

Manitoban Consensual Non-monogamous Couples' Conciliation of their Parenting Role and
their Sexual Lifestyle during the Transition to Parenthood

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List of Acronyms

CNMC:	Consensual Non-monogamous Couple
CNMPC:	Consensual Non-monogamous Parenting Couple
EMERJ:	Expanding the Movement for Empowerment and Reproductive Justice Lens
HIV:	Human Immunodeficiency Virus
HSHR:	Health Sexuality and Harm Reduction
LGBTQ*:	Lesbian, Gay, Bisexual, Transsexual, Gay, Queer etc.
PAIR	Personal Assessment of Intimacy in Relationships
PHAC:	Public Health Agency of Canada
PRSRCS	Parenting-Role-Sexual-Role Conciliation Scale
STI:	Sexually Transmitted Infections
STBBI:	Sexually Transmitted and Blood Borne Infections
VDRL:	Venereal Disease Research Laboratory
WASH:	World Association for Sexual health
WRHA:	Winnipeg Regional Health Authority
WHO:	World Health Organization

Definitions of Terms

Consensual non-monogamous:	a couple wherein a consensual choice is made to not limit sexual relations to their partner (Conley, Moors, Matsick, & Ziegler, 2013).
Heteromononormativity:	the normalisation of heterosexuality in the context of a monogamous relationship as the only natural expression of sexuality (Barker & Langdrige, 2010; Conley et al., 2013).
Heteronormative:	the normalisation of heterosexuality as the only natural expression of sexuality (Merriam-Webster, n.d.).
Heterosexuality:	when a man and woman are attracted to one another (Blank, 2012).
Mononormative:	the normalisation of monogamy as the only natural expression of sexuality (Barker & Langdrige, 2010; Conley et al., 2013).
Open relationships:	a relationship wherein one partner accepts that the other partner has extra-dyadic sexual activities and relations (Fernandes, 2009).
Polyamory:	relationships wherein partners mutually agree to have extra dyadic sexual and emotional intimacy with more than one partner (Barker & Langdrige, 2010).
Polyfamily:	a family wherein the parenting partners or a combination of parenting partners choose polyamory as a lifestyle (Pallota-Chiarolli, Haydon & Hunter, 2013).
Swingers:	swingers with their partners' permission choose to have extra-dyadic sexual relations outside of their primary relationship limiting the degree of emotional involvement (Fernandes, 2009; Jenks, 1998).

Summary of the Thesis

Background: Consensual non-monogamous couples (CNMCs) are viewed less favourably than their heteromononormative counterparts by the general population and by healthcare providers. Research indicates that they are less likely to seek health care and are at greater risk for STIs and HIV. This stigma and judgment perceived by CNMCs can be even further compounded when these couples choose to have a child. No study to date has looked at consensual non-monogamous parenting couples (CNMPCs) during the transition to parenthood. The aim of the present study was to explore Manitoban CNMCs' perceptions of the conciliation between their parenting role and their sexual lifestyle during the transition to parenthood.

Methodology: This mixed methods descriptive, exploratory study used a triangulation design-convergence model. Six participants identifying as CNMCs during the transition to parenthood were interviewed using a semi-structured interview guide as well as completing an online questionnaire.

Results: The participants in this sample experienced challenges in regard to their transition to parenthood as many other parents do, yet this transition was more harmonious for some participants compared to others. Consensual non-monogamy (CNM) was a sexual lifestyle chosen either before or during this transition. However, the lifestyle did stop during conception and pregnancy, and was resumed several months after childbirth. Relationship breakdown may occur, but not necessarily associated with CNM. The conciliation of parenting and sexual roles is facilitated when communication and intimacy are present between partners. Participants emphasized the importance of family before their chosen sexual lifestyle. The relationship with health care providers is critical for participants of CNM as it impacts how they seek health care or disclose their lifestyle. This is more important during the transition to parenthood as more

challenges can be present. Three phases that CNMCs pass through were also identified, contemplation, acting and incorporation, to integrate CNM as a lifestyle.

Discussion: These findings permitted a closer look at the conciliation of the parenting role and the sexual lifestyle of CNMPCs during their transition to parenthood. These findings demonstrated not only how CNMPCs were similar and different from participants in other studies, but also highlighted how they were uniquely distinct. This distinction appears to stem from a certain resilience gained from the three phases of the incorporation of CNM as a lifestyle that appears to buffer these couples in situations of stress. A new proposed model, *CNMPCs' Model of Resilience during the Incorporation of CNM as a Lifestyle While Parenting*, is suggested. There is a need for more psychosexual education for perinatal nurses in regard to sexuality minorities such as CNMPCs in the context of the transition to parenthood.

Résumé de la thèse

Contexte : Les couples consensuels non monogames (CNMCs) sont perçus moins favorablement que leurs homologues hétéro-mononormatifs par la population en général et par les prestataires de soins de santé. Les recherches indiquent qu'ils sont moins susceptibles de demander des soins de santé et démontrent un plus grand risque de contracter une *ITSS* et le *VIH*. Cette stigmatisation et ce jugement perçus par les *CNMC* peuvent être encore aggravés lorsque ces couples choisissent d'avoir un enfant. À ce jour, aucune étude n'a examiné la vie des couples parentaux consensuels non-monogames (*CNMPC*) lors de la transition à la parentalité. Le but de la présente étude est donc d'explorer les perceptions des *CNMC* manitobains quant à la conciliation entre leur rôle de parent et leur style sexuel au cours de la transition à la parentalité.

Méthodologie: Une étude exploratoire descriptive avec méthodes mixtes a été développée, utilisant un modèle de convergence conception-triangulation. Six participants s'étant auto-identifiés comme membres d'une relation non monogame consensuelle lors de la transition à la parentalité ont été interrogés à l'aide d'un guide d'entrevue semi-structurée ainsi que par le biais d'un questionnaire en ligne.

Résultats: Les participants de cet échantillon ont connu des difficultés en ce qui concerne leur transition vers la parentalité, à l'instar de nombreux parents. Cette transition était plus harmonieuse pour certains participants que pour d'autres. La non-monogamie consensuelle était un mode de vie sexuelle choisi avant ou pendant cette transition. Cependant, ce mode de vie a été suspendu pendant la conception et la grossesse, pour être repris plusieurs mois après l'accouchement. Une rupture de relation peut survenir, mais pas nécessairement associée au style de vie sexuelle. La conciliation des rôles parental et sexuel est facilitée lorsque la communication et l'intimité entre les partenaires sont présentes. Les participants ont souligné

l'importance de la famille avant le style de vie sexuelle choisie. La relation avec les prestataires de soins est essentielle pour les participants de la non-monogamie consensuelle, car elle influence la manière dont ils consultent pour leurs soins de santé ou divulguent leur mode de vie. Ceci est encore plus important pendant la transition à la parentalité, car davantage de défis peuvent alors être présents. Trois phases ont aussi été identifiées pour permettre l'intégration de la non-monogamie consensuelle comme style de vie : contemplation, agir et intégration.

Discussion: Cette étude a permis d'explorer plus en profondeur la conciliation du rôle parental et du rôle sexuel chez les parents non-monogames consensuels lors de la transition à la parentalité. Les résultats ont démontré que les participants sont à la fois similaires et différents de leur homologues hétéro-mononormatifs. Plus particulièrement, ces parents sont uniques à cause de la résilience qu'ils ont développée lors de l'intégration de la non-monogamie consensuelle en tant que style de vie. Cette résilience semble avoir aidée ces couples lors de la transition à la parentalité. Un nouveau modèle, *CNMPCs' Model of Resilience during the Incorporation of CNM as a Lifestyle While Parenting*, est proposé. Les résultats de cette étude mettent l'emphase sur le besoin de développer davantage d'éducation psychosexuelle pour les infirmières œuvrant dans le contexte périnatal.

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Introduction

There is a dearth of research in regard to consensual non-monogamous couples (CNMCs), even less with these couples who are parents. They appear to be receiving a different level of care when accessing the health care system (Barker & Langdrige, 2010), even going as far as to not disclosing their lifestyle or sexual style to health care professionals (O'Byrne & Watts, 2011), including nurses. Consequently, they are at greater risk for contracting sexually transmitted infections (STIs) and the human immunodeficiency virus (HIV) (O'Byrne & Watts, 2011). This is of greater concern during the transition to parenthood because these same infections can be transmitted to their children during pregnancy, birthing, and breastfeeding. Thus, not only is the health of the parents involved, but also that of their unborn and born children. The chasm which already exists between these couples and health care professionals increases during the transition to parenthood. For example, the situation is compounded by nurses who are not well versed with sexuality, are not comfortable discussing it, are not trained for it, and do not know how to respond to the needs of consensual non-monogamous parenting couples (CNMPCs) and how to intervene in clinical situations involving them and their children.

The aim of the present study was to explore Manitoban CNMCs' perceptions of the conciliation between their parenting role and their sexual style during the transition to parenthood. This study was conducted on 'consensual non-monogamous parenting couples' (CNMPCs). CNMPCs include swingers and polyamorists who make up the greater majority of these couples. According to Barker and Langdrige (2010), participants in previous studies were asked to self-identify as either swingers or polyamorous, however, this may limit the number of potential study participants. It is for this reason that the terms 'CNMCs' and 'CNMPCs' will be found throughout the thesis.

The first chapter is divided into seven sections: the clinical context; the statistical evidence; the empirical evidence; the conceptual framework; the proposed solution; the epistemological position; and finally, the purpose of the study and research questions.

The second chapter is separated into ten sections. This literature review starts by reviewing the literature search procedures followed by certain definitions including reproductive justice, sexuality, sex, gender, sexual health, border sexuality, heterosexuality, heteronormativity, and mononormativity. It also presents the alternative forms of consensual non-monogamous couples including open relationships, swingers and polyamorous couples (only the two latter types of coupleships are presented in this study as they are the bulk of CNMCs). The section pertaining to the transition to parenthood explains what this transition is as well as delving into the role changes, the quality of the conjugal relationship and its associated sexuality. This is followed by a section on the dearth of non-monogamy research which includes the challenges faced by swingers and polyfamilies in today's society followed by research with CNMPCs. The next section presents nurses and human sexuality, the importance of being well versed on the subject, health risks involved with non-monogamy as well as nurses and their work with sexual minorities. This chapter comes to a close with the conceptual framework which combines the Reproductive Justice Framework with Cowan and Cowan's Ecological Model of the Transition to Parenthood, and a summary of the chapter.

The third chapter encompasses the methodological procedures. The research type and design are presented followed by the setting, the population and the sample size. The recruitment methods are then explained. This is followed by an overview of the data collection methods, the study procedures, and data analyses that were used in this research study. The ethical considerations are highlighted at the end followed by a summary for the chapter.

The fourth chapter presents the results from the qualitative and quantitative data that were collected for this study from a sample of six participants. The participants' profile and their

beliefs are presented at the beginning of the chapter. The next section presents the qualitative data analysis that features five themes, 15 categories and 35 subcategories, that emerged from the qualitative data analysis. The five identified categories are the following: perceptions of CNMPCs regarding their transition to parenthood, communication and intimacy during transition to parenthood, relationship evolution and sexual style during the transition to parenthood, conciliation of roles during this transition, and relationship with health care providers.

The final chapter consists of a discussion of the research findings. A comparison of the CNMPCs in this study with previously published studies is first presented. Secondly, the findings of CNMPCs' perceptions of the transition to parenthood are discussed. This is followed by a discussion related to communication and intimacy during the transition to parenthood and highlighting the resilience demonstrated by the participants in the present study. The findings related to parenting with an alternative sexual style are also presented. In this section, the phases of the incorporation of CNM as a lifestyle are discussed and compared with previous models as well as how parenting while being CNMPCs differ. In the following section, the findings related to the conciliation of the parenting role and the sexual lifestyle are discussed. In the next section, the findings related to CNMPCs' experiences with health care professionals are presented. This is followed by a section that presents a reflection on the conceptual framework used for the present study, and the presentation of a new proposed model, *CNMPCs' Model of Resilience during the Incorporation of CNM as a Lifestyle While Parenting*. The implications of the present research related to nursing education, nursing practice, and nursing research are presented. The final section of this chapter presents the strengths and limitations of the present study followed by a conclusion.

Chapter 1 - Research Problem

This chapter presents the clinical context in which the research problem was identified, an overview of the statistical evidence and that of the empirical evidence, the conceptual framework, the proposed solution, the epistemological position, the purpose of the project, and the research questions.

1.1 Clinical Context

Two clinical situations occurred when I was working as a public health nurse with consensual non-monogamous couples (CNMCs). CNMCs are defined as couples wherein a consensual choice is made to not limit sexual relations to their partner (Conley et al., 2013). CNMCs can be included in what is known as a border sexuality. A border sexuality is one that goes beyond heterosexual monogamous normality (Pallota-Chiarolli, 2010). The following two situations made me aware of the need to increase my knowledge about this particular segment of the population, as well as to seek further training in human sexuality.

The first situation occurred during a postnatal home visit in 2010 with a polyfamily in which two couples were living together as a parenting unit. A polyfamily is defined as a family wherein the parenting partners or a combination of parenting partners choose polyamory as a lifestyle (Pallota-Chiarolli, 2010). The biological father was part of one couple while the biological mother was part of the other one. During this visit, the members of this polyfamily shared with me the very negative experience that they had in the hospital. The perinatal health care professionals at the hospital did not understand their lifestyle, allowing only one of the couples in the room during labor and birth due to the hospital's very restrictive definition of family.

The second situation occurred during the summer of 2011 when there was an increase in syphilis in a certain region of Manitoba. Over time, through clinical observations, it emerged

that this outbreak may have been linked to an alternative sexual style called swinging, which is associated with what is known as key parties. These parties are characterized by high risk sexual behaviours, alcohol and substance use. Prior to this incident, clients living this alternative sexual style did not come to health care agencies for sexually transmitted infections (STI) testing nor did they seek medical care due to perceived judgment from healthcare providers. To remedy this problem, and to increase the use of the health care system, public health nurses in this particular region of Manitoba were medically delegated to screen, test and administer medications to treat STIs in consultation with the Medical Officer of Health. Of particular concern during this outbreak was the age of those affected, all of whom were at the reproductive phase of their lives.

In both of these situations, it would appear that the CNMCs had a difficult time during their encounters with both the health care professionals and the health care system. The CNMCs in these situations felt like they were being judged by health care providers for a conscious choice they had made with their partners, which led them to either not divulge their sexual practices or seek health care altogether. The nurses and other health care professionals also demonstrated a lack of training in human sexuality, especially in sexual health in regard to alternative sexual styles, including the segment of the population who are swingers or polyamorous couples.

To better understand this segment of the population, a clinical placement in the master's nursing course NSG5610 was undertaken from January 4, 2015 to April 10, 2015. This clinical placement was essential as it laid the groundwork for the present study. One of the clinical placement objectives was to identify and describe the various hangouts and venues frequented by CNMCs. Over 16 different events and venues were identified where CNMCs meet other likeminded people. Only general observations and descriptions were possible to be obtained;

otherwise, the Research and Ethics Board of the University of Ottawa would have to be consulted and permission obtained from either event organisers or participants themselves for more data to be collected. Unfortunately, events put on by the various swingers clubs in Manitoba were not included in the observations to uphold their need for discretion. However, a list of contacts or key informants was created during the clinical placement in order to be able to connect with them in the future for research purposes.

1.2 Statistical Evidence

What is known about Canadian families? In 2016, there was a total of 9,840,730 families in Canada, 67.9 % of which were composed of married couples with or without children, 14.2% were composed of lone parent families, and 17.8% were composed of common-law partners with or without children (Statistics Canada, 2016b). Manitoba has seen one of the largest population growths in Canada between 2011 and 2014 (Canadian Broadcasting Corporation, 2015). This growth can be explained by immigration and a very high birth rate. This high birth rate is largely due to the fact that Manitoba, along with the other Prairie Provinces, has one of the youngest populations in Canada (CBC, 2015). Manitoba's birth rate was 1847 births per 1000, the country's second highest birthrate. The highest fertility rates are amongst women 30 to 34 years of age (Winnipeg Free Press, 2018).

In 2005, the Supreme Court of Canada legalized swingers clubs, reinforcing that what happens in the bedroom is of no concern to the courts (R v. Labaye, 2005). This judgment guaranteed that consenting adults were allowed sexual freedom as never seen before. There are currently no statistics in regard to what percentage of swingers are married and have children, however, it would appear that CNMCs (open relationships, swingers and polyamorous couples) compose approximately 4% of the population of the United States (Matsick, Conley,

Ziegler, Moors, & Rubin, 2014), which is very similar to the percentage of the Lesbian, Gay, Bisexual, Transexual, Queer (LGBTQ) community in this same country (Matsick et al., 2014).

However, this sexual freedom can potentially come at a certain cost, especially when considering that swingers may be at increased risk for STIs such as chlamydia, gonorrhea and syphilis (O'Byrne & Watts, 2011). Also, swingers and polyamorous people do not tend to seek out health care on a regular basis, particularly for sexual health concerns (Barker & Langdrige, 2010; O'Byrne & Watts, 2011). This can affect not only the people involved, but also their reproductive capacity and potential offspring, as the majority of swingers are of reproductive age (Jenks, 2014). Some STIs, if not treated adequately, can lead to consequences such as infertility, infections, miscarriage, stillbirth and harm to the fetus (Center for Disease Control, 2016). Indeed, the health of these Canadian families could be affected: parents who are swingers or polyamorous may contract STIs and HIV requiring health care services, the health of their unborn and born children could be potentially endangered, and the parents' ability to care for their children may be compromised (Miller & Murray, 1999).

CNMCs seem to be at greater risk for certain STIs such as chlamydia, gonorrhea, and syphilis. There has been an increase in the reported numbers of chlamydia, gonorrhea and syphilis cases nation-wide up from 2005 until 2014 (49.2 % increase for chlamydia, 61.3% increase for gonorrhea, and 95% increase for syphilis) (Public Health Agency of Canada, 2017). Manitoba has amongst the highest rates of chlamydia and gonorrhea in the country. The national rate for chlamydia in 2014 was 307.4 per 100 000 while the Manitoba rate was 490.9 per 100 000 (PHAC, 2017). For gonorrhea, the national rate in 2014 was 45.8 per 100 000 while the Manitoba rate was 86.4 per 100 000 (PHAC, 2017). Lastly, the national rate for syphilis in 2011 was 6.6 in 100 000 while the Manitoba rate was 7.8 in 100 000 (PHAC, 2017). There was also one reported case of congenital syphilis in Canada that same year.

Chlamydia and gonorrhoea mostly affect 15 to 24 years old, while syphilis tends to affect an older population, between the ages of 20 and 39 (PHAC, 2017). Across the country, most of the syphilis cases have been seen amongst men who have sex with men; however in Manitoba, there appears to be more women affected than in any other provinces and territories (Froese, 2018). Winnipeg has experienced a recent spike in syphilis cases in the first 6 months of 2018 (Froese, 2018). Of the cases noted, the majority has been amongst heterosexual men and women living in the Point Douglas and Downtown areas of Winnipeg. This has also led to having newborns diagnosed with congenital syphilis for the first time in the past 50 years (Froese, 2018). The previous outbreak in 2016 appeared to be greater among men who have sex with men as well as 100 reported cases of infectious syphilis in Manitoba (WRHA, 2016a). This would be of less concern for the swinging population in Manitoba as male homosexual contact is frowned upon. However, in the polyamorous community where a large majority identify as both polyamorous and bisexual, this could pose certain concerns as the targeted interventions aimed more towards men who have sex with men (WRHA, 2016a) may not necessarily apply or reach members of the polyamorous community. The WRHA has also noticed an increase in syphilis among the female population. Of particular concern is that currently, one in five cases of syphilis has been diagnosed among pregnant women in Manitoba, with one case of congenital syphilis (WRHA, 2016a). Women who contract syphilis before or during pregnancy have a greater chance of developing complications during pregnancy and their fetuses having birth defects (blindness, deafness) as well as contracting congenital syphilis. An even greater risk for women who choose to remain consensually non-monogamous during pregnancy as currently is the situation in Manitoba, these pregnant women are being screened for the Venereal Disease Research Laboratory (VDRL), HIV and other STIs only at the beginning of their pregnancy. This is of particular concern because people who are

infected with chlamydia, gonorrhea, and syphilis have an increased chance of HIV transmission (LeBlanc, 2013).

This statistical evidence supports the pressing need to find out more about couples who choose to be consensually non-monogamous especially during the transition to parenthood.

1.3 Overview of Empirical Evidence

There is a paucity of empirical evidence on CNMCs during the transition to parenthood. In this section, the transition to parenthood will first be briefly described followed by the research that has been conducted on CNMCs and the studies that have been conducted on nurses and sexuality. The empirical evidence presented here is in relation to these studies.

The transition to parenthood occurs from the moment a couple decides to have a child or when a child is conceived until he or she is two years of age (Cowan & Cowan, 2010). During this transition, multiple physical, psychological, emotional, social, and sexual changes occur in the new parents' relationship (Cowan & Cowan, 2000; de Pierrepont et al., 2016a, 2016b; Polomeno, 2000b; Rossi, 1989). Certain parents cope well during the transition to parenthood and are able to take on their various roles. Other parents have a more difficult time; if the new parents do not reconcile their various roles, breakdown of the family unit can occur (Polomeno, 2000b).

A few studies have been conducted on CNMCs and their sexual practices. The purpose of the Fernandes and Gaither study (2009) was to "gather information about the sexual activities of swingers, to determine the prevalence of STDs and to evaluate the safe sex practices of swingers" (Fernandes, 2011, p. 15). After obtaining a convenience sample of 2844 participants, these authors used meta-data analysis to obtain their research findings. Fernandes and Gaither (2009) question whether multiple partners are the main factor explaining the increase in STI

risk. They noted that, although their sample had low rates of STIs, the incidence of STIs was slightly higher among the participants who engaged in unsafe sexual practices, and that women were more likely to acquire an STI during swinging than men (Fernandes & Gaither, 2009).

O'Byrne and Watts (2011) conducted an exploratory pilot study using direct observation and questionnaires with people attending one of the swingers clubs in the Ottawa region. A total of 72 individuals (32 men and 40 women) completed a survey during the 8 hours of observation done on 2 separate occasions. The purpose of their study was to get a better understanding of the subculture of swingers, the cultural sexual norms associated with that sexual style, and STI transmission. They identified 5 factors that influence the possibility of STI transmission:

“(1) the groups, heterogeneous distribution of sexual partners; (2) the group's elevation mean number of sexual partners per person (5); (3) the group-level rate of concurrent sexual partnerships (i.e., both primary and swinger partners); (4) the groups relatively high rates of unprotected sex (ranging from 15.5% for vaginal sex to 80.3% for oral sex); and (5) the group's low levels of health service utilisation for STI (fewer than half the participants underwent “routine” testing, even though nearly a fifth had previously been diagnosed with an STI)” (O'Byrne & Watts, 2011, p. 93).

The findings from the O'Byrne and Watts study are different from those presented in the Fernandes and Gaither study (2009), however, they corroborate those from the Dukers-Muijers, Niekamp, Brouwers and Hoebe study (2010), in which swingers were found to have higher rates of STIs even when compared with either men who have sex with men or prostitutes.

The research team of Matsick and collaborators have conducted one large scale study with a sample of 2777 participants from the general population, publishing articles using subsets

of the data analyses (Conley et al., 2013; Matsick et al., 2014). The purpose was to focus on societal attitudes in regards to CNMCs. They focused on the stigma associated with being consensually non-monogamous. They found that CNMCs, when compared to monogamous couples, whether same sex or otherwise, were viewed less favourably by the general population. Matsick et al. (2014) found that amongst CNMCs, swingers were viewed even less favourably than couples in open relationships or even polyamorous couples, and that the general population appears to have a difficult time disassociating the sexual act from love.

Pallota-Chiarroli (2010) is a specialist and a researcher with 'Border Families', who lie on the outskirts of what is considered heteronormative and mononormative. She conducted an initial exploration of American and Australian studies by using quantitative and qualitative data to gain insight into the experiences of children coming from polyfamilies and their experience with the education system (Pallota-Chiarroli, 2010). The number of participants and the exact methodological procedures in her writings are not very clear. The stigma associated with polyamorous couples may extend to their offspring, who may choose to conform to society by being the 'perfect student' and not disclose the information to the schooling system, or by being a voice for those outside of what society deems 'normal' (Pallota-Chiarroli, 2010). This marginalisation may also extend to the research being done with this population as well as the researchers themselves as they may have certain biases and prejudices.

Sova (2012) and Vaillancourt and Few-Demo (2014) explored disclosure and non-disclosure of the swinging lifestyle. In both cases, a cultural norm of non-disclosure was noted which extended to their children. Sova's (2012) findings, similar to those of Pallota-Chiaroli's (2010) findings, noted a hesitancy to disclose the swinging lifestyle related to its implication for their offspring. On the other hand, Vaillancourt and Few-Demo (2014) found that the non-disclosure was more in relation to the individual couple's need for privacy more than for secrecy.

