably linked with the performance of class and race (West and Fenstermaker 1995). Bettie (2000) argued that the versions of femininity performed by women are structured and constrained by their social class. By violating the gendered class norms expected of women at their socioeconomic level, the participants failed in performance of both their gender and class. Middle class women that chose to access health care facilities commensurate with their class status often felt their status as non-monogamous was more stigmatized by providers at these facilities. The policing of class norms may be more important to those that are most privileged by them. Instead of sirens, the sound of the police in middle class health care facilities is that of lectures and health care denial. Marriage acted as a barrier to non-judgmental health care here, both by reinforcing the assumption of compulsory monogamy and by standing in contrast to health care requests that would seem to indicate the violation of monogamous behavior expectations within marriage. Providers seen as catering to lower class socioeconomic groups were viewed as having greater acceptance of non-normative behavior in general and non-monogamy in particular. Non-monogamous women in this study, both sex workers and

polyamorous, utilized public and non-profit health care facilities in order to avoid being seen as outside the norm and to reduce their experiences of stigma during sexual health care visits.

Felt stigma due to discreditable identity constrained participants' health care choices, but was not enough to prevent them from accessing STI testing. Enacted stigma occurred in response to both disclosures of discredited identity and in the presence of activities that served as "flags" for discredited identity. Providers' behaviors in response to participant disclosure served to police women's bodily autonomy under the guise of risk prevention. Stigma management strategies reflected participants' awareness of class divisions in women's sexuality.

Although some differences between sex workers and polyamorous women in perception of sexual health care were expected, the accounts of these women shared more commonalities than differences. If not directly stating that they were a sex worker or polyamorous, participant accounts were indistinguishable from one another. Lay definitions create a dichotomy between the experiences of legal and illegal non-monogamy. However, the experiences of these women were more similar than disparate, and emphasize the common experiences of all non-monogamous women rather than a false distinction based upon legality. Whore stigma, and compulsory monogamy, colored the experiences of both groups of women in similar ways and to a larger degree than did their position as occupationally or relationally non-monogamous.

Limitations

As these interviews were conducted anonymously, verification of age and race for all participants was not possible. Women that chose to participate in this study may be inherently different than women that declined to participate. Recruiting from online sites limited participants to those that used those sites, meaning mostly out or activist-minded women. The

sensitive nature of sexual health may influence what participants chose to share during interviews, although the anonymity offered by conducting interviews over the phone helped to address this. Length of time between last sexual health care visit and interview may have influenced the clarity of participants' recollections. The lack of racial diversity in the participant group did not provide sufficient insight into the experiences of non-monogamous women of color. Future research should take these limitations into account when expanding the scope of this study.

CHAPTER 8: CONCLUSION

Throughout interviews, respondents had many suggestions about how to improve their experience with sexual health care providers. These suggestions fell into three group types. First, women desired more resources from their own communities, such as a list of healthcare providers friendly to alternative lifestyles and non-monogamous arrangements. Second, women suggested provider-based changes to the current system, such as sensitivity training and a modification of existing intake and screening questionnaires to be more inclusive and sex positive. Third, respondents thought it might even be best to promote a new class of health care provider explicitly for the needs of sex workers and non-monogamous individuals in general, educated by the community and specializing in the kinds of services needed by non-monogamous women.

Access to health care services, regardless of occupational status, is critical for all individuals. Increasing health care provider awareness of the impact that stigma has on access to care is critical to improving access to non-judgmental care for all women, non-monogamous and otherwise. Hearing what this stigma looks and feels like from the viewpoint of non-monogamous women provides an important part of that awareness.

APPENDIX A: INTERVIEW QUESTION SCHEDULE

Question Outline for Qualitative Interviews:

- 1) "Where do you go to get your health care needs met?"
- 2) "Can you tell me about your last visit to a sexual health care facility?"
- 3) "Can you tell me about what factors impact your selection of health care providers?"
- 4) "Are you able to disclose your work to your health care providers?"
- 5) "Can you tell me about any memorable experiences that took place during a sexual health care visit?"
- 6) "Do you have any concerns about your experiences while visiting health care professionals?"

Demographics:

- 1) "What is your age?"
- 2) "What is your race?"
- 3) "What is the highest level of education you have completed?"
- 4) "Do you rent or own your living space?"
- 5) "Have you ever been homeless?"
- 6) "Do you work for an agency, do you have a booking agent, or are you Independent?"
- 7) "Have you ever worked on the street?"
- 8) "In what settings do you normally work? I'm not asking where you work, but in what types of places"
- 9) "How many years have you been in this business?"
- 10) "Did you enter into this business voluntarily? What were your main motivating factors for entering this business?"
- 11) "How do you advertise for clients?"

APPENDIX B: IRB APPROVAL LETTER



University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Approval of Human Research

From: **UCF Institutional Review Board #1**
FWA00000351, IRB00001138

To: **Rachael M. McCrosky**

Date: **December 01, 2014**

Dear Researcher:

On 12/1/2014, the IRB approved the following human participant research until 11/30/2015 inclusive:

Type of Review: IRB Continuing Review Application Form
Project Title: A Qualitative Study of Indoor Escort/Companionship Workers' Experiences During Health Care Visits Focused on Sexual Health
Investigator: Rachael M. McCrosky
IRB Number: SBE-13-09765
Funding Agency:
Grant Title:
Research ID: N/A

The scientific merit of the research was considered during the IRB review. The Continuing Review Application must be submitted 30 days prior to the expiration date for studies that were previously expedited, and 60 days prior to the expiration date for research that was previously reviewed at a convened meeting. Do not make changes to the study (i.e., protocol, methodology, consent form, personnel, site, etc.) before obtaining IRB approval. A Modification Form **cannot** be used to extend the approval period of a study. All forms may be completed and submitted online at <https://iris.research.ucf.edu>.


If continuing review approval is not granted before the expiration date of 11/30/2015, approval of this research expires on that date. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

Use of the approved, stamped consent document(s) is required. The new form supersedes all previous versions, which are now invalid for further use. Only approved investigators (or other approved key study personnel) may solicit consent for research participation. Participants or their representatives must receive a copy of the consent form(s).

All data, including signed consent forms if applicable, must be retained and secured per protocol for a minimum of five years (six if HIPAA applies) past the completion of this research. Any links to the identification of participants should be maintained and secured per protocol. Additional requirements may be imposed by your funding agency, your department, or other entities. Access to data is limited to authorized individuals listed as key study personnel.

In the conduct of this research, you are responsible to follow the requirements of the [Investigator Manual](#).

On behalf of Sophia Dziegielewski, Ph.D., L.C.S.W., UCF IRB Chair, this letter is signed by:

A handwritten signature in black ink that reads "Joanne Muratori". The signature is written in a cursive style with a small dot above the letter 'i' in "Muratori".

Signature applied by Joanne Muratori on 12/01/2014 10:07:16 AM EST

IRB Coordinator

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