In other words, not sharing the lifestyle was not to protect themselves per se, but because their sexual lives and activities were considered private.

Studies conducted on CNMCs such as swingers and polyamorous couples tend to use samples consisting of a homogenous group. Swingers and polyamorous couples are often white, upper-middle class, higher than average level of education, and between the ages of 30 to 40 (O'Byrne & Watts, 2011). Sheff (2011) brought up the possibility that participants who are already marginalized in some way, whether by race, gender or socioeconomically, may choose not to participate in research that would increase their stigma (Sheff & Hammers, 2011). No studies could be found that explore CNMCs during their transition to parenthood, or during the perinatal period that includes sexuality.

Studies have also been conducted with nurses and their comfort level in regard to discussing sexuality with their clients (Irwin, 2006; Magnan & Reynolds, 2006; Magnan, Reynolds, & Galvin, 2005). Irwin (2006) conducted a study that consisted in exploring nurses' need of training in psychosexual health. In response to the need found, he later studied the effects of psychosexual health training on British nurses in relation to their capabilities and comfort level in dealing with sexuality. The training provided increased nurses' comfort level with matters dealing with sexuality. Magnan, Reynolds and Galvin (2005) performed a descriptive correlational design pilot study among medical, surgical and oncology nurses ($N=148$) to explore barriers to addressing sexuality in nursing practice using the *Sexual Attitudes and Beliefs Survey*. Magnan and Reynolds (2006) conducted another descriptive correlational study with a convenience sample of nurses ($N=302$) examining barriers to addressing sexuality using the same questionnaire. The findings from these three studies reveal that nurses are not comfortable with the subject of sexuality nor are they comfortable discussing it with their clients. The identified barriers include the following: embarrassment with the subject matter such as a

low comfort level, feeling that they are intruding on patients' personal lives, not recognizing the importance of their clients' sexuality, the severity of the illness, feeling that it is not their role to discuss this subject matter, lack of confidence, thinking that their patients do not expect nurses to talk about sexuality, as well as lack of training during their initial programs (Irwin, 2006; Lamp, Alteneider & Lee, 2000; Magnan & Reynolds, 2006; Schuster, Unsain, & Goodwin, 1982).

If nurses are uncomfortable discussing sexuality in general, how are they to care for CNMCs and their sexual health? How are they to provide care to those couples who have children? To date, only one study has been conducted on healthcare providers' perceptions of CNMCs. In the Knapp study (1975), a third of the interviewed family life counsellors thought that consensually non-monogamous couples' have personality disorders and that more than 20% would attempt to convince their clients to return to being monogamous as a solution for their marital difficulties. Healthcare providers, especially nurses, need to not only be aware of alternative sexual styles and lifestyles, but also on how choosing a particular sexual style or lifestyle can affect different aspects of people's lives, particularly during the transition to parenthood. There is also a need to develop appropriate sexological interventions to answer to the needs of this population.

1.4 Proposed Solution

CNMCs appear to be viewed less favourably by the general population (Matsick et al., 2014; Moors, Matsick, Ziegler, Rubin, & Conley, 2013). People who are stigmatized for having a different sexual style potentially have a higher level of substance use, a higher risk in sexual behaviours as well as an increased risk for suicide (Matsick et al, 2014). It can be posited that when considering the multiple studies that have been conducted on nurses' attitudes and knowledge about sexuality, these couples may continue to encounter difficulties when seeking health care (Irwin, 2006; Lamp, Alteneider, & Lee, 2000; Magnan & Reynolds, 2006; Schuster,

Unsain, & Goodwin, 1982). These difficulties may be in part related to the barriers that nurses have identified to discussing this subject (Irwin, 2006; Magnan & Reynolds, 2006; Magnan, Reynolds, & Galvin, 2005). Nurses working in perinatal health appear however to have a higher comfort level discussing sexuality compared to other healthcare professionals (Kautz, Dickey, & Stevens, 1990; Magnan & Reynolds, 2006). This could in part be due to the nature of their work involving a need to be comfortable with the language related to reproduction. Yet, in one study (Propst, Phillips, & Andrew, 2001), the perinatal nurses reported lacking training in sexuality.

Training for nurses and other perinatal health care providers in human sexuality would appear to be a partial solution. This education can be provided prior to entering practice in entry level programs. Unfortunately, due to the parsimony of research done with CNMCs, and a lack of knowledge in regards to health care providers' perceptions of these couples, determining which education would be required can prove difficult. Further research would be needed for this aspect. This research could then complement what little is known and serve to increase the awareness of health care providers working in the areas where consensually non-monogamous couples are likely to come into contact with the health care system such as perinatal health, sexual health, and marital and family counselling, and know how to intervene with them.

More research needs to be done to assess health care providers' perceptions, more specifically, frontline nurses' perceptions towards CNMCs, especially in the areas of perinatal health, sexual counselling, and sexual health. Even more importantly, studies need to be conducted to gain a better understanding about consensually non-monogamous couples' experiences with the health care system and their reasons for not utilizing health care services. All encounters with health care providers are important, however during the transition to parenthood, CNMCs' non-disclosure of their sexual style can lead to negative consequences not only for themselves but also for their child(ren). No research to date has explored these

particular couples' perceptions about their entire experience of consultation with health care providers during the transition to parenthood.

1.5 Conceptual Framework

Society and its dominant culture influence most cultural norms and behaviors throughout the lifespan. For example, a person's body, including his or her sexuality, cannot be separated from cultural perceptions. In turn, these cultural perceptions influence how a person interacts with others sexually (Corbin, 2005).

The conceptual framework for the present study consists of the Reproductive Justice Framework (Expanding Movement for Reproductive Justice, 2008); the family part of this framework is enhanced by Cowan and Cowan's Ecological Model of the Transition to Parenthood (2000).

The Reproductive Justice Framework (EMERJ, 2008) is useful for the present study as it can help to identify issues that people may have in relation to their bodies, gender or sexuality. This framework is based on the concept of social justice which serves to eliminate any kind of power inequalities by abolishing reproductive oppression (Asian Communities for Reproductive Justice, n.d). It evolved from two previous frameworks, that of reproductive health and the other from reproductive rights. The Reproductive Justice Framework is particularly relevant for CNMCs because until recently, this population was not able to be publicly open up about their sexuality. Even today, their sexual style is viewed less favourably compared to others in society (Moors et al., 2013). Sheff and Hammers (2011) explained that in the case of polyamorists, it is the privilege of perversities, arguing that people who have the protection of race, class and education, feel that they can more fully express and be open about their sexual styles. Consequently, this better explains the reasoning behind the relatively homogenous groups that are made up of swingers and polyamorists. This Reproductive Justice Framework can help to

not only change the previously homogenous research samples that were used in studies dominated mostly by white middle-class researchers, but also by recruiting CNMCs from a variety of backgrounds and with different socio-economic and cultural characteristics. This framework also looks at family, health and safety, access and opportunity.

The family part of the Reproductive Justice Framework is enhanced by the addition of the Cowan and Cowan Ecological Model of the Transition to Parenthood (2000). In this study, the family subsystem of the conjugal relationship is being focused on. The couple during the transition to parenthood must deal with many simultaneous changes at different levels (physiological, psychological, emotional, relational, social), which can put stress and strain on their relationship. Intimacy and sexuality are the two dimensions the most affected during the transition to parenthood (Polomeno, 2013). The Cowan and Cowan model has five aspects to it, namely, the parenting experience, the couple's relationship, their extended family, connections with institutions such as hospitals, and the parent-child bond. All five aspects will be retained to guide the current study.

1.6 Epistemological Position

Critical social theory has its roots in emancipatory knowledge wherein through critical dialect, self-reflection and freedom from oppression can occur (Mill, Allen, & Morrow, 2001). According to Guba and Lincoln (1994), the goal of critical theory is to see things under a new light. In other words, to be able to recognize that what is seen as universally known may not in fact be as such. From an ontological standpoint, it is being able to understand that the historical realism that a person perceives grew from the political, cultural, economic, ethnic, and gender factors. From an epistemological position, it is not the product that is emphasized; rather, it is the transformative process combining reflection and action classified more as transactional and

subjective. From a methodological standpoint, the process of transformation comes from a dialectical process, a dialogue between research and active participant (Guba & Lincoln, 1994).

This perspective permits a better understanding of the context in which CNMCs situate themselves in regard to society as a whole, the 'wherein' (Pepin, Kerouac, & Ducharme, 2010). What is already known is that CNMCs do not fit into what society considers normal heteromononormativity, and that they are already seen less favourably than the general population. Consequently, these couples have a tendency to not seek health care compared to the general population. This epistemological position permits a closer look at the barriers that these couples encounter when seeking health care. In other words, this position would help nurses broaden their view of health, sexuality, and sexual health by considering the factors that influence non-monogamous couples' decisions to seek health care and interact with health care professionals. Nurses have the potential to be more understanding and caring towards a segment of society that is considered as an outlier. In the long run, by incorporating this position, there will hopefully be changes in regard to nursing education and human sexuality, and nurses' comfort in working with marginalised/stigmatised populations.

1.7 Purpose of Study and Research Questions

Many factors can affect a couple's adaptation to the transition to parenthood such as the quality of their relationship, their capacity to adapt to new roles as well as their intimacy, their vulnerability, and their sexuality (Cowan & Cowan, 2010; de Pierrepont & Polomeno, 2014; Polomeno, 2014). However, no research to date has been conducted on consensually non-monogamous couples during this transition.

The purpose of this study is to describe how Manitoban CNMCs reconcile their parenting role with their chosen sexual style during the transition to parenthood.

The following research questions have been elaborated to respond to the purpose of the study:

- 1) How do CNMCs living in the Winnipeg and surrounding areas compare in regards to sociodemographic, relational, professional and parenting characteristics to the other CNMCs already studied (qualitative and quantitative data)?
- 2) What are the perceptions of CNMPCs in regard to their transition to parenthood, their sexual style, the conciliation of their sexual and parenting roles, and their relationship with health care professionals (qualitative data)?
- 3) What are the perceptions of CNMPCs in regard to their parenting sense of competence, their emotional and sexual intimacies in their conjugal relationship, and their conciliation of the parenting role and the sexual role (quantitative data)?
- 4) What are the similarities and differences between the perceptions of CNMPCs in regard to their transition to parenthood, their sexual style, the conciliation of their sexual and parenting roles, and their relationship with health care professionals (qualitative data) with their perceptions in regard to their parenting sense of competence, their emotional and sexual intimacies in their conjugal relationship, and their conciliation of the parenting role and the sexual role (quantitative data)?

Chapter 2 – Literature Review

This chapter addresses the existing literature about CNMCs in their transition to parenthood. The literature search procedures are first presented. Next, the different concepts associated with reproductive justice are presented such as sexuality, sex, gender, sexual health, border sexuality, heterosexuality, heteronormativity and mononormativity. Next, sexuality as a human right is featured, followed by marriage, divorce and infidelity. Alternative forms of CNMCs will then be examined. The next sections cover the transition to parenthood as well as consensual non-monogamous research. The last three sections focus on nurses and sexuality, the conceptual framework which encompasses the Reproductive Justice Framework and the enhancement of the family by including Cowan and Cowan's Ecological Model of the Transition to Parenthood is presented, and a summary for this chapter.

2.1 Literature Search Procedures

To identify eligible pertinent literature resources, a literature search strategy was applied to the following electronic databases: CINAHL, Medline, PubMed, Embase and Proquest. Key words used to conduct searches were: *sexual partners**, *swinger*, *mate sharing*, *heterosexual*, *extra dyadic*, *comarital mate*, *nurses* AND "*human sexuality*", *transition to parenthood* and *polyamory**. Articles that had been found through this search strategy were then looked up in the Web of Science to obtain more articles. References were also manually referenced to obtain further articles, published reviews and manuscripts. Both French and English resources were retained. For the terms *swinger*, *mate sharing*, *extra dyadic*, *comarital mate* and *polyamory*, no year limit was placed as the eligible literature was limited. For the terms *transition to parenthood*, *human sexuality*, *heterosexual*, no articles were retained prior to the year 2000. The final number of articles, chapters, and books that were retained was 122.

2.2 Definitions

This section will define different concepts associated with reproductive justice such as sexuality, sex, gender, sexual health, border sexuality, heterosexuality, heteronormativity and mononormativity.

2.2.1 Definition of Reproductive Justice

Three frameworks representing reproductive health, reproductive rights and reproductive justice (Ross, n.d) have evolved combining women's empowerment, women's health, and oppression related to women's health issues. Reproductive health addresses inequalities in health services or service delivery. Reproductive rights focus on women's legal right to reproductive health services (Ross, n.d). On the other hand, *reproductive justice* combines social justice with reproductive rights (Ross, n.d), as presented in the following citation:

“Reproductive Justice exists when all people have the social, political and economic power and resources to make healthy decisions about our gender, bodies, sexuality and families for ourselves and our communities. Reproductive Justice aims to transform power inequities and create long-term systemic change, and therefore relies on the leadership of communities most impacted by reproductive oppression. The reproductive justice framework recognizes that all individuals are part of families and communities and that our strategies must lift up entire communities in order to support individuals” (Asian Community for Reproductive Justice, n.d., p. 1).

Reproductive justice includes the following rights: “(1) the right to have a child; (2) the right not to have a child; and (3) the right to parent the children we have, as well as control our birthing options such as midwifery” (Ross, n.d., p. 4). Reproductive justice concentrates on the

inequalities that take away these rights from women. In northern Canada, Sexual and *Reproductive Justice* is the term that is more widely used and can be defined as a concept that:

“embraces intersectionality and places an individual woman’s bodily rights within the wider context of systems (racism, colonization, globalization, etc.) and structures of power (economy, legal system etc.) that can limit her ability to have control over her body, define her gender and sexual identity, seek sexual pleasure and freely decide, if, when, and how she wants to have children” (Canadian Research Institute for the Advancement of Women, 2014, p. 1).

However, for the purpose of this thesis, the more general term of ‘reproductive justice’ will be retained as it is the term that is most frequently used in the literature.

2.2.2 Definitions of Sexuality, Sex, Gender, Sexual Health, and Border Sexuality

Sexuality will be first defined as it plays an important role in the quality and length of a conjugal relationship (Lawrance, 1994), especially in the context of heterosexual monogamy. The definition of *sexuality* as proposed by the World Health Organization and universally accepted by health care professionals is as follows:

“... a central aspect of being human throughout life [that] encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors” (WHO, 2010, p. 2).

Certain authors explain that sexuality is a social construct, and that the expression of sexuality varies, depending on the construct being created (Blank, 2012; Foucault, 1976; Gagnon & Simon, 2005; Lacqueur, 1990; Mathews-Grieco, 2005). A person's sexuality and the expression of this sexuality are therefore influenced by a myriad of factors including those presented in the WHO's definition of sexuality.

Another way of considering *sexuality* is as a sexual script which came to fruition with the cutting-edge research of Gagnon and Simon in 1973 (Simon and Gagnon, 1984). These researchers have gone beyond gender related normalities. Gagnon and Simon indicate that sexuality is a social construction. In their view, the construction of sexuality is a lifelong process influenced by a variety of factors or 'scripts', which:

"are a metaphor for conceptualizing behavior within social life. Most of social life most of the time must operate under the guidance of an operating syntax, much as language is a precondition for speech. For behavior to occur, something resembling scripting must occur on three distinct levels: cultural scenarios, interpersonal scripts, and intrapsychic scripts" (Gagnon & Simon, 1984, p. 53).

The majority of sexual scripts focus particularly on heterosexual interactions, with the man typically being the initiator of sexual activity, and the woman being on the receiving end (Gagnon & Simon 2005). Heterosexual scripts have had a great influence in sexual research. These heterosexual scripts, which are ingrained scripts in today's society, pose great difficulty when trying to disregard bias. This can cause a researcher to pose certain assumptions in regard to the roles played in relationships, including that within sexuality (Seal, O'Sullivan, & Ehkart as cited by Kimmel, 2007). Thus, the sexual act is no longer biologically determined by gender (Kimmel, 2007) or as some authors would say, considered beyond the heterosexual normality (Blank, 2012).

It is also important for healthcare professionals including nurses to know about the definitions of sex, gender and sexual health. Sex can be defined by biological characteristics (born male or female) (WHO, 2010), as opposed to *gender* which is more than the expression of a person's anatomical or biological gender (Lauretis, 1987). Gender, which is a social construct, is a representation of different institutional discourses such as family, religion, educational system, communication methods, medicine, and legislature. Other less obvious discourses that influence gender include language, art, literature, film and/or various theories (Lauretis, 1987). A person's gender and sexuality are both influenced by biological sex throughout the lifespan, both of which start in infancy and are in constant evolution. The WHO defines *sexual health* as so:

“a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence” (WHO, 2010, p. 1).

Healthcare providers need to gain an understanding on how individuals come to identify themselves, whether it be by their biological sex or by other means. Healthcare providers' own sexual scripts and values can influence the care they provide their clients. For example, if a health care's provider's view on sexuality is a more conservative one, he or she may have a difficult time engaging in a conversation with someone who falls into the category of a border sexuality. A border sexuality is one that goes beyond heterosexual monogamous normality (Pallota-Chiarolli, 2010)

2.2.3 Definitions of Heterosexuality, Heteronormativity, and Mononormativity

The definition of *heterosexuality* depends on the context. Simply put, *hetero*, when considering its Greek origins, implies that it involves two different beings (Blank, 2012). In today's society, it can be defined by a man and a woman being attracted to one another (Blank,

2012). Heterosexuality became the societal norm, at a very specific time in history: the term was created to normalize the alliance between a man and a woman, becoming the foundation for gender, which included a set of expected behaviours for each sex around 1896 (Blank, 2012; Foucault, 1973; Lacqueur, 1990). It would appear that both the terms 'homosexual' and 'heterosexual' came into existence not for scientific purposes but in a quasi-legal process, a way to differentiate more formally a person's sexual attraction (Blank, 2012). Heterosexuality became the foundation of society itself due to the usefulness of this term. The people who followed these new sets of societal conventions were afforded the most privacy and the least amount of stigmatization (Foucault, 1973). The term eventually became synonymous for 'sexually normal' (Blank, 2012).

The term *heteronormative*, first used in 1991 according to the Merriam-Webster dictionary, is "of, relating to, or based on the attitude that heterosexuality is the only normal and natural expression of sexuality" (Merriam-Webster, n.d.). Along with heteronormativity came the expectation of couples remaining in a monogamous heterosexual relationship. This leads to *mono-normativity* which is a concept referring to the normalisation and naturalness of monogamy by the dominant section of society (Barker & Langdridge, 2010; Conley et al., 2013). This normalisation and naturalness of monogamy would not only affect what could be considered as the cultural norm, but could have consequences for those who do not fall into the categories of heterosexual and/or monogamous (Barker & Langdridge, 2010; Conley et al., 2013).

2.2.4 Consequences Associated with 'Heteronormativity' and 'Mononormativity'

Conley and colleagues (2013) posit that monogamy is still favoured in society and that non-monogamy is stigmatized by the general population, even when a CNMC has every characteristic of a strong relationship. This 'stigma' also applies to the health care system as the

normalization of heterosexual monogamy or heteronormativity and mononormativity influence different spheres of the health system, which in turn would affect CNMCs (Barker & Langdrige, 2010). According to O'Byrne and Watts (2011) and Conley et al. (2013), the necessity of continuing research amongst CNMCs is apparent as this could lead to a different level of health care received by these couples compared to the general population, especially in the clinical domains of perinatal health and sexual health (Barker & Langdrige, 2010; Conley et al., 2013; Holmes & O'Byrne, 2006; O'Byrne & Watts, 2011). For example, swingers are less likely to access the health care system (O'Byrne & Watts, 2011), while swingers and polyamorous couples are less likely to divulge their complete health history (Barker & Langdrige, 2010).

In their critique, Barker and Langdrige (2010) indicate that heteronormativity and mononormativity influence all spheres of the health system including care received by swingers and polyamorous clients. However, only one study conducted by Knapp in 1976 has explored healthcare providers' (participants in this case were counsellors) perceptions of CNMCs. More than 20% of the family counsellor participants admitted that they would try to encourage their clients to change their lifestyle if there were marital or sexual problems (Knapp, 1976). Jenks noted in 2014 that swingers and polyamorous couples had more of a tendency to seek out mental health care services (psychologist or counsellor) than the general population (Jenks, 2014), and they rarely divulged the fact that they followed an alternative lifestyle (Weitzman, 2010). On the other hand, very few health professionals have the necessary training to meet the unique relational and sexual needs of the CNMCs (Barker & Langdrige, 2010; Holmes & O'Byrne, 2006; Moors et al, 2013).

The Declaration of Montreal (WASH, 2005) presents certain rights that are related to sexuality and are linked to the protection of the delivery of health care through specific goals, especially Goals #4 to #6, and Goal #8 which are the following:

“Provide universal access to comprehensive sexuality information and education; Ensure that reproductive health programs recognize the centrality of sexuality; Halt and reverse the spread of HIV/AIDS and other sexually transmitted infections (STI’s); Achieve recognition of sexual pleasure as a component of wellbeing” (WASH, 2005).

These goals highlight the importance that health care should be connected to sexuality and be inclusive of all different sexual styles.

2.3 Sexuality as a Human Right

More recently, the World Association for Sexual Health (WASH) has approved its most current Declaration of Sexual Rights by its advisory council in 2014. This declaration, listing 16 sexual rights, was initially approved in 1997 at the 13th World Congress of Sexology in Valencia, Spain. It was then revised and later approved in the Hong Kong General Assembly in 1999. The Declaration of Hong Kong (WASH, 1999) contains the following sexual rights:

“1. The right to sexual freedom, 2. The right to sexual autonomy, sexual integrity, and safety of the sexual body, 3. The right to sexual privacy, 4. The right to sexual equity, 5. The right to sexual pleasure, 6. The right to emotional sexual expression, 7. The right to sexually associate freely, 8. The right to make free and responsible reproductive choices, 9. The right to sexual information based upon scientific inquiry, 10. The right to comprehensive sexuality education, 11. The right to sexual health care” (World Association for Sexual Health, 1999).

In the Declaration of Montreal (WASH, 2005), sexual goals were added to the list of the original list of sexual rights. More interestingly, at the International Conference on LGBT Human Rights in 2005, certain parts of the Declaration of Montreal were retained in relation to LGBT

sexual rights highlighting the following five areas: essential rights, global issues, diversity of the LGBT community, participation in society as well as creating social change.

The WHO then updated this list by establishing a list of basic human rights of which sexuality is now a part of (WHO, 2010). As part of this update, sexual health is now directly connected to sexual rights. These rights include:

“the rights to equality and non-discrimination; the right to be free from torture or to cruel, inhumane or degrading treatment or punishment; the right to privacy; the rights to the highest attainable standard of *health (including sexual health)* and social security; the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage; the right to decide the number and spacing of one's children; the rights to information, as well as education; the rights to freedom of opinion and expression, and the right to an effective remedy for violations of fundamental rights.” (WHO, 2006, updated 2010).

The following rights from the Declaration of Sexual Rights (WASH, 2014), as presented in Appendix 20, are the most pertinent for the purpose of this thesis: rights #1 to #7, #9 to #10, #12 to #14, and #16. These rights emphasize freedom, autonomy, privacy, sexual expression and association, of which in the situation of CNMCs is not always the case. Most importantly is the right to sexual education and sexual health care. As swingers and polyamorous couples tend not to disclose their lifestyle, these rights are most definitely affected when they seek health care.

2.4 Marriage, Divorce and Sexual Monogamy

In this section, marriage and divorce will be defined followed by infidelity/non-monogamy.

2.4.1 Definition of Marriage

Marriage has changed and the forms of relationships that couples find themselves in have evolved. This is partially attributed to women entering the workforce, and how their roles have changed in relationships, the family, and the workplace (Eichler, 2012). Nowadays, both partners are equally invested in the economic welfare of the family, and children are more frequently being looked after in daycare centers (Eichler, 2012). Canadian Law defines civil marriage as “the lawful union of two persons to the exclusion of all others” (Hurley, 2005). Although this definition has expanded to include same-sex marriages, society still values heterosexual monogamous unions (Conley et al., 2013). Quebec is the province that has the highest rate (37.8%) of common-law relationships in Canada. In the rest of the country, marriage appears to be the greater expected norm for couples’ relationships even if as an institution, the frequency of marriage has declined from 92% in 1961 to 67% in 2011 (Milan, 2013). Couples are increasingly choosing common-law as their model of relationship, which involves cohabitation without the formal marriage ceremony (Eichler, 2012). Contrary to 1981, where 93.7% of people in Canada were married and 6.3% were common-law partners, in 2011, about 80.1% of people were married and 19.9% were common-law partners (Milan, 2013).

2.4.2 Definition of Divorce

A divorce occurs when a marriage is legally ended by the courts in Canada (Department of Justice, 2015). There are two types of divorce in Canada. The first is the no fault divorce, during which the couple lives separately for a year after which they can file for divorce (Department of Justice, 2015). The second is the fault divorce. This latter type of divorce does not have the same wait period during the court process. The reasons for fault divorce include adultery, and physical and mental cruelty (Department of Justice, 2015). A certain focus will be on adultery as it contributes to our understanding of CNMCs.

The patterns of divorce appear to be directly influenced by the various legislative changes. The number of divorces increased right after the Divorce Act was enacted in 1968 followed by another increase in 1986, after reducing the separation requirement to one year. The divorce rates have been relatively stable in the last few years. In 2008, approximately one fifth of divorces were marriages lasting 5 years or less, 22.6 % between 5-9 years, 41.6% between 10-24 years, and 16.4% for marriages lasting over 25 years (Milan, 2013). The majority of divorces in 2008 that were finalized were considered as no fault divorce (separation of one year or more) at 93.6% (Milan, 2013). The rest of the finalized divorces (fault divorce) were due to marital breakdown: 3.7% for adultery; 1.6% for mental cruelty; and 1.2% for physical cruelty (Milan, 2013). These rates do not take into account couples who are cohabitating and not married. In Canada, in 2008, 21.1 per 10 000 marriages ended in divorce, whereas the rate in Manitoba was slightly lower at 18.6 per 10 000 marriages (Milan, 2013).

Most divorces occur within the first 7 years of marriage (Cherlin, 1981), with the largest rate of increase being in the first 3 years of marriage as opposed to marriages of other duration (Milan, 2011). According to Ambert (2009), the highest rates of divorce occur in the third and fourth years of marriage at the rates of 26.1 and 25.8 per 1000 marriages respectively. The reasons behind the increase in divorce rates are: “secularization trends, the liberalization of norms concerning individual choice, the lessening of religious influence, the liberalization of divorce laws leading to the normalization of divorce, and marriage breakdown associated with not being happy and fulfilled” (Polomeno, 2007, p. 17). The risk factors that have been associated with divorce are marrying at a young age (Eichler, 2012), and “low income, poverty and cohabitation before marriage” (Polomeno, 2007, p.17). In regard to parenting couples, the majority of children arrive in the first 7 years of marriage (Ambert, 2009; Polomeno, 2007), at a time when most married couples are vulnerable to relationship difficulties and divorce (Ambert, 2009). There appears to be a clash between partnership and parenthood at that time (Polomeno

& Dubeau, 2009). According to Heinecke, Guthrie and Ruth (1997), 18% of new parents will separate and divorce within four years of the arrival of the first child. As for Cowan and Cowan (2010), they found that 25% of parenting couples divorced after five years of marriage.

2 4.3 Sexual Monogamy

A monogamous relationship or monogamy is when both partners commit to being “sexually and relationally exclusive” (Conley et. al, 2013, p. 2). Non-monogamy is when one or the other or both partners are not sexually and/or relationally exclusive. In more recent years, ‘consensual non-mongamy’ has emerged as another term referring to any relationship in which the partners agree to have extra sexual or romantic involvement with someone outside of their relationship (Fernandes, 2009). Consensual non-monogamy includes but is not limited to open marriages, open relationships, swingers and polyamorous couples.

If sexual monogamy is in fact the ideal or the norm, why do so many men and women seem to fall short? Humans have always displayed a variety of sexual attitudes, behaviors and customs that are determined culturally and socially (Gould, 1999; Polomeno, 2007).

Anthropologists maintain that sexual exclusivity or monogamy was not always the case (Ryan, 2007) and that infidelity has been prevalent throughout history (Corbin, 2005; Fernandes, 2009; Mathews-Grieco, 2005). History suggests that people were more biologically inclined towards polygamy or perhaps some form of serial monogamy in order for them to stay together long enough to raise a child (Fernandes, 2009). Sexual promiscuity in primitive people would appear to have been the greater social norm.

Different types of sexual arrangements have been documented throughout history: polyandry, polygamy and polygyny. Polyandry exists when a woman would be married to one family instead of one person (in the case of scarcity of women), polygamy refers to many marriages occurring between more than one person, and polygyny happens when there are

many wives (Polomeno, 2007). Non-monogamy was not always accepted for both sexes. Marriage has been regarded as the only context in which sexual behaviour could be expressed. Until the last century in European societies, it was widely accepted for men to have a mistress or two while married (Corbin, 2005). On the other hand, their wives were expected to be faithful to their own partners (Corbin, 2005; Fernandes, 2009). This social expectation of wives' sexual exclusivity would appear to have originated out of necessity, one in which the rightful heir would receive the inheritance or take over the family's lands; as so, the husband had to be sure that he had fathered his own children. It was in the wives' best interest to remain faithful as it would allow them greater freedom and a guarantee that they would receive care until the end of their days (Corbin, 2005; Mathews-Grieco, 2005). Any behaviour that deviated from these norms was considered socially unacceptable (Fernandes, 2009). Indeed, monogamy and non-monogamy have always coexisted (Corbin, 2007; Mathews-Grieco, 2005; Ryan, 2007).

Infidelity can be defined as any "romantic involvement or sexual activity with a person other than the primary partner" (Fernandes, 2009, p. 6). Fernandes (2009) explains how several terms are used to represent infidelity: 'cheating', 'having an affair', and 'extra-dyadic sexual involvement'. Canadian law uses the term 'adultery'. In the 1950's when the divorce rate was at its lowest, about a third of married men and a quarter of married women admitted to being unfaithful before the age of 45 (Kinsey, Pomeroy, Martin, & Gebhard, 1953). The most current statistics on infidelity vary greatly from year to year: according to the research done in the United States in the late 1990s, less than 25% of married heterosexual relationships engaged in extramarital sex (Laumann, Gagnon, Michael, & Michaels, 1994). However, Schmitt in 2005, found that about 73% of men and women admitted to having extramarital affairs although this was not the preferred societal practice at that time (Schmitt, 2005). Treas and Giesen (2000) proposed that extra-marital activity is directly correlated with the degree of marital satisfaction: a lower level of marital satisfaction will increase the possibility of an extramarital affair. If one or

the other or both partners are dissatisfied or unhappy with their relationship, there will be a greater likelihood of 'cheating' (Treas & Giesen, 2000). Another factor is related to the perceived inequity in the relationship: if there is an imbalance in regard to the efforts put into the relationship, then the likelihood of infidelity increases (Fernandes, 2009).

The top five reasons why men have extramarital affairs are: feeling attracted to the other person; boredom in the current relationship; an opportunity presented itself; they were unhappy in their relationship; or the other person made them feel attractive. On the other hand, women's top five reasons for having extramarital affairs are that they felt attracted to the other person, were unhappy in the current relationship, the other person made them feel attractive, were bored or felt the current relationship was ending (Brand, Markey, Mills, & Hodges, 2007).

Brtnicka, Weiss and Zverina (2009) found that 4 to 38% of men admitted to infidelity during pregnancy and in the first few months following the birth of their child. De Pierrepont, (2016) found that 4.5% of pregnant franco-ontarian women thought of having an extramarital affair while 4.5% actually did go on to having an extramarital affair. On the other hand, 9% of men thought of having an extramarital affair during pregnancy, while 6 % actually did so. In the first twelve postpartum months, 3% of new mothers and 23.9 % of new fathers thought of cheating, while none of the women did go on to having an extramarital affair and 11% of the men actually did. It appears that extramarital affairs do occur during the transition to parenthood, even if it is not extensively reported in many studies. More research is needed to better understand why this is emerging as a new social and sexual phenomenon.

2.5 Alternative Forms of CNMCs

Historically, it would appear that monogamy is not a natural phenomenon, and is in fact a choice:

“There is powerful evidence that human beings are not “naturally” monogamous, as well as proof that many animals, once thought to be monogamous, are not. To be sure, human beings can be monogamous (and it is another question altogether whether we should be), but make no mistake; it is unusual-and difficult” (Barash & Lipton, 2001, p. 1).

Thus, different types of CNMCs are possible. Consensual non-monogamy encompasses couples who agree to have sexual, romantic and/or emotional relationships with others (Barker & Langdrige, 2010; Moors et al., 2013). The common thread in all CNMCs is that all participants are fully aware and are in agreement with the sexual, romantic and/ or emotional aspects of relationships with others (Matsick et al., 2014). Even if there is a paucity of research that has been conducted with CNMCs (Fernandes, 2009; Jenks, 2014), different studies have identified the following: the first non-traditional sexual style in a long-term relationship is more commonly known as the open relationship or the open marriage followed by swingers and polyamorous couples. These three different types of CNMCs will be explained in more detail in the next section. Conley and colleagues in their literature review found that in a study using an untargeted convenience sample, between 3.5 % and 5 % of individuals in a relationship identified as either swingers, polyamorous or being in an open relationship (Conley et al., 2013).

2.5.1 Reasons for Choosing Consensual Non-monogamous Couples

The current study is focusing on the umbrella term CNMCs. There is a part of the literature that uses this term, however, other literature focuses on swingers and polyamorous couples. It is understood that swingers and polyamorous couples are part of the CNMCs. For this reason, the present study looks at the literature not only on CNMCs but also on swingers and polyamorous couples. This decision has been made so as not to limit the literature review

but also so as not to limit potential participants by asking them to self-identify either as a swinger or as being polyamorous (Sheff, 2011).

2.5.2 Open Relationships

2.5.2.1 Definition and History of Open Relationships

There is a lack of consensus regarding the definition of an open relationship in the literature. It appears that it is the “umbrella term for all forms of consensual non-monogamous relationships” (Matsick et al., 2014, p. 476). In open relationships, one partner accepts that he/she and the other partner have extra-dyadic sexual activities and relations (Fernandes, 2009). For the most part, when agreement to an open relationship is being discussed and negotiated by the partners, permission is given to pursue sexual relationships without the primary partner’s involvement and are intended to be neither romantic nor loving (Matsick et al., 2014). The movement for open relationships started in the 1960s during the sexual revolution, “with its natural progression to the free love theory” (Fernandes, 2009, p. 13). The term ‘open relationships’ has been more frequently used to define extra dyadic sexual relationships in the lesbian, gay, bisexual and/or queer communities (Labriola, 1999).

2.5.2.2 Sexual Practices

Labriola (1999) found that there are three models of open relationships: ‘the primary secondary model’, ‘the multiple primary relationship model’ and the ‘uncommitted multiple partners model’. The most frequently practiced model of open relationships is the ‘primary secondary model’ in which the couple itself is the pivot around which all other relationships are considered. In this first model, the primary relationship takes priority and all other relationships are not allowed to become equally important. The primary couple lives together and decides the rules about their relationship. All other secondary partners must choose to abide by these rules and if they do not, then they can no longer take part in sexual activities. Interestingly enough,

this type of open relationship can be considered as similar to swinging. The primary secondary model comes closest to a traditional marriage (Labriola, 1999).

The second model of open relationships, the 'multiple primary partners' model', resembles more the polyamorous relationships. In this model, three or more people are in a primary relationship and all participants have an equal say in the relationship discussion. Each of the primary partners may choose to have secondary partners. Another take on the 'multiple primary partners' relationships is polyfidelity. This is a closed model in which there are multi-adult families interacting with each other. It is a closed system since the sexual partners can only be family members (Labriola, 1999).

The last model of open relationships is, the 'uncommitted multiple partners model'. In this model, the participants remain essentially single, are not looking for a primary committed relationship, and prefer to participate in more than one sexual relationship. Sexual satisfaction and intimacy are desired through uncommitted non-monogamy (Labriola, 1999).

2.5.2.3 Sexual Satisfaction

In the literature, marital/conjugal and sexual satisfaction do not appear to be assessed under the umbrella term 'open relationships'. As there are many ways of defining open relationships, research in this area tends to focus on one or more of the different models. However, the greater evidence applies to marital/conjugal and sexual satisfaction for swingers and polyamorous couples and not to 'open relationships' per se.

2.5.3 Swingers

2.5.3.1 Definition and History of Swinging

Swingers, with their partner's permission, choose to have extra dyadic sexual relations outside of their primary relationship. Swingers limit the degree of emotional involvement with

other partners, opting more for the pleasure of the sexual experience (Fernandes, 2009; Jenks, 1998). It is difficult to identify the exact moment in history when swinging came into existence, and was known as such. According to Fernandes (2009), it could have started either as early as 1914 to 1925 in the Greenwich Village District of New York City, or as an extension of the 'free love' movement that exploded in the 1960's. Key Clubs appeared during World War II, in which air force pilots would exchange each other's wives, based on which keys they would pick up at the end of the evening's activities (Fernandes, 2009; Gould, 1999). More organized clubs evolved with time, known as 'suburban sex clubs' or 'wife-swapping' clubs (Fernandes, 2009). The term 'swingers' gradually replaced 'wife-swapping' in the 1970s to better reflect the women who were active and willing participants in the *lifestyle* (another common term used for swinging that was coined in the 1980s). It was at that time that the North American Swing Clubs Association was created (Fernandes, 2009). According to Fernandes (2009), there appears to be an increase in the number of swingers' clubs in the last 10 years across the world (Fernandes, 2009). In Canada, this increase may be attributed to the legalization of swingers clubs by the Supreme Court in 2005 (R. v. Labaye, 2005).

2.5.3.2 Demographics

The most recent studies (Fernandes, 2009; Jenks 2014) continue to demonstrate the homogeneity of the swinging population. There are between 4 to 15 million people in the United States who are considered as swingers (Sloan, 2005, as cited by Fernandes, 2009). The majority of them are white, upper-middle class, higher than average level of education, and between the ages of 30 to 40 (slightly higher than in the 1970s). Most of them have grown up in a religious family but are no longer practising (Fernandes, 2009; Jenks, 1998; Moors et al., 2013; O'Byrne & Watts, 2011). One of the biggest changes noted over the years is the more liberal political mindset that seems to be taking hold in this group (Jenks, 2014). No statistics are available for swingers in Canada.

2.5.3.3 Sexual Practices

Why do people choose the swinging sexual style? According to Fernandes (2009) and Jenks (1985), the three reasons that people choose to swing are to play out sexual fantasies, have sexual variety, and it is a way for partners to explore and engage in different sexual experiences and behaviours.

Swingers identify for the most part as heterosexual, and are partial to 'normal' sexual practices. Sexual relations between women are widely accepted (Barker & Langdrige, 2010; O'Byrne & Watts, 2011), while sexual relations between men are considered taboo, even to the point of club exclusion (O'Byrne & Watts, 2011). Fernandes (2009) found that two-thirds of the men in his study introduced swinging in their relationships compared to one-third of the women; these statistics are similar to those presented in the Jenks study (2014). Less than 1% of the participants engaged in the swinging lifestyle to satisfy their partners and 8% of men and 50% of the women engaged in homosexual contact (Fernandes, 2009). These findings are similar to those found in the O'Byrne and Watts (2011) study where sexual relations between men were considered taboo. Vaillancourt and Few-Demo (2014) confirmed this cultural norm of 'heteronormativity' as well. In their study, they found that apart from their swinging lifestyle, the participants maintained traditional marital and family contexts.

For a person to be interested in swinging, a few predisposing factors are usually present in his or her personal profile, foremost, a strong interest and involvement in sex (Jenks, 1985). As Gilmartin (1975, cited by Jenks, 1985) noted, swingers tended to start dating earlier, more often, and were more likely to have had sexual intercourse sooner.

2.5.3.4 Sexual Satisfaction

According to Bergstrand and Williams (2000), the higher the marital satisfaction prior to engaging in swinging, the higher this satisfaction is afterwards. Fernandes (2009) collected data

on marital and sexual satisfaction from men and women swingers by using self-administered questionnaires. The men's marital satisfaction was lower than that of the women's, but compared to other studies done on the general population, it was higher (Fernandes, 2009). In regard to sexual satisfaction, the same applies: swingers tended to have a greater degree of sexual satisfaction compared to that of the general population (Fernandes, 2009).

Approximately half of swingers believed that the *lifestyle* improves the quality of the relationship (Bergstrand & Williams, 2000). Swingers also placed more emphasis on companionship and family life (Kimberly & Hans, 2015).

2.5.4 Polyamory/Polyamorous Couples

2.5.4.1 Definition and History of Polyamory

Polyamorous couples are not only looking for other sexual partners, but they are also searching for a certain level of emotional intimacy with more than one partner (Barker & Langdrige, 2010). Once these relationships are formed, polyamorous couples define their relationships by either their parenting or domestic roles (Barker & Langdrige, 2010). Polyamorists also value equality in their partnerships (Boyd, 2017). There are different types of polyamorous couples and the different make up of polyamorous couples are similar to open relationships because of their sexual practices.

2.5.4.2 Demographics

In the United States, there are over half a million polyamorous families (Weitzman, 2006). No statistics on polyamorous couples exist in Canada. However, in a survey conducted by the Vanier Institute of the Family in 2016 noted that the number of Canadians participating in polyamory has grown (Boyd, 2017). This study conducted via social media had 547 responses and the highlights were presented per se: "More than two-thirds of respondents (68%) said that they are currently involved in a polyamorous relationship, and, of those who weren't, two-fifths

(39.9%) said that they had been involved in such a relationship in the last five years. More than four-fifths of respondents said that in their view the number of people who identify as polyamorous is increasing (82.4%), as is the number of people openly involved in polyamorous relationships (80.9%)” (Boyd, 2017, p. 3.) This size of polyamorous families ranged from three to five people with the majority being in the three-person polyamorous relationship.

The revenue of polyamorous couples is slightly lower than that of swinging couples (Jenks, 2014). However, polyamorous couples differ very little from swingers in regard to all other sociodemographic characteristics (Boyd, 2017; Weitzman, 2006). Upon closer examination of the sociodemographic data on swingers and polyamorous couples, one cannot help but notice that they form a very homogeneous group. They need to be affluent enough to afford and to attend the swingers clubs or to be part of them as well as have access to the internet in their homes to plan their sexual activities. There are limitations to the evidence that is presented in this area of research as the groups were homogenous and could not be generalized to other sectors of the adult population.

2.5.4.3 Sexual Practices

The most important difference to note is that in polyamorous couples, a greater majority of them identify themselves as both polyamorous and bisexual (Weitzman, 2006). Polyamorous couples are more open-minded when it comes to alternative forms of sexual expression such as sadomasochism (Weitzman, 2006). The sexual practices of polyamorous couples are very similar to those of open relationships.

2.5.4.4 Sexual Satisfaction

Polyamorous couples appear to have greater marital and sexual satisfaction than that of the general population (Barker & Landridge, 2010). The literature indicates that swingers and polyamorous couples are generally more satisfied with their lives than the general population.

This brings to question the reasons behind these different types of satisfaction. Are they more satisfied because of their lifestyle or because of their socioeconomic position (Barker & Langdrige, 2010; Jenks, 1998; O'Byrne & Watts, 2011; Sheff & Hammers, 2011)? The answer to this question is not clear from the literature.

2.5.5 Health Risks and Health Care Practices Associated with Non-Monogamy

In public health, there is a supposition that sexual contacts occur between random heterosexuals (O'Byrne, Holmes, & Woodend, 2008). When considered in this regard, the greater the number of sexual contacts, the greater likelihood of being at risk for an STI and/or HIV (Fernandes, 2009; O'Byrne, Holmes, & Woodend, 2008). The literature suggests that CNMCs are at higher risk for STIs and HIV (Fernandes, 2009; O'Byrne, Homes & Woodend, 2008, since research on sexuality and harm reduction have assessed and targeted populations that have high risk behaviours leading to a higher incidence of sexually transmitted and blood born infections (O'Byrne & Watts, 2011). However, according to Fernandes (2009), swingers have lower rates of STIs when they are compared to the general population, and those who engage in unsafe sexual practices such as no condom use would be more at risk for STIs. There is currently no STI and HIV data available on polyamorist couples as they tend to be included with the swinging population.

On the other hand, O'Byrne and Watts (2011) posit that swingers would be more at risk for syphilis, gonorrhea and chlamydia. The factors that would make this population more at risk are:

“(1) the groups, heterogeneous distribution of sexual partners; (2) the group's elevation mean number of sexual partners per person (5); (3) the group-level rate of concurrent sexual partnerships (i.e., both primary and swinger partners); (4) the groups relatively high rates of unprotected sex (ranging from 15.5% for vaginal sex to 80.3% for oral sex);

and (5) the group's low levels of health service utilisation for STI (fewer than half the participants underwent "routine" testing, even though nearly a fifth had previously been diagnosed with an STI" (O'Byrne & Watts, 2011, p. 93).

Although couples reported their lifetime incidence of STIs in two studies (Knapp, 1975; O'Byrne & Watts, 2011), O'Byrne and Watts (2011) found that consensual non-monogamous couples have less of a tendency to seek health care, including sexual health and counselling. When seeking health care or counselling, they also have less of a tendency to mention their lifestyle (Barker & Langdridge, 2010). The lower incidence of STIs could be related to their self-reported lack of health care seeking practices. To be able to self-report an STI, a person has to be aware that he or she has one. The lack of health care seeking practices in all regards is of concern, especially in relation to sexual health.

STIs can lead to infections, miscarriage, stillbirth or harm to the fetus (CDC, 2016) The Winnipeg Regional Health Authority experienced a syphilis outbreak as of November 2015 (Marshall, S., personal communication) that continues today (Froese, 2018). This outbreak appeared to be greater among men who have sex with men (WRHA, 2016a). In 2015, there were 100 cases of reported infectious syphilis in Manitoba (WRHA, 2016a). This would not appear to concern the swinging population as male homosexual contact is frowned upon. However, in the polyamorous community where a large majority identify as both polyamorous and bisexual, this could pose certain problems, as the targeted interventions aimed at men who have sex with men (Healthy Sexuality and Harm Reduction, 2015) may not necessarily reach CNMCs. The WRHA has observed an increase among the female population. Of current concern is that one in 5 cases of syphilis has been diagnosed among pregnant women in Manitoba as well as one case of congenital syphilis (WRHA, 2016a). Manitoba has one of the

highest rates of chlamydia and gonorrhea in the country (WRHA, 2016a). There is no data available on STIs and HIV in relation to non-monogamous couples who are parents.

2.6 The Transition to Parenthood

In this section, the transition to parenthood will first be defined. This will be followed by the various role changes that occur during this transition period. The quality of relationship and intimacy in during the transition to parenthood will also be explored. Sexuality during the various phases including pregnancy, childbirth, breastfeeding and the postpartum period will finally be presented.

2.6.1 Definition of the Transition to Parenthood

According to Polomeno (2013), the transition to parenthood can be defined as “the period starting with the decision to have a child or becoming pregnant and terminating when the child is 2 years old” (p. 36). Polomeno (2000a, p. 40-41) identifies 9 phases during this transition:

- “Phase 1 - the decision to become pregnant
- Phase 2 - physically creating the baby
- Phase 3 – pregnancy
- Phase 4 – birth
- Phase 5 - immediate postpartum, including the first 6 weeks;
- Phase 6 - 1 ½ - 6 months
- Phase 7 - 6 months to 12 months
- Phase 8 - 12 to 18 months
- Phase 9 - 18 months to 24 months”.

During this transition, multiple psychological, physical, emotional, social, and sexual changes occur in the new parents’ relationship (Cowan & Cowan, 2010; Polomeno, 2000a;

Rossi, 2013). Due to these multiple changes, the partners find themselves re-assessing all aspects of their relationship (Polomeno, 2013). The transition to parenthood is one of the most difficult that a couple will encounter, however, it is the actual arrival of the first child that is the most difficult for the couple (Cowan & Cowan, 2000). Various reasons have been mentioned in the literature to explain why this transition is so difficult from the increased stress to a period of disorganization, as well as the lack of preparation including the limited learning in pregnancy, the rapidity of the transition and lack of guidelines for it (Polomeno, 2013; Rossi, 1989). The two dimensions that are the most affected during the transition to parenthood are intimacy and sexuality (Cowan & Cowan, 2000; de Pierrepont, 2016; de Pierrepont et al., 2016a, 2016b; de Pierrepont & Polomeno, 2014; Polomeno, 2013, 2014).

2.6.2 Role Changes during the Transition to Parenthood

The transition to parenthood can be a time of stress and disorganization for couples. This period of time involves the conciliation of three different but complementary roles, that of partner, parent, and lover (Briggs et al. 2005; Cowan & Cowan, 2000; Polomeno, 2007). The new role of parent has a major impact on the other two roles. At the beginning of the postpartum period, the couple tends to prioritize their parenting role over their roles of partner and lover. After some time, most couples have reached a point at which these three roles are in balance. If too much energy goes to the parenting role, this can unravel the couple's relationship as the two other roles are of lesser importance. This can be a detriment to the couple, as the couple's relationship is essential for the basis of a family (Cowan & Cowan, 2000). Intimacy and sexuality are necessary for the well-being of the coupleship, the family and the children's development (Polomeno, 2014).

During the transition to parenthood, when a family shifts from one stage to another, women mention a number of factors that influence their ability to adapt to their newfound role as

mother and to reconcile the latter with that of partner and lover (Brotherson, 2007; de Pierrepont, 2016; Polomeno 2013). The factors include the lack of sleep and being tired, body image changes, doubts about parenting capabilities, increased workload (chores), unpredictability of mood changes and anxiety, stressing about roles and responsibilities and finally, the stress of changes in their work situation (Brotherson, 2007; von Sydow, 1999). Around 15% of women feel less attractive after given birth (von Sydow, 1999) which may lead to not wanting to fulfill the role as lover. Added to these factors are the necessity of dividing housework and childcare as well as financial worries that can add even more strain (Brotherson, 2007).

In the Condon, Boyce and Corkingdale (2004) study, 312 men were initially assessed at 23 weeks during the pregnancy followed by 3, 6 and 12 months postnatally. This first-time longitudinal cohort study done with expectant and new fathers used self-reported questionnaires measuring psychological, lifestyle, and relationship/sexual variables. The findings revealed gender-related differences during the transition to parenthood. The expectant fathers, as opposed to the mothers, found the most stressful period of the transition to be the pregnancy itself, which stabilized within the first 3 months postpartum. Men who are fathers expressed how providing financially for the family, alterations in sleep patterns and being tired, increased workload around the house (chores), renegotiating relationships with in-laws, less free time for social activities, changes in the couple's relationship and sexuality, and disagreements about changing roles were the aspects that affected them the most during the transition to parenthood. They also were less prepared to deal with potential changes in their sexual role. However, the more men felt competent in their parenting role, the better they felt about the family's functioning (Condon et al., 2004). The adaptation to the fathering role was confounded by gender specific factors including: a more limited support network, lack of role models for parenting, reluctance to seek emotional or psychological support as needed, and finally, "young men have a more

idealized view of pregnancy, childbirth and parenthood compared to young women” (Condon et al., 2004, p. 567).

This transition can be even more difficult if a child is fussy or if either parent suffers from postpartum depression (Lowdermilk, Perry, Cashion, & Rhodes, 2012). An increased strain on a couple’s relationship (partnering role, parenting role, sexual role) can lead to decreased marital satisfaction which can then lead to a decrease in the expression of sexual intimacy. When there is a decrease in sexual intimacy, it can eventually lead to separation and divorce (Briggs et al., 2005; Polomeno, 2007). Another concern during this transition is an increased risk for physical violence during the first postnatal year due to the increased strain on the parenting couple (Lowdermilk et al., 2012; Public Health Agency of Canada, 2009).

2.6.3 Quality of Relationship and Intimacy during the Transition to Parenthood

Timmerman as cited by Polomeno (2013) defines intimacy as “a quality of a relationship in which the individuals must have reciprocal feelings of trust and emotional closeness towards each other and are able to openly communicate thoughts and feelings with each other” (p. 37). She goes further and names conditions that must be present for intimacy to develop: “reciprocity of trust, emotional closeness, and self-disclosure” (Polomeno, 2013, p. 37). Certain couples are more vulnerable during the transition to parenthood than others due to the multiple changes that they encounter, especially those related to the dimensions of intimacy and sexuality. This vulnerability starts with the decision to become pregnant or at the time of conception (Polomeno, 2014). An already vulnerable couple will have more difficulty with this transition leading to the possibility of marital breakdown (Polomeno, 2007). A couple grows in intimacy by being vulnerable and allowing their partner to care and support them in their moments of vulnerability (Polomeno, 2014). There are four patterns of intimacy and vulnerability that have been identified in the transition to parenthood (high intimacy/high vulnerability, high intimacy/low

vulnerability, low intimacy/high vulnerability and low intimacy/low vulnerability). The various combinations of intimacy and vulnerability can have different consequences on a couple's relationship ranging from a couple being deeply committed to one another and continuing a long term relationship to the couple who is not invested in the relationship (Polomeno, 2014).

To be able to reconcile their new roles as parents and changes to their relationship, a certain level of intimacy must be present. Without a sense of intimacy, or the feeling of togetherness/partnership, negative consequences can occur:

“To resolve this, the person may simply let it go, or project it inward and become sad or depressed, or project it outward, towards the other partner, by blaming the other for something that she or he may not have done” (Polomeno, 2013, p. 37).

Unfortunately, if couples do not regain their intimacy, or sense of connection and partnership, they will experience feelings of unhappiness, resentment and bitterness, and this can potentially lead to separation or divorce (Polomeno, 2007).

2.6.4 Sexuality during the Transition to Parenthood

A healthy sexuality is essential for the couple's relationship during the transition to parenthood. Sexual behaviours can be influenced by physiological, psychological and social factors during pregnancy, childbirth, the postpartum period and breastfeeding.

2.6.4.1 Pregnancy

There are many physiological changes that occur during pregnancy that can affect women. Brticnicka, Weiss and Zverina (2009) have explored different physiological causes of sexual fluctuations. The level of progesterone in the bloodstream increases which in turn increases the sensitivity of the breasts and nipples. This increase can also lead to vulvar and vaginal tissue congestion which can either heighten sexual pleasure or cause dyspareunia in

some women. The increase in this hormone may decrease a woman's blood pressure which can lead to fatigue, which in turn can decrease a woman's desire for sexual activity. Women generally experience an increase in vaginal discharge during pregnancy which can lead to an increased risk of infection as well as discomfort during intercourse. During pregnancy, a woman's uterus can respond to a greater level of oxytocin released during orgasm which can lead to some discomfort as it contracts.

Women tend to experience a slight decline in sexual interest in the first trimester of pregnancy, an increase during the second trimester, and a decline in the last trimester (Ladewig et al., 2010; Polomeno, 2000b). However, during the second trimester, sexual interest can be variable for women, and in the last trimester, there is the biggest decline in women's sexual interest/frequency (Brticnicka, Weiss, & Zverina, 2009; de Pierrepont et al., 2016a; von Sydow, 1999). Pauletta, Pereira and Graça (2009) and Polomeno (2000b) stipulated that although the frequency of sexual activity declines for the most part especially in the third trimester, sexual satisfaction does not change during pregnancy compared to the pre-pregnancy level. The fear of harming the baby during sexual intercourse is of concern for many expectant parents (Brticnicka, Weiss, Zverina, 2009; de Pierrepont et al., 2016a; Pauleta, Pereira, & Graça, 2010; von Sydow, 1999). Some women also express concerns in regards to potential or actual dyspareunia, potential miscarriage and or preterm labour (de Pierrepont et al, 2016a; Pauleta et al., 2010).

Women may feel self-conscious of their changing bodies during pregnancy, affecting their self-image and their performance with certain sexual practices (de Pierrepont et al., 2016a; von Sydow, 1999). A woman's lower weight gain during pregnancy is directly correlated with more sexual satisfaction (von Sydow, 1999). Although the women noted a change in their body image (up to 41.5% feeling less attractive), there did not appear to be a change in the men's

sexual desire for their mate according to 75% of the participants in the Paul and colleagues' study (2008).

Men have different experiences during pregnancy. A number of men experience stress associated with pregnancy and note a decline in the importance of sexual activity (de Pierrepont et al., 2016a). According to Ganem (1992), about 2% of men experience sexual dysfunction (premature ejaculation and erectile dysfunction) between 32 and 36 weeks of gestation. De Pierrepont et al. (2016a) in their scoping review found that 65.4 % of men experience some sort of sexual dysfunction during the third trimester of pregnancy. This includes difficulties with premature ejaculation (7.3- 12%), as well as erectile dysfunction (7.3-36.6%) (de Pierrepont et al., 2016a). Certain men can have difficulties reconciling the image of their partner who is a sexual being with that of the partner who is a mother-to-be, to the point that they can no longer make love with her (Ganem, 1992). During a high-risk pregnancy, men are more willing to sacrifice that part of the relationship for the sake of their offspring (Polomeno, 2011). Depending on the circumstances and in the absence of sexual activity, it is important for the couple to express themselves in other ways to be intimate, such as hugging, kissing and non-genital caressing: oxytocin continues to be released during physical contact which in turn helps to maintain the bond between the soon-to-be parents (Polomeno, 2011).

2.6.4.2 Childbirth

A couple's experience during childbirth can affect the sexual dimension of their relationship. Harel conducted a study on sexuality and childbirth in 2007. While studying the couple's experience of childbirth, Harel (2007) noted that some women had sensual and erotic sensations during birth, leading to orgasmic births in some cases. For the first time, birthing was seen as a sexual experience. Some of the women were taken completely by surprise by the sexual part of childbirth, while other women were able to embrace it and used various sexual

practices to induce orgasm and to cope with intrapartum pain. The labouring woman's partner was essential in supporting her, by encouraging the sensual and sexual experience (Harel, 2007). The participating women's labouring patterns and sexual responses were compared and found to be physiologically similar to what happens to women during a sexual encounter culminating in orgasm (Newton, 1955).

2.6.4.3 Parenting/Postpartum Period

There appears to be a decline in postnatal general sexual expression compared to the pre-pregnancy level (Cowan & Cowan, 2000). Both partners report a change in their sexual relationship after having a baby (Cowan & Cowan, 2000). The factors that influence a couple's response to their postnatal sexuality are role transition, the quality of their relationship as well as intimacy and vulnerability (Cowan & Cowan, 2000). It is for the most part the changes in the dynamics and shifting roles that affect the sexual dimension of a couple's relationship and not the other way around (Cowan & Cowan, 2000). Couples need to relearn a way of showing intimacy that does not necessarily lead to sexual activity and relearn each other's sexual scripts or cues (Cowan & Cowan, 2000; Gagnon & Simon, 2005).

The majority of couples resume non-coital sexual contact around 2.7 weeks postpartum while sexual coital activity resumes following the first two postpartum months (von Sydow, 1999). This was also confirmed by de Pierrepont and colleagues (2016b) in their scoping review. In their analysis, certain recurrent items were highlighted: "a period of nonsexuality in the first postnatal months, followed by a gradual return of sexuality from 3 to 5 months postpartum continuing until 12 months or more" (de Pierrepont et al., 2016b, p. 810). Up to 40% of women's first sexual postnatal encounter is problematic and more than half experience dyspareunia, leading to physical and sexual avoidance with their partner (von Sydow, 1999). Women who experienced assisted vaginal deliveries, whether by forceps or vacuum extraction,

and compounded by an episiotomy and/or perineal tears, have prolonged sexual abstinence post-delivery and have an increased in postnatal dyspareunia (Brticnicka, Weiss, & Zverina, 2009; de Pierrepont et al., 2016b; Pauleta et al., 2010; von Sydow, 1999). The literature does not suggest any direct correlations between birth trauma (severity of birth pain, use of forceps, episiotomy), and resumption or interest in postnatal sexual activity, however the findings are still contradictory (de Pierrepont & Polomeno, 2014).

If the childbirth experience has been deemed to be traumatic, women and their partners can suffer from post-traumatic stress disorder. For both parties, this poses serious repercussions for the continued expression of their sexuality in the early postpartum months and beyond (de Pierrepont et al., 2016b; White, 2007).

Many concerns relating to the resumption of sexual activity were expressed by the participants in the study conducted by Pastore, Owens and Raymond (2007). At the fourth postnatal month, they reported the following concerns: when to resume sexual activity, the type of contraception to use, physical recuperation, and breastfeeding (Pastore et al., 2007). Around 12 months postnatally, women were concerned about the sexual desire of each partner and their body image (especially about returning to their pre-pregnancy state), whereas men were more concerned about their increased desire for sexual activity as well as the need for contraception (Pastore et al., 2007).

Fathers in the postpartum period express concerns in regards to potentially hurting their partners especially after a long or difficult birth once intercourse resumes post-delivery (Polomeno, 2011). Other concerns also noted by Polomeno (2011) were: the “distance in their relationship, the woman’s diminished libido, postpartum depression, not enough time and attention for him, and finding the time to make love.” (p. 38). Although men do not notice a

change in their desire for their partner post-delivery, they questioned if their partners would still feel desirable (Polomeno, 2011).

2.6.4.4. Breastfeeding

Brticnicka, Weiss and Zverina (2009) have explored how physiological changes that occur during breastfeeding can affect women that. Breastfeeding women have a higher level of prolactin to assure an adequate milk supply which in turn decreases the level of estrogen present. The lower level of estrogen can cause a decrease in a woman's vaginal secretions as well as a thinning of the vaginal wall, which can increase dyspareunia. The fluctuation in hormonal levels can also explain the fluctuating libido of breastfeeding women. Milk let down can occur during a woman's orgasm because oxytocin is released at that time which may or may not perturb the breastfeeding mother and her partner (Brticnicka, Weiss, & Zverina, 2009).

Breastfeeding has been linked to a low level of coital activity and a decrease in sexual desire and sexual satisfaction for both partners (Brticnicka, Weiss, & Zverina, 2009). Breastfeeding women tend to resume sexual activity later than the non-breastfeeding ones (Brticnicka, Weiss, & Zverina, 2009). Breastfeeding women may not need as much affection or attention from their partner, as these needs are met through breastfeeding (Polomeno, 1999). Up to 30% of women associate breastfeeding with an erotic and sensual experience, some women even reaching orgasm while breastfeeding (von Sydow, 1999). Some women have a negative perception of the sexual dimension of their relationship due to the quality of the relationship that they have with the father of their child (Avery, Duckett, & Franzich, 2000), while other women find that their libido increases (Polomeno, 1999).

Polomeno (1999) found that men may have mixed feelings about their partner's breasts, as breasts that were once viewed sexually are now reserved for the baby's feeding. Other men may view a woman breastfeeding as highly sexual and erotic to the point that they need to

masturbate. They may also have feelings of jealousy as the partner is spending more and more time with their child (Polomeno, 1999).

2.7 Consensual Non-monogamous Parenting Couples

In this section, non-monogamy research will first be presented followed by the challenges faced by swingers and polyfamilies in today's society. The last section will focus on research with consensual non-monogamous parenting couples. However, it should be noted that there is a dearth of literature on how a consensual non-monogamous relationship affects and is affected by the transition to parenthood (Conley et al., 2013; Pallota-Chiarolli, 2010).

2.7.1 Non-Monogamy Research

There are certain themes that recur in non-monogamy research. The first one pertains to how researchers tend to compare consensually non-monogamous practices with those associated with monogamy and infidelity (Barker & Langdrige, 2010). By comparing the two, monogamy is usually viewed more favourably. The second theme relates to how swingers and polyamorous couples identify themselves for recruitment purposes. They are often asked to either identify as one or the other. The pool of participants for research is reduced when participants are forced to choose only one role, such as a swinger, 'the lifestyle' or as polyamorous. To counter this, Sheff (2011) suggests using the definition of 'CNMCs' to classify research participants. Sheff continues by explaining that people, who are already marginalised in other ways, might have less of a tendency to participate in the said lifestyle and/or be willing to participate in these types of studies. The last theme pertains to how the research tends to focus on sexual contracts and boundaries and the 'rules of engagement' (Barker & Langdrige, 2010) as well as this population being identified as a more recent subculture (O'Byrne & Watts, 2011). Due to the lack of research in this area, people who are in consensual non-monogamous relationships are often stigmatized, but their social characteristics (white, middle class), their

social status and accompanying social privileges may buffer some of the negative impacts relating to this stigmatization (Pallotta-Chiarolli, Haydon, & Hunter, 2013; Sheff & Hammers, 2011). It is difficult to ascertain the total complexities of these participants' potential stigmatization.

Overall, little research has been conducted with the swinging and polyamorous populations (Barker & Langdrige, 2010; Matsick et al., 2014; Moors et al., 2013). Most of the published articles are commentaries or critiques of research that have been done in the past (Barker & Langdrige, 2010). The large majority of the research has focused on identifying the sociodemographic characteristics of the swinging and polyamorous populations and comparing the different forms of CNMCs (Jenks, 2014). Most recently, research has focused on studying the swinging subculture in relation to sexual practices (O'Byrne & Watts, 2011). The O'Byrne and Watts' study was conducted to better identify high risk behaviours and target harm reduction interventions (O'Byrne & Watts, 2011). Other recent research has focused on the general population's perceptions of CNMCs (Matsick et al., 2014; Moors et al., 2013). The findings from these studies suggest that CNMCs are stigmatized in comparison to monogamous relationships. As well, swingers are more stigmatized when they are compared to polyamorous couples and couples in open relationships while maintaining a primary partner (Matsick et al., 2014). The general population prefers to think that sexual acts are still associated with an emotional connection or love (Matsick et al., 2014).

2.7.2 Challenges Faced by Swingers

One of the major concerns faced by couples, who are also swingers, is the question of disclosure or non-disclosure of their lifestyle, especially as parents. It would appear that as a whole, swingers tend to lead towards non-disclosure (Sova, 2012; Vaillancourt & Few-Demo, 2014). The decision to disclose or not, however, remains an individual and mutually agreed

upon decision per couple (Sova, 2012; Vaillancourt & Few-Demo, 2014). In the Sova (2012) qualitative study, interviews were conducted with 10 married heterosexual swinging couples and analysed using constant comparison. The swingers' main concern in regards to disclosing their lifestyle was in relation to the potential repercussions to their offspring. They did not want their children taken away or for the people in their lives to think they were bad parents or that they were deviants in all ways. They also tended to form a social circle with other potentially stigmatized people associated with their lifestyle. Vaillancourt and Few-Demo (2014) found that the non-disclosure was not in relation to a need for secrecy, but more of a desire for privacy, and that this level of privacy depended on whether the disclosure would happen or not with their children, families or coworkers. In this study, the swinging couples were also concerned about how they would be perceived once disclosing their lifestyle especially to their children. However, this concern did not prevent them from having a conversation with their offspring once they were old enough if they asked. The main reason of this disclosure would be to contrast the negative images of swingers portrayed by the media.

2.7.3 Challenges Faced by Polyfamilies

For polyfamilies, one of the biggest concerns that they face is whether or not to disclose their lifestyle, to their children, to their children's schools, to their extended families, and in their workplace. This disclosure can come at a certain cost, considering the stigma associated with CNMCs (Conley et al., 2013). Generally speaking, if these said families choose not to disclose their lifestyle, they can remain somewhat invisible to society (Pallotta-Chiarolli, 2010; Sheff, 2011). One of the concerns expressed by children growing up in polyfamilies is the need to be 'the perfect student', 'the perfect athlete', and 'perfect' in other spheres of their lives. Those same phenomena can also be seen in children of same sex couples. The self-monitoring occurs so that they may better blend in with the mononormative society in which they are living in (Pallota-Chiarolli, 2010). Being a parent in a polyfamily requires more than just typical kinship

terms, therefore polyfamilies tend to adapt and add new kinship terms as needed (Pallotta-Chiarolli, 2010). These kinships terms are important for health care providers to be aware of as well as used when working with these families.

Although, there are some obstacles associated with being part of a polyfamily and the possible stigmatization not only for the parents but also for their children, there appears to be great benefits in raising children in this environment. When there are more adults caring for a child, there is less strain in the division of labour and the care of the children, as these tasks can be shared (Pallota-Chariolli, 2010). Other benefits include having a sex-positive attitude and honesty which creates a strong emotional connection with the children, a division of resources (financial, physical, emotional and others), and more time for each parent to be by himself or herself (Pallota-Chiariolli, 2010). The children benefit from more role models in terms of communication, negotiation, varied skills, and abilities (Sheff, 2011). Although no studies have been done to date on these aspects, researchers can question what specific challenges these new parents face as a parenting unit.

2.7.4 Importance of Continuing Non-monogamy Parenting Research

There is little literature available regarding swingers and polyamorous parenting couples (Sova, 2012; Vaillancourt & Few-Demo, 2014) and the studies that have been published have been exploratory and descriptive. A closer look at the factors that affect non-monogamous couples in their transition to parenthood needs to be done, to better equip health care professionals including nurses in assisting these couples during an already difficult transition that is often filled with stress and uncertainty. Polomeno (2013) has written that “a strong marital relationship before children is the best predictor of a strong marital relationship after children arrive” (p. 36), and that this strong relationship is also the strongest predictor for the children’s

health and wellbeing (Polomeno, 2013). How alternative sexual styles affect and are affected by parenthood have yet to be determined.

2.8 Nurses and Human Sexuality

Nurses work closely with their clients throughout the lifespan. Sexuality is an integral part of how a person views himself or herself and the world around them (Crooks & Baur, 2017). In the first section, the reasons nurses need to be well versed in human sexuality are presented. Two other sections are also presented with a special focus on health risks associated with non-monogamy as well as nurses and sexual minorities.

2.8.1 Why Nurses Need to be Well Versed in Human Sexuality

Nurses are expected to work with all populations, including sexual and gender minorities, and across all ethnicities and cultural, spiritual, political, age, ability, family and economic circumstances. Nurses are called upon to support and work respectfully with those who are involved in sexual, reproductive and other behaviours that may be harmful to them or others (Potter & Perry, 2014).

Furthermore, sexuality and sexual health are integral to a person's overall health (WHO, 2006). The World Health Organization (2013) has also prioritized sexual health as a means to improve maternal health. Nurses are required therefore to be well versed in human sexuality, and to incorporate sexuality as an integral part of their client's health assessments (Polomeno & Dubeau, 2009), including perinatal sexuality. They are then expected to be able to assist in all aspects of their clients' care including concerns in relation to sexuality and their sexual style. This is especially important because sexual health is integral to holistic care. According to Evans (2011), there are three domains of health and sexual well-being. The first domain, *foundations of sexual well-being*, takes into account the influence of a person's gender and sexual orientation on his or her health. It also contains "sexual desire and performance; sexual

relationships; reproductive health; safer sexual practices; freedom from discrimination and the ability to express sexuality consistent with self-actualisation and fulfillment” (p. 54). The second domain, *associated aspects of sexual well-being*, encompasses the effects that certain medical conditions or life stages can have on the expression of sexuality. In the third domain of *specific sexual health*, illness and problems are looked at more closely in different sexual health specialities (Evans, 2013). Thus, under such circumstances, perinatal health nurses can apply their knowledge in all three domains.

However, many reasons are given by nurses and others HCPs why sexuality and sexual health are often omitted during health care. Nurses have reported being uncomfortable discussing sexuality with their clients (Magnan & Reynolds, 2006). This is in part due to their lack of knowledge and training and not knowing how to initiate a discussion about sexuality and how to maintain it (Magnan & Reynolds, 2006). Saunamäkin, Andersson, and Engström (2009) indicated, noted that 90% of nurses understood how their clients’ medical conditions could affect the expression of their sexuality. They also noted that two-thirds of nurses that responded were comfortable discussing this sexual health concerns with their clients and that it was part of their obligations as nurses. Although nurses in the study were aware that discussing sexual health concerns with their clients was their responsibility, 80 % did not take the time to discuss. Another 60 % did not feel confident that they would address their clients’ needs adequately (Saunamäkin, Andersson & Engström, 2009). Although there is a lack of support and knowledge, nurses can still strive to deliver quality sexual health related care by using evidenced informed practice as well as personal reflection to improve “practice, sexual health education and training” (Evans, 2013, p. 57). This can be accomplished using the ABC of sexual health learning (Royal College of Nursing, 2001) and/or the EX-PLISSIT Model (Taylor & Davies, 2006, 2007), as identified by Evans (2013). Sung, Jian, Chen, and Chao (2016) also suggest that improving sexual health care in nursing practice can be accomplished by the

implementation of sexual health care training programmes. Implementing evidenced-base sexual health care programme specifically for nurses can improve their knowledge, attitudes and self-efficacy (Sung, Jian, Chen & Chao, 2016). Continuing in the same vein, in the Yildiz and Dereli study (2011), “The average level of which nurses perceive themselves competent in providing sexual counseling is moderate and the level of which nurses can actually provide sexual counseling is insufficient” (p. 89). According to Evans (2013), it would appear that the most common obstacles to discussing sexuality would be a lack of time, a lack of support as well as nurses being uncomfortable talking about sexuality. Therefore, nurses require more psychosexual training in both their undergraduate programs and in clinical practice (Evans, 2013; Sung, Jiang, Chen & Chao, 2016; Yldiz & Dereli, 2011).

Integrating sexuality in nurses’ consultations is especially important during the transition to parenthood as perinatal health and sexuality are two interwoven areas (de Pierrepont & Polomeno, 2014).

2.8.2 Nurses and Sexual Minorities

In Canada, to better assist sexual minorities, certain public policies are in place, including the recognition of same sex marriages and common-law relationships (Barnett, 2014), but these policies do not currently support the sexual lifestyle of swingers and polyfamilies. For health care providers especially nurses, it is important to acknowledge diversity, equity and inclusion of sexual and gender minorities, since the dominant culture often thinks less of these types of population (Moors et al., 2013). The invisibility of sexual minorities including CNMCs can lead to potential health disparities for them. CNMCs have a tendency to not divulge their lifestyle (Barker & Langdrige, 2010; Landry & Kensler, 2019). Health care providers including nurses are already at a disadvantage when serving this specific population as they receive very little sexual health education and training in their undergraduate programs and opportunities for

continuing education (Polomeno & Dubeau 2009), and even less is taught about alternative sexual lifestyles (Barker & Langdridge, 2010).

Nurses need to be able to be more open minded and flexible when working with a diversity of families including CNMCs and to use a non-assumptive language (Landry & Kensler, 2019). The use of non-assumptive language should be integrated not only in health and wellness institutions but also mirrored in post-secondary ones responsible for forming future health care providers (Landry & Kensler, 2019; Malone, personal communication, June 7th 2016). Being able to provide culturally sensitive care to sexual minorities would improve relationships, communication and eventually lead to better health outcomes. Changing the workplace culture by creating an inclusive and accepting environment can make sexual minorities feel more welcome. As with other sexually minorities, applying the Cass model to practice can assist nurses to better understand the evolution of their client's sexual identity and better cater to their specific needs (Landry & Kensler, 2019). The Cass Model breaks down the various stages of 'coming out' for a person living as a sexual minority and describes the various challenges encountered in each stage. By being culturally sensitive with communication, respect and a non-judgmental approach, clients will ultimately lead to better health outcomes (Landry & Kensler, 2019).

Landry and Kensler (2019) in their article do not include people who identified as CNM. These authors suggest that people identifying as a sexual minority would be more comfortable if the same prior above-mentioned things were done in the nurse-client relationship. However, more research needs to be done to assess health care providers including nurses' knowledge and attitudes in regard to sexuality in general, but especially during their clients' transition to parenthood. It is during this time period that the most changes occur for the couples, especially those relating to intimacy and sexuality (Polomeno & Dubeau, 2009). Couples would be better

prepared for this transition if nurses and other perinatal health care providers would open the dialogue and seek to give much needed education on the subject matter (de Pierrepont & Polomeno, 2014; de Pierrepont & Polomeno, 2015; Polomeno & Dubeau, 2009). Since clients do not feel comfortable broaching the subject of sexuality, they would prefer that health care providers initiate the dialogue (Magnan & Reynolds, 2006).

2.9 Conceptual Framework

Figure 1 (see p. 63) presents the conceptual model for this study. The Reproductive Justice Framework (Expanding Movement for Empowerment and Reproductive Justice, 2008) is the main framework used in this study. Cowan and Cowan's Ecological Model of the Transition to Parenthood is integrated under Family to enhance the family part of the Reproductive Justice Framework.

2.9.1 Reproductive Justice

The reproductive justice movement was first started in the United States by women of colour. In the 1980s and 1990s, the initial activists' focus was on feminist issues, abortion and reproductive rights. They initially felt that access to birth control was the key to economic and social mobility as well as self-determination (Price, 2010). These movements were influenced a great deal in the early 1970s by the global, transnational women's movement. This movement placed human rights at its core of its fight for women's rights reiterating that women's rights were essentially human rights (Price, 2010). Another great influence on the reproductive justice movement was the women of colour's frustration with mainstream pro-choice movements. These movements focusing solely on the women's right to choose abortion and not all reproductive rights. The term Reproductive Justice first came to light in 1994. Women of colour:

“were envisioning from perspectives of women of color engaged in both domestic and international activism, and attempting to create a lens applicable to the United States

with which to interpret and apply the normative (but not universally agree) understandings reached in Cairo... As activists in the U.S., we needed an analysis to connect our domestic issues to the global struggle for women's human rights that would call attention to our commitment to the link between women, their families, and their communities." (Ross, 2006, p. 6, as cited by Price, 2010).

These movements such as SisterSong and Asian Communities for Reproductive Justice (ACRJ) choose to not only focus on the choice to have or not to have a child. They leaned towards a human rights and social justice perspective so that they could essentially not only look at the choice but to look at the barriers that women could encounter towards "mak[ing] healthy decisions about [their] bodies, sexuality and reproduction for [themselves], [their] families and [their] communities in all areas of [their] lives" (ACRJ, 2005, p. 1). In essence the reproductive justice movement not only focuses on the choice or not to have a child but also for women to have the right to have children and parent the children they have (Price, 2010).

The Expanding the Movement for Empowerment and Reproductive Justice (EMERJ) (EMERJ, 2008) lens is a concrete way of integrating the Reproductive Justice Framework in research or more practically when working with communities, in this case, CNMPCs. This lens assists in identifying the challenges that people face in regard to their gender, bodies and sexuality (EMERJ, 2008). With the help of this lens, issues can then be identified that affect a certain group or population looking at a group's experiences and identities.

This Framework (see Figure 1 on p. 63) is composed of an outer circle representing the community. The first step in considering Reproductive Justice issues is to look at the community in which the persons who may be vulnerable or oppressed live in. The community is defined by the identities in the outer circle: "race, class, immigration status, gender, sexuality, ability, age, geography, and religion/faith" (EMERJ, 2008, p. 2). The goal of this first step is to determine

how the identities that define a certain community can be affected either positively or negatively by reproductive oppression.

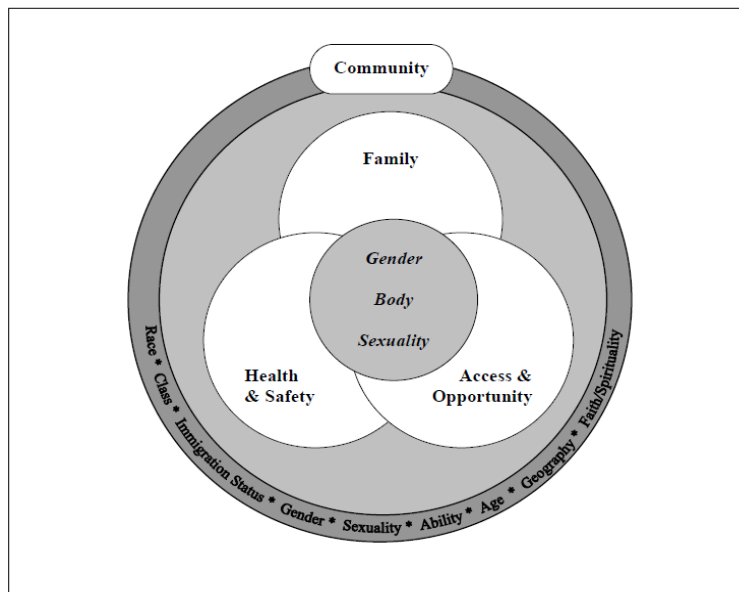
The second step is to look at the three arenas that encompass gender, body and sexuality: Family (in which it is defined by the persons involved); Health and Safety (complete well-being: physical, mental, emotional and spiritual); and Access and Opportunity (access to everything needed such as health care, education, jobs, housing and a life in which to thrive). When focusing on the arena of Family, it is important to identify the ways in which people may be denied in their ability to have and maintain their family. Applying the lens to the second arena, Health and Safety, involves the ways in which health and or safety may be compromised. The third arena area touches on Access and Opportunity, in which opportunities may be taken from people because of their gender, body or sexuality. This focus area not only includes health services but focuses as well on housing, employment, and education amongst others.

In the third step, issues in regard to gender (roles and expectations, identity and expression, oppression), body (physical control, physical conditions, health care) and sexuality (sexual health, knowledge, sexual identity and its expression) are identified. This third step focuses on identifying the challenges present in the community in relation to self-determination by taking into account gender, body, and sexuality.

By using the EMERJ Lens, the foci can be applied directly to the present study. The different foci of the EMERJ Lens assisted in framing the interview guide and choosing and/or creating the various questionnaires. To begin, the defined community for the present study consists of CNMPCs in and around Winnipeg. CNMPCs are looked upon less favourably than others by the general population (Matsick et al., 2014). It can be posited that this may extend towards the health care providers they may encounter. Under the first focus, Family, the literature review already indicates that CNMPCs are concerned about how the disclosure of

their lifestyle may negatively impact their children, more specifically that their children may be taken away from them (Vaillancourt & Few-Demo, 2014). The second focus looks into Health and Safety. The literature indicates that CNMCs fail to divulge their lifestyle when accessing health care, which can negatively impact their health and that of their offspring. This focus will allow for a greater exploration of CNMPCs and their experiences with the health care system. In the third focus, Access and Opportunity, relates directly to the present study due to the lack of disclosure of participants to their children, family and friends and colleagues in their workplace for fear of being marginalised or penalized for their lifestyle (Sova, 2012). This is even more concerning if CNMCs are also part of another group considered marginalized in some way (Sheff, 2011). In the present study, all three foci will be explored further as the EMRJ Lens was used to guide the semi-structured interview questions.

Figure 1 - The Reproductive Justice Framework (EMERJ Lens)



Reproduced with permission from: <http://www.racialequitytools.org/resourcefiles/ACRJ-RJ-Lens-Toolkit.pdf>

2.9.2 Cowan and Cowan's Ecological Model of the Transition to Parenthood

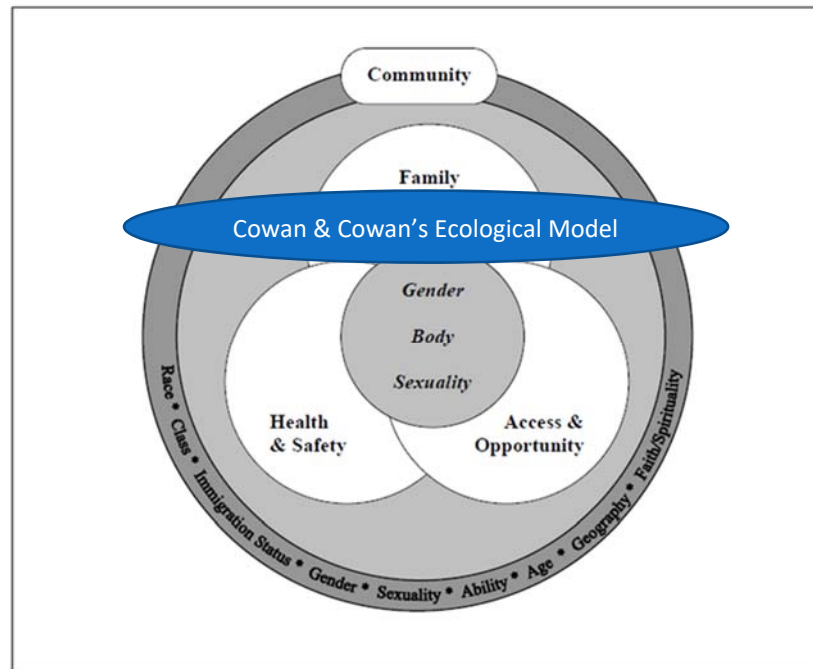
One of the key elements identified in the EMERJ Lens is Family. Since Cowan and Cowan (2000) present an ecological model for the transition to parenthood, it was retained to conceptualize parenthood with family for the present study. In lieu of adding to the existing literature on what happens when partners become parents, Cowan and Cowan created and evaluated a new preventative program, 'Becoming a Family Project' (Cowan & Cowan, 2000). Their study started as a pilot study which lasted 3 years, with a total of 16 participating couples, which then became a 10 years research project including 96 couples (72 expectant couples and 24 non parent couples). These couples were followed from their pregnancy till their child's first kindergarten year. Most importantly in this study, Cowan and Cowan were able to develop an ecological model encompassing the five central aspects of family life:

"1. The inner life of both parents and the first child, with special emphasis on each one's sense of self, view of the world and emotional well-being or distress. 2. The quality of the relationship between the husband and the wife, with special emphasis on their family roles and patterns of communication. 3. The quality of the relationships among the grandparents, parents, and the grandchildren. 4. The relationship between the nuclear family members and key individuals or institutions outside the family (work, friends, child care), with special emphasis on the stress and support that these people and institutions provide. 5. The quality of relationship between each parent and their first child." (Cowan & Cowan, 2000, p. 5).

These five aspects of this model are retained for the present study on CNMPCs. These five aspects helped the study conceptually, by providing a guide to choosing and creating the online questionnaires to be used as well as creating the interview guide, especially for the focus area of the Family within the Reproductive Justice Framework. Figure 2 (see p. 65) represents the adapted conceptual framework for the research study. The blue circle in the figure

represents where the five aspects of the model are situated within the framework to enhance family.

Figure 2 – Adapted Reproductive Justice Model



Adapted with permission from: <http://www.racialequitytools.org/resourcefiles/ACRJ-RJ-Lens-Toolkit.pdf>

2.10 Summary of Chapter

At the beginning of this chapter, various definitions were presented including reproductive justice, sexuality, sex, gender, sexual health, border sexuality, heterosexuality, heteronormativity, and mononormativity. Sexuality as a human right was then discussed. The clarification of these terms permitted the reader to better understand the various themes covered in the subsequent sections. The history and definitions as well as current statistics on marriage, divorce, and sexual monogamy were then presented. This was followed by an explanation of alternative forms of CNMCs including open relationships, swingers and polyamory/polyamorous couples. The next section described the transition to parenthood: its

definition, role changes, the quality of relationship, intimacy and sexuality in relation to pregnancy, childbirth, parenthood/postpartum and breastfeeding. This was followed by the section on CNMPCs by discussing non-monogamous research and the challenges faced by swingers and polyamorous couples. The next section pertained to nurses and sexual health, sexual health risks, and why it is important for nurses to be well versed in human sexuality as well as their comfort level. Health risks practices related to non-monogamy in general and then more specifically to CNMPCs were featured. Finally, the conceptual framework to be used in this research was explained by discussing the Reproductive Justice Framework and how the Family part is enhanced by Cowan and Cowan's Ecological Model of the Transition to Parenthood.

Chapter 3 - Methodology

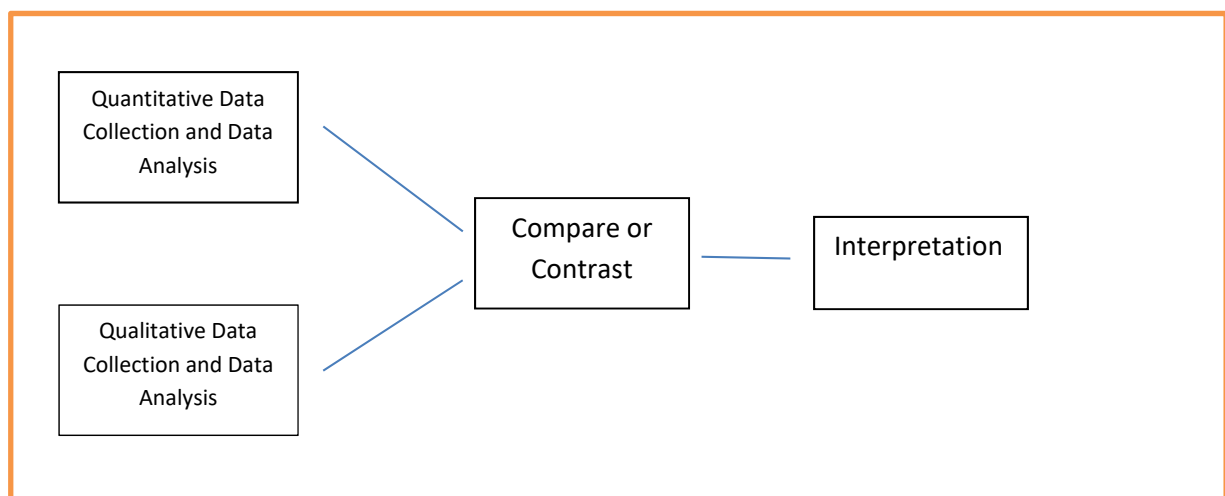
This chapter addresses research methodology. First, a brief description of the study design will be explained. Afterwards, the population and sample size will be presented followed by the study setting and methods of recruitment. The various stages of the study will then be detailed in the study procedures. Data collection and data analysis methods will also be covered. Finally, ethical considerations and a chapter summary will be featured.

3.1 Research Type and Design

This mixed methods study used a descriptive, exploratory research design. Mixed methods studies use more than one method of data collection in order to overcome the limitations or the weaknesses of a single design or complement strengths of another, and can address the research question(s) at different levels and explain and interpret as well as explore a research phenomenon (Creswell & Plano Clark, 2007). This study was also exploratory and descriptive (Fortin & Gagnon, 2016) as to date no research had been conducted on CNMCs during their transition to parenthood.

Figure 3 - The Triangulation Design-Convergence Model

(Adapted from Creswell & Plano Clark, 2007)



There are four main types of mixed methods designs: the triangulation design, the embedded design, the explanatory design, and the exploratory design. A triangulation design-convergence model (see Figure 3 on p. 67) was chosen for this study, including “a single phase, [and] both types of data are given equal emphasis” (Creswell & Plano Clark, 2007, p. 84). In this case, “the two sets of results are converged during the interpretation, and the intent is to draw valid conclusions about a research problem” (Creswell & Plano Clark, 2007, p. 84). This design was chosen for two reasons: 1) it is effective in saving time as both the quantitative and qualitative data are collected simultaneously, and 2) both data sets are of equal importance (Creswell & Plano Clark, 2007).

3.2 Setting, Population and Sample Size

This study took place in the prairie province of Manitoba, more specifically in the City of Winnipeg and its surrounding areas. Winnipeg is composed of multiple community areas or neighbourhood clusters including Assiniboine South, Downtown, Fort Garry, Inkster, Point Douglas, River East, River Heights, St-James-Assiniboia, St-Vital and Transcona. These neighbourhoods are very distinct from each other when considering sociodemographic characteristics. Winnipeg is a multicultural and multilingual city. It is also home for many people who are descendants of the First Nations. People of First Nations descent compose a larger percentage of Winnipeg’s population (10%) than the national average of 4.3 % (Statistics Canada, 2006). This number is expected to rise as birth rates amongst this population is greater than average (Statistics Canada, 2006). There is also an influx of indigenous people and immigrants from other countries into Winnipeg, the province’s largest city. The projected population for Winnipeg is expected to reach one million habitants over the next 20 years (CBC, 2013).

The sample was obtained from the population of this setting. The sample was a non-probabilistic, purposive one as Fortin and Gagnon (2016) explain that a non-probabilistic purposive sample is used when working with vulnerable or marginalized populations such as consensual non-monogamous partners. A purposive sample is achieved when selecting and recruiting participants based on predetermined selection criteria (Fortin & Gagnon, 2016). The selection process created a more homogenous group, which will allow a more in depths study of the phenomenon (Fortin & Gagnon, 2016).

The inclusion criteria were: 1) must be 18 years old and more; 2) have been in a consensual non-monogamous relationship in the last 2 years; 3) have started to be consensually non-monogamous before or during the transition to parenthood; 4) be a primary parent for the child(ren); 5) the child must still be in their care and have always been since birth; and 6) speak, read and write in English. The exclusion criteria were: 1) be in a same sex exclusive relationship; 2) be a secondary parent with little or no contact with the children; and 3) started being consensually non-monogamous after the last child was over the age of 2.

There are no current guidelines to determine the sample size but several publications are available to help with this determination. One way to decide the sample size is based on data saturation. For qualitative data obtained through conducting interviews, data saturation has been met when no new themes, findings, concepts or problems arise when additional data have been analyzed (Francis, Johnston, Roberston, Glidewell, Entwistle, Eccles, & Grimshaw, 2010; Guest, Bunce, & Johnson, 2006). Creswell and Plano Clark (2007) stated that achieving data saturation depends on the type of study conducted (phenomenology, ethnography or mixed methods). These same authors also mention that to achieve data saturation in a mixed methods study, between 4 to 10 interviews must be completed. Guest, Bunce and Johnston (2006) in their study attempted to find out at which point data saturation occurred in a homogenous group. They found that 73% of all codes (themes) for their codebook were found after the first 6

interviews and “the full range of thematic discovery occurred almost completely within the first twelve” (Guest et al. 2006, p. 66), with 97% of all the codes being discovered.

Francis et al. (2010) propose a more precise approach for data saturation. They counter what Guest et al. (2006) had proposed in their research by indicating that there was no way that 97% of data saturation could have occurred after 7 or 12 interviews, as they had analysed the data after every 6 interviews. Francis et al. (2010) make two recommendations: 1) a minimum sample size for initial analysis be determined prior to the start of research, and 2) determining “stopping criteria” (p. 1234). For this latter recommendation, stopping criteria are established by how many more interviews resulting in no new themes emerging after the minimum sample size is finished to determine data saturation.

Participants for this study were selected according to predetermined criteria (Guest et al., 2006), and were asked similar questions including the same set of questions from a semi-structured interview guide (Fortin & Gagnon, 2016). These two strategies limited the number of themes that emerged, and so, the Guest et al. and Francis et al. recommendations were applied as guidelines for the sample size in this study. Three interviews were conducted before initial analysis. Afterwards, interviews were added in groups of three to the data set, until no new themes emerged. A total of 6 interviews were conducted in this study.

3.3 Recruitment

After clearance was received from the ethics approval from the Research and Ethics Board of the University of Ottawa, participants were recruited in a variety of ways. The sample was partially obtained through key informants met during the clinical placement (January-March 2016) associated with the master’s course NSG5610. Numerous events were attended and allowed meeting key informants and providing recruitment possibilities. An information letter (Appendix 1) was sent to some of these key informants to invite them to participate in the study.

This information was then forwarded to other the members of their community who may have been interested in participating.

The second method of recruitment was through Fetlife. This is a platform very similar to Facebook, with an adult content. Clients use monikers instead of real names, normally related to their fetishes. The same moniker used during the clinical placement in NSG5610 was chosen and a page was created to connect with various clubs on the site (Appendix 2). An information/invitation letter (Appendix 1) was also provided to the Winnipeg Sex Positive Club and other local groups where CNMCs may be found. Another form of recruitment took place through the two or three local swingers' clubs in Winnipeg. These local swingers' clubs received an email (Appendix 4) that included an information letter (Appendix 1). This letter was then forwarded by the clubs' executives to their members. To increase research visibility, posters (Appendix 3) were placed with the owners' permission at local fetish boutiques such as the 'Love Nest' and 'Smitten'.

An information letter (Appendix 1) was also sent to *Aquarius Bathhouse*, requesting permission to place posters on its site. 'Aquarius' is a bathhouse that serves a very diverse clientele. To be able to enter Aquarius, a person must rent a room or a locker. He or she is then given towels, condoms, and sheets for the beds. Strict rules and etiquette are enforced: for example, if a door is closed, no knocking or entering; if the door is opened, anyone can enter; if a white chain is across the door, a person is invited to watch at the door but not to enter without first asking permission; a person must ask permission before touching another person. The bathhouse is designed to suit a variety of interests. On the first floor, there are showers, a sauna and private rooms. On the second floor, there are a few single rooms and couple rooms, theme rooms (for example, hot tub room, cage room, wheel room), as well as a home theater featuring various porn videos. On the first and second floors the lighting is adequate, but the basement is

an altogether different story: there is a dungeon, with various equipment to suit almost anyone's desires and fetishes, which can be used by the establishment's patrons. There are numerous private smaller rooms, as well as areas with 'glory holes'. There is a large 'cake' like bed in one of the areas downstairs, with seating all around, for everyone to enjoy. In the basement, they also have an area that has a home theater featuring mostly gay porn (Aquarius Bathhouse, 2019). Aquarius is one of the places that CNMCs frequent the most, as it provides a relatively inexpensive way to meet up with other couples to practice their lifestyle. It is common for Aquarius to host birthday parties for those who live the lifestyle as well (personal conversation with key informant-name not disclosed).

The fourth method of recruitment used was the snowball technique. This method involves participants proposing other names for the recruitment of subjects (Fortin & Gagnon, 2016). The main advantage of this recruitment technique is that it works very well with vulnerable and hard to reach populations (Fortin & Gagnon, 2016). Since this study is the first of its kind, this technique was helpful in the initial exploration of the aforementioned phenomenon. The study participants were invited to forward the information sheet via email (Appendix 1) to other potential subjects. The referred participants were then screened according to the research selection inclusion criteria.

3.4 Data Collections Methods

Quantitative and qualitative data were collected using various methods, including a questionnaire to collect sociodemographic and other characteristics, and complementary research instruments as well as a semi-structured interview guide.

3.4.1 Data Collection in Mixed Methods Research

Since this study used the triangulation design-convergence model (Creswell & Plano Clark, 2007), all of the data (quantitative and qualitative) were collected at the same time (one

phase), then analysed separately over a period of time. In such a mixed methods research design, it is only after the separate data analyses are completed that the data are converged.

3.4.2 Sociodemographic, Professional, Relational and Parenting Characteristics

A questionnaire was used to collect basic sociodemographic, professional, relational, and parenting characteristics (see Appendix 5). The development of this questionnaire was inspired by Jenk's (2014) online survey which was created to not only get a more current picture of swingers today but to compare swingers to polyamorists. This in-depth sociodemographic questionnaire permitted the student researcher to compare the data obtained from the study sample with characteristics of CNMCs published from previous studies.

The questionnaire containing 24 questions was used to obtain data on sociodemographic, professional, and relational characteristics as well as general mindset characteristics (conservative or liberal). The sociodemographic characteristics included age, civil status, citizenship (length of time in Canada), cultural affiliation, spoken language and revenue. The professional variables included employment status and types of work. The relational characteristics included gender, sexual orientation, and relationship description. The parenting characteristics included the presence of children, their number, their ages, and childcare arrangements. The political and religious affiliations included choice of political party, belief in a higher power, religious affiliation, church attendance, and current beliefs on marriage, divorce, and death penalty. These final variables are included in this study as they had been presented in previous studies (Jenks, 1998, 2014) by determining whether the participants had a conservative or a liberal mindset when comparing polyamorous people to swingers.

3.4.3 Qualitative Data

Each participant auto-identified being in a consensual non-monogamous relationship. Interviews were done individually. Participants who were a part the same relationship were offered a joint period of reflection after the individual interviews.

A semi-structured interview guide (Appendix 6) was developed for the purpose of this study in order to ensure that certain themes or questions were covered during the interview (Fortin & Gagnon, 2016). This format allowed some flexibility as there is not only continuity between interviews but also allowed the participants to engage more fully with the researcher. This increased participation fits well with the social critical theory wherein the research participants must play an active role. Semi-structured interviews are most often used in mixed methods research as they help during the data transformation process, or coding (Schreier, 2014).

The interview guide was developed by incorporating themes from the EMERJ, the Cowan and Cowan's Ecological Model as well as various other research themes that emerged during the literature review. The interview guide contained 32 questions and was divided into four different sections. The first part of the interview guide containing twelve questions explored the person's perceptions of his or her transition to parenthood. The second part contained three major questions with multiple sub questions focusing primarily on the couple's sexual style. The third part of the guide comprising eleven questions delved into the conciliation of the parenting and sexual roles. The final part of the interview guide, composing of six questions, focused on consensual non-monogamous partners and their perceptions of health care professionals and the health care system.

Prior to its first utilization, the interview guide was reviewed by members of the thesis committee for face and content validity. Face validity "is the appropriateness, sensibility or

relevance of the test and its items as they appear to the person writing the test” (Holden, 2010, p. 647). Content validity is a way to measure the extent to which the research instrument, in this case, the interview guide, covers the phenomenon being studied (Fortin & Gagnon, 2016).

Face and content validities were carried in the following manner. The members of the thesis committee filled in the Face and Content Validity Assessment Form (Appendix 7). After this, corrections were made to the interview guide and reassessed a second time. The interview guide was then reviewed by two health care professionals and allied parties using the same assessment form. Corrections were made as needed and discussion of the revised version was carried out with the thesis supervisor. In the last step of the validation of the interview guide, a pretest was done with one participant to assess if he/she understood the questions, determined if the questions were clear and in the right order, and obtained other comments as to the functionality of the interview guide. The semi-structured interview guide was modified as needed and finalized for the rest of the research participants. The pretest participant was not included in the final sample.

3.4.4 Quantitative Data from Research Instruments

Complementary research instruments were used during data collection to help compare the quantitative data with the qualitative data. These research instruments included the “Parenting Sense of Competence Scale” (Gibaud-Wallston & Wandersman (Appendix 8), 1978, as cited in Gilmore and Cuskelly, 2008) questionnaire, the “Personal Assessment of Intimacy in Relationships Inventory” (PAIR; Schaefer & Olson, 1981) (Appendix 9), as well as “The Parenting Role-Sexual Role Conciliation Scale” (Appendix 10) developed for this study.

3.4.4.1 Parenting Sense of Competence Scale (PSCO)

The PSCO (Appendix 8) was developed in 1978 by Gibaud Walkston and Wandersman (Gilmore & Cuskelly, 2008). This scale was developed to include two subscales:

value/comforting and skills/knowledge (Rogers & Matthews, 2004). The scale was developed further by Johnston and Mash in 1989 to measure parenting self-esteem (Rogers & Mathews, 2004), and contained two subscales: efficacy and satisfaction. Efficacy was defined as the competence and confidence level in handling any issues that may arise in child rearing (Johnston & Mash, 1989). Satisfaction was defined as the affect associated with parenting, for example, anger or anxiety (Johnston & Mash, 1989). In the latest study done by Gillmore and Cuskelly (2008), a factor analysis was carried out on the PSOC. Even if the factor analysis revealed 3 factors, a decision was made by the authors to keep it as a two-subscale research instrument measuring parenting efficacy and satisfaction.

The PSOC is a 17 items scale (with 2 subscales), rated with a 6 points-Likert scale, from 1 = "Strongly Disagree" to 6 = "Strongly Agree". Eight items (1, 6, 7, 10, 11, 13, 15 and 17) are reversed scored (Appendix 9). The seven questions under the subscale 'Efficacy' focus on the parents' competence, capability levels and problems solving abilities in their role as parents. The nine questions developed to examine the subscale 'Satisfaction' focus on parents' anxiety, motivation and frustration. A total score is obtained by adding the values for each item. A higher score indicates a more positive parenting experience (Gillmore & Cuskelly, 2008). The PSOC has an internal consistency using Cronbach's alpha ranging from 0.75-0.88 for the subscales and for the total scale (Johnston & Mash, 1989; Lovejoy, Verda, & Hays, 1997; as cited by Gillmore & Cuskelly, 2008; Ohan, Leung, & Johnston, 2000).

3.4.4.2 Personal Assessment of Intimacy in Relationships Inventory (PAIR)

The PAIR Inventory was created by Mark Scheafer and David Olsen in 1981 to assess the different dimensions of intimacy in relationships. Permission was obtained from Enrich Canada in September 2017 to use this inventory (see Appendix 22). It was initially created for dyadic heterosexual relationships from the initial friendship stage to other relationship stages

such as steady dating to marriage. At the beginning of the development of the PAIR Inventory, seven dimensions of intimacy containing 350 items were included (emotional, social, intellectual, sexual, recreational, spiritual and aesthetic). Of the 350 items, 113 were chosen and placed in each of the seven intimacy subcategories; a pilot study was then done in which psychometric test construction criteria were used (Schaefer & Olsen, 1981). Ten items were then selected for each subcategory using item analysis and factor analysis for 6 types of intimacy (emotional, social, intellectual, sexual, recreational, spiritual) as well as fifteen items for a conventionality scale, for a total of 75 items (Schaefer & Olsen, 1981).

During the second phase of the PAIR's development, testing for validity and reliability was done. Item and factor analyses were conducted to assure that adequate items were chosen for each subcategory of intimacy: this resulted in having six items in each subscale (Schaefer & Olsen, 1981). The second phase version is useful in that it measures expected level of intimacy versus realized level of intimacy. Pearson correlation coefficients were used in the third phase. The PAIR inventory was correlated with the Locke-Wallace Marital Adjustment Scale (Locke & Wallace, 1959). It was hypothesized that the participants who completed the PAIR Inventory would have higher perceived scores, and then they should also have higher scores on the Locke-Wallace Marital Adjustment Scale. This hypothesis was confirmed for all subscales of the PAIR Inventory except for the spiritual one, which ended up being removed from the final version (Schaefer & Olsen, 1981). A positive correlation was found between all the other subscales in the PAIR inventory and the Locke-Wallace, the coefficients exceeding .30 (Schaefer & Olsen, 1981).

The final version of the PAIR Inventory contains five subscales representing five dimensions of intimacy: emotional, social, sexual, intellectual, and recreational. All of the six scales developed have a Cronbach Alpha reliability of at least 0.70. The PAIR inventory

measures the perceived and expected levels of intimacy in a relationship. The scores are obtained by adding up the values for each item. Perceived and expected levels of intimacy can also be compared using the mean score. If a discrepancy is found between the perceived and expected levels of intimacy in a certain subscale, then there are difficulties in that area, in other words, less satisfaction with it (Schaefer & Olsen, 1981). Although the PAIR Inventory was designed initially to measure intimacy between heterosexual relationships, it has also been used successfully in same-sex and cross-sex relationship studies (Rhoads, 2014).

Two subscales were chosen from the PAIR inventory, the *sexual* and *emotional intimacy* subscales. These chosen subscales of the PAIR Inventory are mainly used in counseling to compare the scores obtained from the perceived and expected levels of both sexual and emotional intimacy. The difference between the perceived and expected levels is what the PAIR Inventory calls a 'discrepancy' (Olsen & Shaeffer, 2000). The purpose of the PAIR Inventory is not to evaluate whether couples have a high or low level of intimacy in a particular area, but to look at the discrepancy between the perceived and expected levels of intimacy. The absolute range of scores for each subscale of the PAIR Inventory falls between 0 and 96. In the initial study (Olsen & Schaeffer, 2000), the average perceived score for each of the sexual and emotional intimacy subscales fell between 48 and 58 for a non-clinical sample of 385 respondents. The range of discrepancy between the two scores (perceived and expected) in the initial study ranged from 0 to 70. This would indicate that a large range of discrepancy would be normal in any given population. The average discrepancy between the perceived and expected scores was 14 to 20 points. The greater the discrepancy between the two scores (perceived and expected), the lower are the levels of satisfaction in these areas. For the sake of this study, however, the perceived levels of intimacy for both sexual and emotional intimacy were obtained in order to be able to get a snapshot of where the couples were during the transition to parenthood and to be able to respond to Research Question #3 (see page 18). The

Cronbach alpha reliability coefficients for the sexual intimacy subscale and the emotional intimacy subscale are respectively 0.77 and 0.75.

3.4.4.3 The Parenting Role-Sexual Role Conciliation Scale (PRSRCS)

No research instrument could be found in the literature (English and French) that measures the conciliation between the parenting role and the sexual role during the transition to parenthood. The only research instruments that could be found measure work family balance (Netemeyer, Boles, & McMurrian, 1996), which did not explore the sexual dimension during the transition to parenthood.

The “Parenting Role-Sexual Role Conciliation Scale” (PRSRCS) (Appendix 10) was created by the student researcher and the thesis supervisor for the purpose of this study. Its creation was partially inspired by the format of the Work-Family Conflict Scale and the Family-Work Conflict Scale developed by Netemeyer, Boles, and McMurrian (1996). The initial list of items was drawn from the literature, particularly the writings of Basson (2000), Cowan and Cowan (2010), Fernandes (2009), Jenks (1985), Pallotta-Chiarolli (2010), Pallotta-Chiarolli, Haydon and Hunter (2013), and the Polomeno Perinatal Sexuality Scale (Polomeno, 2016). The ten items of this initial list represent four subcategories: family and sexual styles balance, parenting and sexual role balance, child care arrangement, and social network reactions. Each item is assessed according to a five-point Likert scale from 1 “Never” to 5 “Always”. Items 2, 3, and 8 are reversed for their values. A mean score is obtained by totalling the values of each item and then dividing by ten. A higher mean score represents a greater degree of conciliation between the parenting role and the sexual role during the transition to parenthood.

Face and content validities, which were previously defined, were obtained in the following way. The members of the thesis committee filled in the Face and Content Validity Assessment Form for the Parenting Role-Sexual Role Conciliation Scale (PRSRCS) (see Appendix 11). After this, corrections were made to the PRSRCS and reassessed a second time.

The PRSRSC was then reviewed by two health care professionals and allied parties using the same assessment form. Corrections were made as needed and discussion of the revised version was carried out with the thesis supervisor. After face and content validity was obtained, three more questions were added to the scale (Appendix 10). The thirteen items of the revised list represent four subcategories: family and sexual styles balance, parenting and sexual role balance, child care arrangement, and social network reactions. Each item is assessed according to a five-point Likert scale from 1 “Never” to 5 “Always”. Items 2, 3, and 8 are reversed for their values. A mean score was obtained by totalling the values of each item and then dividing by thirteen.

In the last step of the validation of the PRSRCS, a pre-test was done with 1 participant to assess if he/she understood the questions, determined if the questions were clear and in the right order, and obtained other comments as to the conduct of the PRSRCS. The PRSRCS was modified as needed and finalized for the rest of the research participants. The pre-test participant was not included in the final sample.

3.5 Study Procedures

After the initial phase of submitting and having the research protocol approved by the thesis committee, ethics approval was sought from the Research and Ethics Board of the University of Ottawa and obtained July 2017. Recruitment of potential participants began in September 2017. Once a potential participant was identified and had approached the student researcher, the latter verified that the participant met the inclusion criteria and answered any questions that he or she had regarding the research study. An information sheet (Appendix 1) was sent to the participant by email. Implied consent (Appendix 12) was obtained for the online questionnaires and audio recorded verbal consent (Appendix 13) was obtained from the participant prior to the interviews. Copies of the informed consent were kept by the student

researcher and the thesis supervisor as per the obtained ethics approval from the University of Ottawa.

Once informed consent was obtained, participants were invited to fill out a questionnaire containing questions pertaining to sociodemographic and other characteristics, as well as three research instruments on the sense of parenting competence, emotional and sexual intimacy, and the conciliation of the parenting role and the sexual role. This survey was done by supplying a link to the participant to an online survey using the platform "Qualtrics" at the beginning of the interview. This platform was chosen to guarantee, the privacy of the data collected via the online surveys. The online survey was answered on a tablet that was supplied to the participant prior to the interview or sent via email or via SKYPE before the interview was conducted. Each participant was attributed a participant number so that his or her personal characteristics could not be identified.

Once the sociodemographic, professional, relational, and parenting characteristics questionnaire and the other research instruments were completed, the semi-structured interview was conducted, either in person or via Skype, at a predetermined location and time that was mutually convenient for both the participant and the student researcher. If the interviews were conducted in person, a room was reserved for this purpose at the University of St-Boniface. The interviews lasted between one to two hours. The interviews were audio recorded and then transcribed.

The interviews were individualised due to the nature of some of the content that was explored. This allowed participants to have a separate space to speak openly about all aspects of their lives (Fernandes, 2009; Morris, 2001). This is especially important because in the Fernandes study conducted with swingers in 2009, the researcher found that there was a marked difference in the answers obtained for marital and sexual satisfaction when gender was

taken into account (Fernandes, 2009). According to Morris (2001), individual interviews are preferred when there is a possibility of having a dichotomy in the partner(s)' shared experience or a divergence of opinions in the lived experience of the research phenomenon under study.

After the individual interview, an optional period of reflection (either individual or joint) was offered to participants who are from the same relationship. The optional period of reflection was provided to each participant as the study is founded in social critical theory wherein the researcher and the participant are encouraged to have a dialogue, a sort of back and forth to allow the researcher to further explore the subject without having the constraints of an interview guide. This period allowed the participants to discuss anything that may have not already been included. During the period of joint reflection, participants were able to come together and discuss elements of the individual interviews that they chose which is very similar to the Work-Sharing Couples Project conducted by Bjornholt and Farstad (2012). In their study, interviews were conducted with each partner separately. These individual interviews were then followed by a period of joint reflection (Bjornholt & Farstad, 2012). The period of joint reflection created a common reflective space. It also allowed for co-development of arguments (partners were able to corroborate, clarify and support each other's statements that were revealed in the individual interviews). It also brought to light patterns of communication which added context and nuances to the narrative (Bjornholt & Farstad, 2012; Morris, 2001). The data obtained during the joint reflection were not added to the study, unless the participant(s) agreed to do so. This data were then written down verbatim as it was given and added to the interview transcriptions.

The quantitative and qualitative data were analysed separately and then compiled together for the interpretation phase of the data analysis. If any questions arose regarding the data, the student researcher communicated with the concerned participant and sought clarification for the answers to the interview questions. After completing the data analysis, the

research participants were invited to review research findings with the student researcher. The participants also received a summary of the research findings after the data had been analysed and the study was completed.

3.6 Data Analysis

In this section, the way data are analysed in the context of mixed methods research will be explained. Then, data analysis for the qualitative data as well as the quantitative data will be presented.

3.6.1 Data Analysis in the Context of Mixed Methods Research

In mixed methods research, there are two strands of data: qualitative and quantitative (Creswell & Plano Clark, 2007). In the triangulation design-convergence model, the qualitative and quantitative data are collected and analysed separately (Creswell & Plano Clark, 2007). The data are then compiled (converged) in the interpretation phase, after which the results are compared for similarities and differences. This convergence was used to validate and substantiate the results.

3.6.2 Qualitative Data Analysis

Creswell and Plano Clark (2007) propose an approach to analyse qualitative data but its description is very brief and does not provide enough details in a multi-stage way. To compensate for this, the Schreier (2014) approach to qualitative content data analysis was applied in order to enhance this section. This systematic approach to data analysis (Schreier, 2014) used inductive and objective methods to be able to infer themes that came up during data analysis. This approach began by submersing in the data by reading repeatedly after the interviews were transcribed following eight steps: “1) Deciding on a research question, 2) Selecting the material, 3) Building a coding frame, 4) Segmentation, 5) Trial coding, 6) Evaluating and modifying the coding frame, 7) Main analysis, 8) Presenting and interpreting the

findings” (Schreier, 2014, p. 174). The coding frame was then divided into main categories according to the main research topics after initially going through the transcripts. General impressions and thoughts were noted followed the general themes in the interview guide (Transition to Parenthood, Sexual Style/Sexuality, Conciliation of Roles and Health Care Professionals). This process allowed the researcher to get a sense of the bigger picture. Subcategories were then created after this initial submersion. This process continued as long as themes emerged. Once the coding frame emerged and categories and subcategories created, these were defined. These codes were then categorized based on their relationship to one another. This general method of conventional data analysis is important since it allows the information to come directly from the participants without imposing categories (Schreier, 2014). Once this process of segmentation was completed, a trial coding was done. The coding frame was then applied to two rounds of coding (coding the material on day one and then again between days 10 and 14 by the same researcher) (Schreier, 2014). This method of coding is used to assure the validity of the obtained themes (Schreier, 2014). The coding scheme was then assessed with the thesis supervisor, and adjusted as needed. Once the trial coding was completed, the results of the trial coding were evaluated for both consistency and validity.

During the process, the two rounds of coding were first compared for consistency. This permitted the researcher to reorganize the coding frame to eliminate any inconsistencies and subcategories that could be interchangeable. To ascertain validity, the categories were examined to determine to which degree they describe the research concepts and questions. After this trial coding phase, the main analysis was completed. The remaining data were broken down into the coding units. Any inconsistencies that arose during the main analysis phase was presented to the thesis supervisor and the members of the thesis committee to be discussed and resolved. This approach to the analysis of the qualitative data is relevant as the purpose of

this study is descriptive and exploratory in regard to the phenomenon that is under consideration (Lincoln & Guba, 1985 as cited by Hsieh & Shannon, 2005).

3.6.3 Quantitative Data Analysis

Descriptive statistics (Creswell & Plano Clark, 2007) were applied to all variables contained in the initial questionnaire as well as the research instruments (the PSOC, the 2 subscales of the PAIR, and the PRSRC) as the sample size was not large enough to conduct any other statistical analyses. Mean, median, standard deviations and frequencies were calculated using SPSS Statistics version 24 (IBM, 2016).

3.6.4 Methodological Rigor

Mixed methods research needs to respond to methodological rigor (Fortin & Gagnon, 2016). To assure methodological rigor in mixed methods research, the study needs to adhere to the criteria of the dominant research method (Fortin & Gagnon, 2016). However, in the present study, equal emphasis was put on the qualitative and quantitative components.

To assure methodological rigor, for the *qualitative* data, the four criteria of credibility, transferability, fidelity, and objectivity were followed (Fortin & Gagnon, 2016). Credibility refers to which extent the description of the phenomenon given by the researcher reflects the lived phenomenon of the participant. To assure credibility of the qualitative and quantitative data, triangulation was used with multiple sources of data to corroborate or not research findings. Transferability refers to the possibility of applying the research findings to other situations. This criterion was met by keeping a reflective journal, which assures an adequate description of the contexts during which the data are collected. Fidelity, on the other hand, serves to evaluate the integrity of the data collected over time and in similar contexts. In other words, if the same study would be conducted with participants meeting similar characteristics, the results would be similar. For this reason, consistency and validity were obtained as mentioned previously.

Objectivity assured that the results reflected by the researcher were in fact the point of view of the participants and not that of the student researcher.

For the *quantitative* data, since the sample size was small in the present study, internal and external validities were based on the quantitative results on their own, especially because descriptive statistics were used. By using research instruments with sound psychometric qualities that had been already in use and proven in multiple other studies (PAIR and the PSOC), the student researcher was able to guarantee reliability and validity of the obtained results. As for the PSCRSC which was developed for the present study, prior to its first utilization, both face and content validities were obtained; this scale was subsequently slightly modified. This tool was then pretested to ascertain that the obtained results for the scale reflected the concepts that were being measured. As Polit and Beck (2018) state, if the quantitative data support the quantitative data in mixed methods research, the researcher can be more confident in the inferences drawn from the two data sets. This ensures enhanced validity of the research findings (Polit & Beck, 2018). The credibility of the quantitative results was also obtained by comparing the quantitative data to the qualitative data by means of triangulation.

3.7 Ethical Considerations

CNMCs fall into the category of border sexuality (Pallota-Chiarolli, 2010). Border sexualities encompass sexualities that do not fit in the “gay/straight divide and are beyond the monogamous heterosexual or homosexual framework” (Pallota-Chiarolli, 2010, p. 1). These border sexualities can include bisexual, sexually fluid or sexually flexible identities (people who are attracted to both male and female), multisexual families (parents and other family members who are of varying sexual identities) and polyamorous or multipartnered families. For this last group, Pallota-Chiarolli (2010) defines them as: “parents and other family members who are in

openly negotiated loving/intimate/sexual relationships with more than one person” (p. 2). CNMCs would be considered a more vulnerable population and as such, viewed less favourably than the general population. In this regard, it was important when conducting research with them to focus on who benefits from the research being done as well as why. Research studies conducted with vulnerable populations must benefit these same people (Pepin, Kerouac, & Ducharme, 2010). Keeping this in mind, this mixed methods study was undertaken with the social critical theory. The interviews occurred in the form of dialogue, using semi-structured interviews guided by themes that were added to by the participants themselves. The participants were asked to actively engage in the research study before, during and after its completion. Because of this, the research was adaptable so as to focus not only on the phenomenon of interest but on what the participant wanted to discuss or add to the research. The end goal is to provide better care for this population, as nurses will gain a better understanding of the couples’ sexual style and lifestyle from their own perspective as well as to how they reconcile their parenting role with their sexual style.

Prior to starting the recruitment phase of the research, ethics approval was sought from the Research and Ethics Board of the University of Ottawa (see Appendix 21). Each participant received an information letter (see Appendix 1) detailing the background of the study, its purpose and design, the study procedures, the length of the study, the possible side effects, the benefits of the study, the withdrawal procedures, how confidentiality is maintained, as well as who to contact if the participant has any questions in regard to the study. Each participant, after having had an opportunity to review the information, and prior to participating in the research, was invited to sign a consent form or give implied consent indicating that he/she understood the research. The consent form included general information, a short description of the research project, the length and conditions of participation, compensation (or lack thereof), conservation

and protection of data, how information about research will be received, the voluntary aspect of the research (ability to withdraw) as well as the researcher's responsibilities (Appendix 12).

To maintain the confidentiality of research participants, close attention was paid to the conservation of data. Each consent form contained a participant number, which was then used to identify any further documentation (recording of interview, transcription of interview and questionnaires) provided by the research participant. The participants were given the option of conducting the interview in person or via Skype. All data were kept on an encoded flash drive (password protected) and paper copies were kept in a locked cabinet in the student researcher's office at the University of St. Boniface. All data will be kept for 5 years, starting on October 1st, 2017 and terminating on October 1st, 2022. After this five years' time period, all data pertaining to the research will be destroyed according to the University of Ottawa procedures.

3.8 Summary of this Chapter

This chapter addressed the methodology used to describe CNMCs' perceptions during their transition to parenthood living in and around Winnipeg. This mixed methods study used a descriptive, exploratory research design, particularly the triangulation design-convergence model. A variety of recruitment methods were used, including using key informants, contacts with key associations, and the snowball technique. A variety of qualitative and quantitative data collection methods were utilized including, a sociodemographic, professional, relational and parenting questionnaire, a semi-structured interview and a variety of complementary research instruments (PSCO Scale, PAIR Inventory and the PRSRCS). The semi-structured interview guide and the PRSRCS were both validated for face and content validities prior to utilization. The quantitative data were analyzed using descriptive statistics (Fortin & Gagnon, 2016), while the qualitative data were analysed using general qualitative analysis (Schreier, 2014). Ethical

considerations were also presented in relation to the present study and for obtaining approval from the Research and Ethics Board of the University of Ottawa.

Chapter 4 - Results

This chapter presents the results from both qualitative and quantitative data collected from a sample of six participants who took part in the study. Firstly, the participants' profile and their beliefs are presented. This is followed by the second section that presents the themes, categories and subcategories that emerged from the qualitative data analysis. The next five sections present the results in relation to the perceptions of CNMPCs regarding their transition to parenthood, intimacy and communication during transition to parenthood, the conciliation of roles during the transition to parenthood, and finally, CNMPCs' relationship with health care providers. The quantitative data are integrated with the qualitative data within the different sections. The last section presents the summary for this chapter.

4.1 Participants' Profile and Beliefs

This section presents the participants' profile and beliefs (see Appendices 14 and 15). The results presented in this section correspond to the first research question (see p. 18). A total of eight participants responded to the online questionnaire and only six of them completed both the online questionnaire and the semi-structured interview; four of the six participants participated as two couples in this study.

For the first section of the participants' profile concerning the sociodemographic characteristics (see Appendix 14), four participants identified as female and two as male. The participants' ages ranged from 31 to 45 years of age ($M = 37.67$ years; $SD = 6.37$). Their income ranged from under \$19 000 to over \$60 000, with 50% making over \$60 000. All participants were Canadian-born: five were born in Manitoba, one in Quebec. The majority identified as Canadian while one participant identified as Métis. All of the participants spoke English, while two of them also spoke other languages such as French, Spanish and Hungarian.

For the second section concerning employment characteristics, half of the participants worked part-time, while the other half worked full time. Most of the participants worked in administrative fields or in the software industry (66.7%), another in health care, and the last one as a professional housekeeper.

For the third section concerning the relationship characteristics, five participants identified as bisexual or pansexual and one as heterosexual. At the time of study, four participants declared their marital status as married, one as common-law, and one as separated. During the transition to parenthood, five of six participants were married, and one was common-law. Four participants are still married after the transition to parenthood whereas two are divorced.

The fourth section presents the parenting characteristics. Two participants had one child, one participant had two children, and three participants had 3 or more. The children's ages ranged from 2 to 14 years ($M = 10.63$; $SD = 4.36$). One of the participants did have a child who was 28; that child was not included in the study because this participant was not in an open relationship at the time.

This final section presents the participants' values and beliefs (see Appendix 15): these data were obtained so that they could be compared with those from samples in published studies (Jenks, 2014; O'Byrne & Watts, 2011; Sheff & Hammers, 2011). The political affiliations of the present sample varied from conservative to liberal. All participants believed in marriage, same-sex marriage and divorce. Four were against the death penalty. The majority of the participants (66.7%) believed in a higher power, however, only 33.3 % attended religious services on a regular or semi-regular basis.

4.2 Themes, Categories and Subcategories That Emerged from the Qualitative Data

The Schreier (2014) method was used to analyse the qualitative data. Five themes (see Table 1 on p. 92) emerged from this data analysis: perceptions of CNMCPs and their transition to parenthood, intimacy and communication during the transition to parenthood, relationship evolution and sexual style during the transition to parenthood, the conciliation of roles during the transition to parenthood, and the relationship with health care providers. Fifteen categories and thirty-five subcategories were identified in relation to the five themes. All of the themes, categories and subcategories were identified entirely from the data collected after the first three interviews. No new themes, categories or subcategories were found between the fourth and sixth interviews.

Table 1 - Themes, Categories and Subcategories That Emerged from Qualitative Data Analysis

<i>Themes</i>	<i>Categories</i>	<i>Subcategories</i>
<i>Perceptions of CNMCPs regarding their transition to parenthood</i>	Decision to become a parent	Conscious decision Unplanned pregnancy
	Pregnancy	Positive reactions Negative reactions Health complications
	Childbirth	Uncomplicated Complicated
	Birth to 2 years	Birth to one year One year to 2 years of age
<i>Communication and intimacy during the transition to parenthood</i>	Communication	Changes in communication with the arrival of children Impact of mental health on communication

	Intimacy	Changes in sexual intimacy Changes in emotional intimacy
<i>Relationship evolution and sexual style during the transition to parenthood</i>	Contemplating CNM	Comparison of societal norms Initiator of the discussion
	Acting on CNM	Arriving at a consensus Importance of communication Exploration of various sexual styles and CNM
	Incorporating CNM as a lifestyle	Disclosure Sexual and health related practices Influence of gender and sexual identity on sexual expression
<i>Conciliation of roles during the transition to parenthood</i>	Family functioning	Household chores Childcare responsibilities Prioritization
	Impact of sexual style on parenting	Each other' expectations as parenting partner, sexual partner, and conjugal partner Flexibility and ability to discuss difficult subjects with children
<i>Relationship with healthcare providers</i>	Fear of judgment	Heteronormative assumptions Perceived judgment Fear of repercussions of lifestyle on parenting
	Health risk awareness	Informed consumer Pregnancy and STI prevention
	HCPs' lack of training in CNM	Lack of sexual education in schools Prenatal period

	Factors facilitating and hindering the relationship	Factors that facilitate the relationship. Factors that hinder the relationship
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4.3 Perceptions of CNMPCs Regarding their Transition to Parenthood

The *first* theme that emerged from the data analysis was pertaining to the *perceptions of CNMPCs in relation to their transition to parenthood*. Four categories are associated with this first category: *the decision to become a parent, pregnancy, childbirth, and birth to two years of age*. The results from the Parenting Sense of Competence Scale are presented at the end of this section. The results in relation to this section correspond to various parts of the Research Questions 2, 3 and 4 (see p. 18).

4.3.1 Decision to Become a Parent

The first category concerns the decision to *become a parent*. This decision can happen either by making a conscious decision, after much deliberation and communication, or may come about in a more unexpected fashion. All of the participants had conversations with their primary partners during their relationships about having children prior to conceiving. Four participants made a conscious decision to become parents. One participant (P1) stated: “It was the next logical step.” For the other two participants, pregnancy was unplanned as both of them were in postsecondary school at the time. These latter two participants expressed how they did not have enough time to think about the transition to parenthood due to everything else that was happening all at the same time.

“well for one of them I was in school for most of it so, I was being distracted so ya it was fine” (Participant P4).

“I had moved to Winnipeg and their dad came with me [...]. Umm, I was working and I was enrolled in college and 2 weeks after I found out I was pregnant.” (Participant P3).

4.3.2 Pregnancy

The second category in relation to *pregnancy* resulted in three subcategories: positive reactions to the pregnancy, negative reactions to the pregnancy, and health complications.

All participants expressed happiness and excitement about their pregnancies and having children. For four of them, the participants who received more support and/or were able to give support were better able to handle the transition to parenthood. However, some participants did have a negative reaction to the pregnancy. One participant (P3) expressed some anxiety about her second pregnancy because her first child had been identified as ‘high needs’. Another participant (P4) had health issues which led to difficulties in the relationship between her primary and secondary partners. “I felt jealous of her partners” and “felt like a third wheel”. Two of the participants who were part of the same relationship (Participants P1 and P2) experienced multiple spontaneous abortions which affected their pattern of communication and changed the support they were able to provide to each other during this period of time. Participant P1 claimed, “...he was very.... unsupportive, emotionally unavailable”, which was a change as before the perinatal losses, “we were very giving to each other, very considerate of each other”.

4.3.3 Childbirth

The third category in regard to *childbirth* contains two subcategories: uncomplicated and complicated childbirth. For the four female participants, two of them had uncomplicated birth experiences, while two others had difficult births which included multiple gestation, perineal tearing, and postpartum hemorrhage. Despite the difficult birth, one particular participant (P1) described the immediate bond that she experienced with her child, “Instant love...I would do it a million times over for her”. Another participant (P6) claimed that it took time to grow into the role

of parent and bond with her offspring. One participant (P4) claimed that her male partner was traumatized after childbirth: “No guy ever wants to see that”. Because of this, it took longer to resume sexual relations postnatally with her primary partner, while she had continued with her secondary partner. One of the male participants (P2) described the childbirth experience as “hard, beautiful, interesting, fascinating, scary.”

4.3.4 Birth to Two Years of Age

This section contains two subcategories pertaining to the fourth category of *first two years of life* with a new child: the immediate postpartum period up to one year, and one to two years.

The immediate postpartum period (first six postnatal weeks) and the period from 6 weeks up to one year were often characterized by postpartum depression (PPD) for several participants. Three of the four female participants were diagnosed with PPD, while five of the six participants dealt with PPD either in a partner or themselves. One female participant who developed PPD after the birth of her second child was diagnosed with postpartum psychosis after the third one.

Two of the three female participants who were diagnosed with PPD had a decreased desire to communicate their needs or resolve problems with their partner.

“There was a lot of resentment and it started to grow, and then, that led to further communication breakdown where I don’t want to share anything with him because I need to have my words shared especially during the PPD stuff, because I was dismissed yelled at, criticized, um... not and just overall not supported which made me... want to share less.” (Participant P1).

“That intermediate time, communication really eroded apart. I don’t say this in a blaming way though it sounds blaming, it was mostly my wife kind of holding back not telling me how she felt or letting me know what she needed from me. Um so... then that kind of came to a head this summer in some sort of conversations and all these things she had been holding back for too long finally came out. Um, but we, confronted those, we dealt with them, made some changes and then like I said, the communication, is not all the way rebuilt to where it was but mostly to where it was.” (Participant P2).

Five participants stated that they had a difficult time meeting their own needs during the initial postpartum period and into the first year. The only participant who did not suffer from PPD was better able to recognize and prioritize his own needs and to do so earlier in the postpartum period. Indeed, mental health concerns did affect intimacy and communication patterns in the postnatal period (see Section 4.4).

For this sample of participants, the postpartum period was compounded by parents experiencing complications associated with their children or sleep deprivation. Five participants had a ‘high needs’ child as their first and/or third child. One of the participants struggled with her third child who had difficulty gaining weight while breastfeeding and was born deaf, so this child was oftentimes inconsolable. Another participant (P2) described the first three postnatal months as being traumatic because of the lack of sleep and the inability to console their child in the initial postpartum period. Sleep deprivation was another factor that made the postpartum period difficult: four participants expressed how sleep deprivation in the first six months was ‘extreme’.

“She is very much the high needs child... and uh... then I mean...about 10 days in, the colic started, the screaming, like just the consistent screaming and trying the ovol and gripe water the biogaia, and warm water and the tummy compressions and nursing

and... it was a very trying time. She didn't really stop screaming till 13 weeks."

(Participant P1).

However, one of the participants (P2) became more involved as a parent once the child was a year of age as both he and his partner were working by that time. Sharing the childcare responsibilities made this male participant realize how difficult parenting can be:

"I wish I could go back, to those early days, especially that first year before she went to work with a greater understanding of what it means to be home with a child uh... all day and offer better support being armed with that knowledge, but unfortunately I didn't really have the opportunity to understand what that was like until she went back to work and it became my role to do the same so... lots of things I'd do different." (Participant P2).

All of the participants in the study expressed how adjusting to having children took time. This adjustment was more difficult when they went from one to multiple children (birth of twins). The adjustment to parenthood differed between the male and female participants. The men identified themselves as a parent when their first child was born whereas the women identified themselves as a parent during their pregnancies (three of the four female participants). Participant P1 explained it this way, "When I became pregnant, I became a parent... I would say that once my daughter was born he became a parent."

4.3.5 Results from the Parenting Sense of Competence Scale

The results from the Parenting Sense of Competence Scale (PS CS) are added in this section to broaden the picture of CNMPCs' perceptions of their transition to parenthood. One of the factors influencing parents' transition to parenthood is their sense of mastering their parenting role, which has an impact on the family's functioning as a whole (Condon et al., 2004). This scale measures parental efficacy and satisfaction and the results can reveal a parent's

confidence in handling issues of childrearing (see Table 2 on p. 100). The total score can potentially range from 17 to 102, with the higher score indicating the parent's higher level of confidence in his or her parenting. All participants' total scores were on the higher side of the PSCS, with a range of between 74 and 90 ($M = 84.00$; $SD = 6.85$). The male participants (P2, P5) in the study had amongst the lowest total scores for their parenting sense of competence (75, 77), as well as one female participant (P1), who had a total score of 74. These three participants (P1, P2, P5) were less confident in their parenting role.

A deeper analysis of the results from the Parenting Sense of Competence Scale (PSCS) were carried out on the *efficacy* and *satisfaction* subscales (see Appendix 16). The items that are part of the *efficacy* subscale are #1, #6, #7, #10, #11, #13, #15, and #17, while those for the *satisfaction* subscale are #2, #3, #4, #5, #8, #9, #12, #14, and #16.

For the *efficacy* subscale ($M = 41.33$; $SD = 2.77$), if at least 5 out of 6 participants scored 5 and more (on a six-point Likert scale), it was considered high efficacy, otherwise it was considered low efficacy. The only item that produced the lowest score for the efficacy subscale was Item #7, 'Being a parent is manageable and any problems are easily solved'. Four participants scored 5 out of 6, while 2 others scored 3 out of 6. This would indicate that there are challenges associated with parenthood and that these problems are not easily solved. However, for Item #17, 'Being a good parent is a reward in itself', had the highest number of participants (four out six) who scored 6 for it ('Strongly agree'). For this sample of parents, being a parent was rewarding, despite the challenges that are part of the transition to parenthood.

The scores for the *efficacy* subscale were also compared in regard to the participants who were *couples* (P1 and P2, P5 and P6). The scores for each couple were similar for the *efficacy* subscale, however, there were differences (a difference was considered when there was a difference of two points or more for the item). For Participants P1 and P2, concerning

Item #1 ('The problems of taking care of a child are easy to solve once you know how your actions affect your child') and Item #11 ('If anyone can find the answer to what is troubling my child, I am the one'), the father (P2) scored lower for these items compared to the mother (P1).

Table 2 - The Participants' Scores for the Parenting Sense of Competence Scale

Participant	P1	P2	P3	P4	P5	P6
Efficacy Score (8-48)	43	39	46	43	39	41
Satisfaction Score (9-54)	31	36	48	47	38	43
Total Score (17-102)	74	75	94	90	77	84
Range <i>Mean</i> and <i>SD</i> for <i>Efficacy</i>	41.33 (2.77)					
Range <i>Mean</i> and <i>SD</i> for <i>Satisfaction</i>	41.00 (6.36)					
<i>Mean</i> and <i>SD</i> for <i>Total Score</i>	82.33 (8.36)					

The mother (P1) in this relationship was more efficient for parenting than the father (P2). For the other couple (Participants P5 and P6), there was a difference for them for item #7, 'Being a parent is manageable and any problems are easily solved': the father participant (P5) scored lower for this item (3) compared to the mother (P6), who scored a 5. Overall, the similarity for efficacy was quite high for both of these couples, indicating that there are working together as a team and have found a way to help each other in their parenting.

For the *satisfaction* subscale ($M = 41.00$; $SD = 6.36$), if at least 5 out of 6 participants scored 5 and more (on a six-point Likert scale), it was considered high satisfaction, otherwise it was considered low satisfaction. The items that produced the most frustration, thus affecting their parenting motivation, and lowered their level of satisfaction were: Item #3 ('I go to bed the

same way I wake up in the morning, feeling I have not accomplished a whole lot'), Item #4 ('I do not know why it is, but sometimes when I'm supposed to be in control, I feel more like the one being manipulated'), and Item #14 ('If being a mother of a child were only more interesting, I would be motivated to do a better job as a parent'). On the other hand, the two items that were identified as producing high satisfaction were: Item #8 ('A difficult problem in being a parent is not knowing whether you're doing a good job or a bad one'), and Item #16 ('Being a parent makes me tense and anxious'). The participants felt that they were doing a good job as a parent and that they were relaxed about their parenting role, thus contributing to their perception of satisfaction with the parenting role.

The scores for the *satisfaction* subscale were also compared in regard to the participants who were *couples* (P1 and P2, P5 and P6). A difference was identified when there was a difference of two points or more for each item of the *satisfaction* subscale. For Participants P1 and P2, there was a great difference in their scoring for the *satisfaction* subscale: there were differences for seven out of nine items (78%) (Items #2, #3, #4, #5, #8, #9, and #14), while there was similarity for only two items of this subscale (items #12 and #16). When parenting partners cannot be satisfied with their parenting role, this can indirectly affect their relationship. For the other couple (Participants P5 and P6), only one item (#9) presented a difference, so their perception of satisfaction with parenting was highly similar (89%). For this latter couple, having greater satisfaction with the parenting role can spill over with greater satisfaction with their relationship.

The qualitative results from the PSCS can be compared with those from the qualitative ones previously presented. The PSCS results actually corroborate the results obtained from the qualitative data: for example, the fathers identified with their parenting role later in the process once their child was born or when their child/children was around a year of age. Their scores

were lower than those of the mothers in the sample who identified as a parent during pregnancy. The participant (P2) who had one of the lowest scores was also the one that stated that the initial postpartum period was traumatic. His situation was compounded by dealing with multiple other issues (a partner with PPD, a 'high needs' child, difference of opinions in parenting styles, a daughter preferring being consoled by his partner). All of these factors affected his ability to identify with his role as a parent, but when he did, it was when his child was older.

4.3.6 Summary for this Section

In this section, the results pertained to the first theme, *Perceptions of CNMPC's regarding their transition to parenthood*. When it came to the decision to become a parent, either participants made a conscious or planned decision to do so or, the pregnancy came about more unexpectedly. Participants either had positive or negative reactions to their pregnancies. A number of participants also had some pregnancy complications, which affected their intimacy and communication. Participants recalled either complicated or uncomplicated labor and deliveries, which affected the initial postpartum periods. From Birth to two years of age, participants stated that the adjustment to children took time. A high number of participants were affected by mental health concerns, which in turn played a role in intimacy and communication. They also expressed concerns in meeting their own needs, which was compounded if they had a high needs child. Finally, the results for the PSOC were presented, the participants scoring on the higher end of the scale. When a deeper analysis was conducted on the efficacy and satisfaction subscales, the results corroborated the qualitative data.

4.4 Communication and Intimacy during the Transition to Parenthood

The *second* theme that emerged from the data analysis was pertaining to *communication and intimacy during the transition to parenthood*. Two categories are associated

with the section: *communication* and *intimacy*. The results from the PAIR Inventory-sexual and emotional intimacy subscales, are presented at the end of this section. The results in relation to this section correspond to various parts of the Research Questions #2, #3 and #4 (see p. 18).

4.4.1 Communication

The first category in this theme involving *communication* resulted in two subcategories: changes in communication with the arrival of children and the impact of mental health on communication. These varying levels of communication also played a role in the expression and desire for sexual intimacy (see section 4.4.2)

All participants recognized the importance of communication in maintaining their relationships. Five participants noticed an overall change in their communication patterns during the first year of parenthood and one did not. Two participants noted an improvement in their communication which was out of necessity: they were more open and honest with each other, after having children.

“...then having children, you really do need to be able to communicate, um... you have to be able to communicate your needs with respect to what the children need, um... and and, how you are going to meet those needs together as a team” (Participant P6).

This ability to come together as a parenting team allowed them to be able to come together as a couple, thereby overcoming various obstacles that came their way and being able to hear one another out, by listening and understanding.

Two participants (P1 and P2) noticed a decrease in their ability to communicate as well as their desire to express their wants and needs. This couple reported drifting apart and experiencing a decreased level of intimacy stemming from perinatal losses while trying to conceive. They worked on regaining intimacy in their relationship and increasing their capacity

to communicate with each other, which eventually improved after their child was a year of age. Having a difference of opinion on childrearing practices contributed to the communication breakdown, leading to increased tension in their relationship. An example given by Participant P1 is as follows:

“OMG, she won’t sleep in the bassinet. OMG we’re cosleeping. OMG, I’m going to roll over and kill her, like and [Partner] was being like you can’t bring her into the bed it’s dangerous. I’m like but... it was extremely stressful.”

The added stress of postpartum depression and having a high needs child are two other factors that contributed to the breakdown in their communication.

One participant (P3) noted an increase in intimacy and emotional connection after the birth of her second child, but a decrease after the birth of her third child that was related to having a high needs child and mental health concerns.

“We did have a very intimate relationship, like holding hands and being able to hold a conversation. And like most of that stopped after having my son *third child.” (Participant P4).

When five participants faced mental health concerns, in either themselves or their partner, this added more stress to their relationships, which either brought the couples closer together or drove them apart. These concerns were brought on or compounded for the majority of the participants by having a ‘high needs’ child. Two participants were able to surmount this hurdle by working on rebuilding their communication, eventually leading to an improvement in this part of their relationship. For the other three participants, mental health concerns (PPD and PPD with psychosis) led to a breakdown in communication. For one participant (P3), her mental health concerns ultimately led to the breakdown of her relationship with her partner. This

breakdown occurred during the postpartum period after the birth of her third child during which her primary partner had an extra conjugal affair. This participant (P3) was upset when her partner left because she was alone. In hindsight, she understood the reasons for why he left, “it wasn’t his job to fix me, their dad leaving me made me take responsibility for my own mental health”.

4.4.2 Intimacy

Two subcategories emerged under the second category of *intimacy*. The changes in sexual intimacy are first presented, followed by changes in emotional intimacy.

In general, the male participants did not see a change in their sexual interest throughout the transition to parenthood. The female participants’ libido varied not only amongst themselves but also from one pregnancy to the next as well as after the birth of each of their children. One participant expressed very different levels of sexual desire during her two pregnancies. During her first pregnancy, she turned inward and was not interested in sexual intimacy; however, in her second pregnancy, her libido increased to a point that her partner had a difficult time meeting her needs. Her partner (also a participant in the study) was able to adjust to the changes in their sex life to better respond to his wife’s sexual needs. The other participants experienced little or no change in libido during pregnancy or experienced a decrease in sexual desire leading to decreased sexual intimacy.

All participants waited until after healing from perineal tearing in the postpartum period to resume sexual activity. Those who experienced childbirth complications had a longer period of reduced desire and ability to engage in sexual activity. On occasion, the perineal tearing became an excuse to not resume sexual intercourse, as expressed by the following participant.

“I feel like it (the tear) saved me for a little while of not having, giving me an excuse not to have sex and then the baby crying and then oh oh, baby’s crying I would have to do this to, we started, I started cosleeping in my daughter’s room and I’d say a big portion of that was uh... to kind of escape unwanted advances.” (Participant P1).

All of the participants indicated that the opportunity for sexual intimacy decreased after having children, however, they were still open to exploring new sexual practices, not only in regard to sexual intimacy but to better prepare themselves by meditation or relaxation before the sexual encounter.

Three female participants expressed their perceptions about their postpartum bodies in the interviews, and how these perceptions reduced their sexual desire or interest in being an object of desire. Participant P3 stated that, “I did not feel like myself afterwards or sexy, an object of desire.” They did not feel as attractive during or after the immediate postpartum period. However, perceived attractiveness rebounded by the time the first child was a year of age. Less negative feelings about changes to their bodies were reported with subsequent children.

Breastfeeding also influenced some participants’ levels of sexual intimacy. Two female participants expressed their decreased libido in relation to breastfeeding. Their libido returned as the frequency of breastfeeding decreased. Two of the participants expressed ‘touch fatigue’ (Participants P1 and P6).

“I did not want my breasts touched, I uh... it also, I definitely had the I’ve had a baby on my body all day when I’m with her needing so much touch like...you put her down and she puts her hands up and she needs to be on me all day. The last thing I want is another person on me. So, it was definitely the touch fatigue...” (Participant P1).

The breasts were off limits during sexual play for four participants, while the other two included breastfeeding in their sexual play. Four participants modified sexual positions due to breastfeeding. One of the modifications was limiting the missionary position so as not to apply as much pressure on the breasts, while two other sexual positions, namely, 'female on top' and 'doggy style' were favored.

Two participants (Participants P5 and P6) indicated that after birth, emotional intimacy increased gradually over time, regaining pre-pregnancy levels closer to when their child was a year of age. Two other participants (Participants P1 and P2) noted the beginning of a return to pre-pregnancy levels of emotional intimacy when child was between 10 months and 12 months only.

"There was definitely more intimacy before my daughter, and it's at this point though, it's weird I'd say, it's mostly back to where it was before she was before but in the intermediate time there was a...a...natural dip for a while and it had taken a while to rebuild that. We are still rebuilding that but I would say that we are most of the way towards where we were before she was born." (Participant P2).

Two participants (Participants P5 and P6) claimed that their levels of emotional intimacy only increased during the pregnancy. One participant (Participant P6) described how seeing her partner become a parent and taking on the role of caregiver during pregnancy was fundamental to the increase in emotional intimacy. Both Participants P5 and P6 expressed how emotional intimacy increased after their children were born and how it was due to the need to present themselves as a 'united front' in the face of obstacles regarding their parenting goals. This ability to come together as partners, parents and lovers had increased over time for them.

4.4.3 Results from the PAIR Inventory-Sexual and Emotional Intimacy Subscales

This section begins with an explanation of the PAIR Inventory scoring system, followed by the results from the sexual intimacy subscale and those from the emotional intimacy subscale. Finally, the different ways that the quantitative data align with the qualitative data are featured.

Table 3 - The Participants' Scores for Perceived Level of Sexual Intimacy

Perceived Level of Sexual Intimacy Score (0-96):	P1	P2	P3	P4	P5	P6
Primary Partner	68	88	88	92	92	92
Secondary Partner	88	-	84	92	-	-
<i>Mean and SD for Primary Partners</i>	86.67 (9.35)					
<i>Mean and SD for Secondary Partners</i>	88.00 (4.00)					

All of the participants completed the perceived sexual and emotional intimacy subscales for their primary partner. Three participants answered the items in regard to the sexual and emotional intimacy subscales for a secondary partner. None of the participants responded for a third partner. In the present study, four participants had perceived scores of sexual and emotional intimacies greater than the average reported in the original study (Olsen & Schaeffer, 2000). Two participants had lower than average scores for emotional intimacy (24, 36). The results from the sexual intimacy subscale will first be presented followed by those from the emotional intimacy subscale (see Table 3 on p. 108).

The results for the *sexual intimacy* subscale are as follows (see Table 3 on p. 108). The range of scores for perceived sexual intimacy for the participants' primary partners ranged from

68 to 92 ($M=86.67$; $SD=9.35$). The three participants' perceived levels of sexual intimacy for their secondary partners' scores ranged from 84 to 92 ($Mean=88.00$; $SD=4.00$). However, there was a greater range in the scores for the *sexual intimacy* subscale for the primary partners compared to those for the secondary partners. Despite this, the means for the perceived level of sexual intimacy for primary and secondary partners were similar (86.67 and 88.00). Participant P1 had the lowest perceived level of sexual intimacy score (68.00), yet had a higher perceived level of sexual intimacy score with the secondary partner (88.00). When an analysis was carried out item by item, there were two items where all six participants were fully in agreement (100%): Item #21 (strongly disagree: 'I "hold back" my sexual interest because my partner makes me feel uncomfortable') and Item #33 (strongly disagree: 'My partner seems disinterested in sex'). The greatest similarity in perceived level of sexual intimacy scores for primary and secondary partners were for Participants P3 and P4. When comparing the scores obtained for the participants who were *couples* in the sample (P1 and P2, P5 and P6), there was a greater difference in the perceived level of sexual intimacy scores between the first couple (Participants P1 and P2), 68 and 88 respectively. The other couple (Participants P5 and P6) had greater similarity and higher perceived level of sexual intimacy scores (92, 92) (see Appendix 17).

The perceived levels of *emotional intimacy* scores (see Table 4 on p. 110) for the participants' primary partners ranged from 24 to 92 ($M=69.00$; $SD=30.61$). For the three participants who answered for a secondary partner, the range of the perceived emotional intimacy score was between 80 and 96 ($M=85.33$; $SD=9.23$). However, there was a greater range in the scores for the secondary partners. The mean for the perceived level of emotional intimacy for the primary partners (69.00) was lower than the mean for the perceived level of emotional intimacy for the secondary partners (85.33). There appears to a higher perceived

Table 4 - Participants' Scores for Perceived Level of Emotional Intimacy

Perceived Level of Emotional Intimacy Score (0-96):	P1	P2	P3	P4	P5	P6
Primary Partner	24	36	84	92	92	86
Secondary Partner	80	-	80	96	-	-
<i>Mean and SD for Primary Partners</i>	69.00 (30.61)					
<i>Mean and SD for Secondary Partners</i>	85.33 (9.23)					

level of emotional intimacy with the secondary partners than with the primary partners.

Participant P1 had the lowest perceived level of emotional intimacy score (24.00), yet had a higher perceived level of emotional intimacy score with the secondary partner (80.00). When an analysis was carried out item by item (see Appendix 18), only two items had a 67% agreement for four out of six participants: Item #1 (strongly agree: 'My partner listens to me when I need someone to talk to') and Item #13 (strongly disagree: 'I often feel distant from my partner'). The greatest similarity (5 out of 6 items or 83%) in perceived level of emotional intimacy scores for primary and secondary partners was for Participant P4. When comparing the scores obtained for the participants who were *couples* in the sample (P1 and P2, P5 and P6), there was a greater difference in the perceived level of sexual intimacy scores between the first couple (P1 and P2), 24 and 36 respectively, yet these two participants (P1 and P2) had the lowest perceived level of emotional intimacy scores for the total sample. The other couple (Participants P5 and P6) had greater similarity and a higher perceived level of emotional intimacy scores (92 and 86).

4.4.4 Summary for this Section

In this section, the results from the second theme *Communication and Intimacy during the Transition to Parenthood* were presented. The majority of the participants noted changes in *Communication* during the transition to parenthood, which was also affected when they were faced with mental health concerns during the transition to parenthood. The added stress either brought couples together or led to a breakdown in communication. When it came to *Intimacy*, the level of sexual interest varied greatly between the female participants, as well as from one pregnancy to the next. The changes in their body appearance also affected their desire for sexual intimacy. The men, however, did not note a change. When it came to emotional intimacy, the participants who were couples noted an increase or a decrease with it. The PAIR Inventory sexual and emotional intimacy subscale results were also presented in this section, for both primary and secondary partners. When a deeper analysis of the results pertaining to the two subscales was conducted, they corroborate those from the qualitative data. What emerges from these combined results (qualitative and quantitative) is that, when much time and energy are placed on one role, the other roles may take a back seat. Sexual intimacy and emotional intimacy had been affected by the transition to parenthood, yet they had an impact on the transition itself. There was more variability in emotional intimacy, both from the interviews and the quantitative data, than there was in sexual intimacy. Communication was key to a harmonious transition to parenthood which included these two dimensions of the conjugal relationship. Since this sample of participants was already characterized by a particular sexual lifestyle, more time and energy were going into this part of the relationship. Therefore, emotional intimacy was more affected than sexual intimacy for the CNMPCs.

4.5 Relationship Evolution and Sexual Style during the Transition to Parenthood

The *third* theme that emerged from the qualitative data analysis was pertaining to *relationship evolution and sexual style during the transition to parenthood*. Three categories were identified: *contemplating CNM*, *acting on CNM* and *incorporating CNM as a lifestyle*. The results in relation to this section correspond to various parts of the Research Question # 2 (see p. 18).

4.5.1 Contemplating CNM

The first category of this third theme concerns *the contemplation of engaging in CNM*. Two different subcategories are associated with this first theme: comparison of societal norms and initiator of discussion. Five participants described identifying as CNM as a process of exploration, starting with questioning the value society places on monogamy, well before getting into a relationship or being married. Participant P6 stated:

“...my thinking about monogamy at that time...as well as my spouse’s had developed over time through watching our monogamous parents and grandparents...and seeing a lot of other relationships that were not doing well...I wanted more, I don’t know evidence or um... you know scientific background to why do I think about things in this way, why, and it’s not just me. Why do people stray from their marriages and their monogamy?”
(Participant P6).

All participants began their journey towards identifying as CNM with a conversation. Three of the female participants initiated the conversation about exploring CNM and the other female participant was already CNM from the start of her relationship with her partner and had initiated the conversation with him. One of the male participants initiated the conversation with his partner when they started dating. The two couples (P1 and P2, P5 and P6) were monogamous until they reached a decision to pursue CNM. One participant (P4) and her

partner engaged in the conversation in regards to CNM after a cycle of unfaithfulness. One participant (P6) stated that when people choose the lifestyle for the wrong reasons they split up because the lifestyle only heightens the pre-existing relationship issues.

“Lots of people who come into the lifestyle, come into it for the wrong reasons and are no longer together so... uh... that’s... they you don’t find that balance, they find what their imbalances and it points it out for them because they are unable to cope as a couple regardless of the lifestyle being there or not. The lifestyle just sort of makes it much more obvious where the deficiencies are in their relationships and so, I find that lots of people don’t find that balance, they find the exact opposite and you know don’t stay together, but uh the people that do, the key there is communication.” (Participant 6).

4.5.2 Acting on CNM

The second category in this theme is *acting on CNM*, which contains three subcategories: arriving at a consensus, importance of communication, and exploration of various sexual styles and CNM.

Arriving at a consensus to participate in CNM came about through self-reflection and conversations with the participants’ partners. Five participants, after reflecting on their beliefs in regard to societal norms, arrived at a consensus to engage in CNM. Five participants identified as swingers or being in an open relationship. These participants wanted to limit emotional attachments, as Participant P5 shared, “strictly sex on the side”. One participant identified however as being polyamorous. Participant P3 stated, “...for me it’s not just about the sex. It’s about being attracted to someone for who they are not necessarily what their gender they are or what.” Another participant (P4) made the decision with her partner after her first child was born; they would engage in CNM as a couple but did not want their first encounter with CNM to be

threatening. After this initial exploration with someone they trusted, they decided to explore various other sexual styles and CNM.

“...neither one of us are the same person who wants to settle down and just be with one person and this was before we had kids...someone they trusted, nobody threatening, his best friend.” (Participant P4).

All participants mentioned how communication was important when acting and incorporating CNM as a lifestyle. For example, prior to engaging in CNM, all participants had a set of ground rules to follow when being involved in the lifestyle. Regular check-ins with their partners were essential in order to share their experiences and concerns, being honest with their wants and desires, and being aware of power shifts in their relationships. Communicating with the primary partner was vital to the relationship so that he or she would feel loved, valued and secure.

Two couples (P1 and P2, P5 and P6) made a point of identifying each other as primary to each other when they went out, either by way of dress or actions. This was done both verbally and nonverbally.

“We are primary to each other in that, you know if you look at us in any social gathering, we are a couple and people assume that know that by our body language and all the rest of it.” (Participant P6).

All of the participants explored various sexual styles as well as CNM in a variety of ways. They used the Fetlife platform or other online platforms to initially meet like-minded people. They met in a public space in order to get to know them before initiating in sexual play. Four participants were active members of a local swingers' club, whereas the other two were not. All of them enjoyed attending various lifestyle events where they met other people like them. When

exploring various sexual styles and CNM, all the participants recognized the importance of learning the language associated with this lifestyle, and agreeing to the culture of consent when participating at lifestyle events. This is reflected by the following two participants:

“And then we began or started out and then it evolved into action. So shortly after we were married we joined a dating site where we actively looked for other couples... to get together with...you know that took the foray into that aspect and then we also found a couple of clubs that...were in the city here that were of great interest to us...we joined those clubs and in so doing, we were able to network with likeminded people and were able to have more of those conversations of....how does this happen and why does this happen and this is fun...let’s try things out.” (Participant P6).

“We went to some of the local lingerie and toy shops...there were magazines available that you could put an ad...We did try answering some ads. That didn’t work out too well. There was[a] phone connection site called Lavalife. We did actually meet people for coffee to see if there was a connection...We ended up going to a regularly scheduled alternative lifestyle event...we ended up meeting other people in the swing lifestyle who belonged to a club and we joined that club and have been a member of that clubs since.” (Participant P5).

The majority of participants (five) also engaged in various levels of consensual bondage, dominance and sado-masochism (BDSM) with their primary and other sexual partners. One participant also worked as a professional dominatrix for a period of time. Five participants stated that the degree of BDSM included in the sexual play in the home decreased after the arrival of their children; however, they found alternative ways to express that part of their sexuality by attending a local bathhouse and/or attending lifestyle events.

“There’s a lot of things that uh we enjoy that are on the BDSM spectrum um... neither of us had been to the sadomasochism aspect of it really, we are much more into the bondage and domination side of things.” (Participant P6).

Not all of the participants had good experiences during the initial phase of exploration. One female participant (P1) experienced unwanted touch at a lifestyle event. This participant expressed concerns regarding younger people starting out being CNM. She worried that they might be taken advantage of because of “not having a voice” (P1), and having a more difficult time saying no. Another concern expressed by the participants regarding communication was their ability to consent fully when embarking in sexual play, as their decisions may have been based on limited disclosure from the other parties. Participant P5 shared his concerns in the following way:

“when I found out that a partner that I had did not use uh... any safety with other partners I felt that they were opening themselves up and then subsequently me to uh... medical issues, possible medical issues, even though we, me and and the partner that opened themselves up to use protection.” (Participant P5).

As the participants progressed through the various stages associated with the transition to parenthood, four participants (P3, P4, P5, P6) noted some sexual changes after having children, as they were becoming more adventurous and even more active in the lifestyle. On the other hand, two participants (P1 and P2) decreased their participation in consensual non-monogamy, attributing this to a decreased social network and having a high needs child.

4.5.3 Incorporating CNM as a Lifestyle

Three subcategories were identified in this third category of *incorporating CMN as a lifestyle*: disclosure, sexual and health related practices, and influence of gender and sexual

identity on sexual expression. These subcategories were noted as a sexual identity evolution occurring at the time of the interviews, with three participants identifying as swingers while the other three as polyamorous. Two participants (P1 and P2) began engaging in a polyamorous relationship during the transition to parenthood, which was a shift in their sexual style from the start of the relationship.

For the first subcategory, choosing to whom to disclose can be a difficult decision to make. People must first consider the effects of disclosure not only on themselves but also on their families. This can even lead people to not being able to fully express themselves, as was the case for five participants. Despite this, four participants of the five viewed non-disclosure as a priority. A variety of reasons were given by them such as their worry about professional regulatory bodies, the extended family's conservative mindsets, and protecting their children from stigma.

“There are very few people that actually know about it because of the judgement because of the stigma, because of the ummmm they’re swingers, because of wanting to maintain a professional image, because of wanting to maintain a normal family unit in front of the family, because of not wanting to answer questions to the family and you know very prudish friends.” (Participant P1).

All participants were very careful about to whom they disclosed their lifestyle, especially when their children were younger. They also used caution in expressing themselves fully in their sexuality. One participant (P4) explained it this way when it came to the expression of her sexuality, “There is a difference between shouldn’t and couldn’t.” The participants shared that certain places were not appropriate for this disclosure. For the participants who identified as being swingers, they were not able to express their sexuality fully because of society’s views on swinging.

One particular participant (P3) is now completely open about her lifestyle with everyone, including her family and friends, however, this was not so during the transition to parenthood. Another participant (P6) hesitated in speaking with her family because of society's lack of understanding of border sexualities. She expresses this the following way:

"I do not discuss this with my family. I have a family member, a very close immediate family member who is aware, but they don't have a complete understanding of exactly what it means as a swinger...we do have those conversations, the door is always open and they do on occasion open that door and ask questions...I'm able to discuss that with the one single family member." (Participant 6).

The participants' answers varied as to whether or not they disclosed their lifestyle to their children. Five participants chose not to practice their lifestyle openly around their children. However, three of them would disclose their lifestyle if their children asked them about it. Participant P6 stated that she is more guarded around her children, "there is a filter I need to keep, I can't completely be myself." However, there are some parts of the expression of her sexuality that they are aware of, for example, that she is "part nudist." Another participant (P2) mentioned that he would answer direct questions from his daughter: "Would answer honestly in regards to sexual lifestyle."

In regard to the second subcategory, the participants protected their children from their lifestyle choices in a variety of ways. Five participants only allowed sexual play inside the home if it was with their primary partners, unless it was discreet or with a person considered as a secondary partner or as a caregiver to their children. This did not prevent any participants from introducing sexual partners into the home after friendships developed over time. Two participants (P5 and P6) who are a couple chose to introduce people with whom they engaged in CNM if they were part of a couple to their children after a long period of getting to know one

another. This couple (Participants P5 and P6) chose to introduce the new couple to the children even if they had sexual encounters with one partner of this latter dyad. This network built from other people who participated in CNM ended up being a source of support in times of difficulty. Some participants stated that for certain relationship difficulties, only people with similar lived experiences could understand them and their lifestyle, as expressed by the following participant:

“We are careful who we introduce into the home. Um, in terms of non-vanilla people coming in...They often do get introduced but it’s after a more regular period of getting to know that, getting to know each other...We’ve never introduced a single into the family uh that way. It’s always been a couple even if we are only sexually active with the one member of that couple. We still introduce them as a couple and not as a single. So it affects how we represent ourselves in the home yes, to the children definitely.”

(Participant P6).

Another participant (P4) had a live-in secondary partner after the birth of her second child, and was considered as an Auntie to the children and still is, even after moving out of the family home. This secondary partner continued to assume this role to the children, even though the sexual part of the relationship had ended with the participant and her partner. One of the difficulties experienced by the secondary partner in this triad was that she was not acknowledged as a partner when extended family was over. She was viewed more as a roommate.

“I think one thing that made it harder is that, there is friends and family that did knew/did know [...] back then, that didn’t understand. Because when our partner moved in with us, we did not announce who she was to a lot of people. She was just a roommate. She was Aunty to the kids, she still is.” (Participant P4).

However, in front of the children, she was seen as more than just an Auntie, because of the intimacy that was shown which was similar to that of their primary partner. Two of the participants (P3 and P4) were open about their lifestyle with their families of origin who were accepting of this, yet their partners' families were not (both of whom ended up getting divorced).

In regard to the last subcategory, when it comes to access and opportunity (see Figure 2, p. 65), whether it be seeking healthcare or in the job market, the participants did not appear to be too affected as they were confident in their sexual identity. They were very careful with whom they disclosed their identity. For example, they would not discuss their sexual style in the workplace, regardless of how they identified. One participant obtained employment through the social network she met while participating in CNM.

To be able to make healthy choices when it comes to sexuality and health, people must have complete control of their bodies and be able to make informed decisions. All participants expressed a desire to be healthy and stay healthy, and they did this by taking safe sexual practices and pregnancy prevention seriously. This approach only increased after having children. Two participants (P3 and P4) could not use oral contraceptives or an IUD, and chose condoms as the primary method of pregnancy prevention. All participants were diligent in their use of condoms to prevent sexually transmitted and blood borne infections (STBBIs). Participants also tended to use language such as 'clean' or 'disease free' in regards to their state of health. One participant mentioned how when attending some of the house parties, there is an expectation to bring a copy of a recent STBBI panel to assure that the members are all STBBI free. Four female participants did not engage in CNM when trying to conceive or during their pregnancies. During the time of their pregnancies, the male participants did engage in CNM, but only with partners who they considered were safe. These practices were to protect

their unborn children and assure paternity. This period of abstinence from CNM was directly related to the desire to protect their unborn.

“during the trying phase, during the pregnancy, during the postpartum experience as well there was no sexual ah contact with anybody outside of umm.. my husband for myself and for when my husband did have ummm...a couple of encounters during the pregnancy, it was done extremely safely and just... I mean that’s part of the lifestyle that we live and the you know the making sure that we were being safer for our family.” (Participant P1).

All of the participants put great emphasis on personal hygiene and whole body health (physical, mental, spiritual and emotional well-being). The following participant explained it this way:

“You want to be making better choices, you know you now safe sexual practices and, to making sure that everyone’s mental wellbeing, physical wellbeing and sexual wellbeing and spiritual wellbeing is all being taken care of because it’s not just I find keeping sexually healthy, it’s keeping the entire body healthy to maintain you know good relationships.” (Participant P1).

This led the participants to be more cognizant of the need to look after themselves and their health as well as that of their families in order to be able to participate in CNM. Participant P1 expressed it as thus:

“ there is still that... drive to avoid complacency... where you want to appear, like sexually desirable, you want to appear intelligent, you know you want to appear to have very good hygiene, to have a very strong career, to be interesting and to be somebody that is uh worth the value of a good time right.” (Participant P1).

All participants stated that they were in complete control of their bodies when participating in CNM. Exceptions were noted in the context of consensual non-control, particularly in relation to BDSM practices, such as being tied up, or the feeling that is experienced after multiple intense orgasms which can lead to an almost out of body experience. Another situation occurred when a pregnancy occurred following a CNM experience. The participant reported feeling like things were out of her control due to the uncertainty of paternity and the involvement of multiple parties. She felt pressured to have an abortion by the three other people involved; she did choose to proceed with the abortion.

Gender and sexual identity influenced participants' expression of their sexuality in different ways. The two male participants had a harder time describing how identifying as a male influenced the expression of their sexuality. Both stated that they had a higher sex drive than their partners and sometimes, did not feel that their needs were being met during the transition to parenthood. One of the male participants (P2) sometimes had a difficult time expressing himself fully in the lifestyle because he identified as being bisexual. He explained that at certain swinging events, homosexual contact "is frowned upon" (Participant P2). The four female participants expressed difficulty reconciling their higher sex drive and their femininity. One of the participants (P6) felt that she had a dual personality because she was not able to express herself fully in all aspects of her life. She felt this especially as a female as not being allowed to be sexually expressive and vocal about her desire and need for sexual activity. She explains it as follows:

"In terms of being able to express my true person, my true nature of my sexual... you know scope, I feel like I can't really you know disclose that to just everybody because people might just think very negative thoughts about the fact that a female... feels that sexually expressive. That's not necessarily socially acceptable. Um and in most circles, I

would say it's not...that aspect of it is hard to comes to grip with as being a female. I think if I was male and I had the same feelings, it would be easier to express those feelings and to make those feelings known and it would not have a negative effect on how people view me." (Participant P6).

Another participant echoed this sentiment when she talked about women not being empowered to be as sexually expressive as men yet still yielding the ultimate power of consent to sexual acts. "Women have the power yet they are shamed for it. For their sexuality." (Participant P4).

4.5.4 Summary for this Section

In this section, the qualitative results under *Relationship Evolution and Sexual Style during the Transition to Parenthood* were presented. This theme was subdivided in three categories. The first category, *Contemplating CNMC*, started out with a conversation questioning the value society placed on monogamy. The second category explored *Acting on CNM*. All six participants chose different avenues to explore CNM (online, in person at fetish events, or approaching close friends), and expressed the importance of establishing ground rules prior to engaging in the lifestyle, including BDSM practices. The final category, *Incorporating CNM as a Lifestyle*, was explored and how participants engaged in CNM. The participants were careful with whom they disclosed their lifestyle, most choosing not to mention their lifestyle to their children and families. They also engaged in safe sexual practices (frequent STI testing and use of a barrier method during sexual contact). The participants were very conscious during the time they were trying to conceive of the consequences of unsafe sexual practices for their offspring. The female participants also expressed the difficult time that they had to express their full sexuality, because of a fear of how society perceives female sexuality, especially women with high sexual libidos.

4.6 The Conciliation of Roles during the Transition to Parenthood

The *fourth* theme that emerged during data analysis was the *conciliation of roles during the transition to parenthood*. Two categories are associated with this theme: *family functioning* and *the impact of sexual style on parenting*. The results in relation to this section correspond to various parts of the Research Questions #2, #3 and #4 (see p. 18).

4.6.1 Family Functioning.

The first category within this theme that of *family functioning*, contains four subcategories: household chores, childcare responsibilities, prioritization, and each other's expectations as parental partner, sexual partner and conjugal partner. The results from the Parenting Role-Sexual Role Conciliation Scale (PRSRCS) are presented at the end of this section.

The first subcategory, household chores, ties into the day-to-day running of a household. In regards to household chores, there were things either that facilitated or hindered the conciliation of this part of the roles. Four of six participants recognized that household chores as a shared responsibility facilitated the conciliation of the two roles. For one couple (Participants P1 and P2), the housework remained status quo where the husband took over most of the household chores and cooking, and left the childcare to the mother until she returned to work after her maternity leave.

"I don't think so no... things are about the same. I do the same chores, he does the same chores umm... there's definitely the feeling of inequality through the relationship stuff, where, you know, childcare you know before childcare, wasn't seen as some sort of role and [my partner] still felt like he was doing all the chores around the house and I was like nauh... I've been watching the baby and this definitely counts as you know tasks that need to be happening." (Participant P1).

“I would say 90 % of the domestic chores around the house and I always have, and that’s not, that’s just the way our relationship has always been so, um... there hasn’t really been a reorganization of that based on the pregnancy or not...ummm... so how do we share the domestic chores, well it’s fairly easy, I do, I do almost all of them”

(Participant P2).

After her return to work, the childcare and household chores became a shared responsibility. Three participants (P4, P5, P6) mentioned that having a partner who recognized their needs and limitations and offered to help in whichever way possible increased their ability to reconcile their various roles (parent, sexual partner, partner in the sharing of household chores).

The second subcategory focusing on childcare responsibilities included the coming together as parents and identifying with their parental role. Three participants said they came together as parents once they decided to have children, while the other three claimed that they became parents at birth. When participants identified as being a parent, they were better able to engage in childcare responsibilities. For the most part, the female partner stayed home with the children (three out of four participants) during the first year after birth. After this, they took turns in the role of caregiver according to their work schedules.

“So for us, we worked different schedules so he worked night shift for the most part and I worked in the evenings so he would work a night shift, sleep all day when I was with the kids. Then I would go work in the evenings while he was home with the kids and then he would go to work. So we didn’t see each other a lot. We were supportive in our roles there, but it was just the way that it was so um... one of us had to be at home with the kids but it didn’t mean that both of us did.” (Participant P4).

They also traded off looking after their children when it came to going out with friends, and pursuing their sexual style solo or together.

“Which is kind of another reason why we were more supportive of each other like getting out and be like, here’s our chance, we are going to be alone together in the next 3 weeks, go have some fun. Instead of it getting in the way we actually recognized that there needs to be one of us here but, you know, both of us don’t have to be here so... so ... play” (Participant P4).

One participant (P3) stated that her partner took a backseat in parenting after their third child was born due to the high needs of this child, leaving sole responsibility with her. This increased the tension between them played a role in the breakdown of their relationship. The participant who had a secondary partner in the house during the transition to parenthood felt that the conciliation of roles was easier because there were always extra hands to help with the children and their care.

The third subcategory involves the participants being able to prioritize. The participants prioritized for household, childcare, sexual lifestyle and other aspects of their relationship. All participants valued family (including extended family) above all else as well as quality time. They also actively sought time as a couple (or triad) as well as with time with their families. The participants stated that their primary partners and families took precedence in any decision regarding their sexual lifestyle.

Different strategies were used to be able to prioritize their sexual lifestyle. All participants mentioned how having a support network was important during the transition to parenthood and in pursuing their sexual style. An example of a support network would be a family member caring for the children so that the couple could host a party or attend a lifestyle event. Two

participants (P5 and P6) after a lifestyle event, took turns taking on all the childcare and household responsibilities, thus allowing the other partner to recover (get adequate sleep, food and rest). This also included training the children to seek out the parent who was not sleeping when they needed something. In addition, coming together to prioritize which tasks needed accomplished and communicating this to each other helped to reconcile the parental and sexual roles. One participant (P5) noted “my lifestyle affects my decisions, but my decisions haven’t necessarily affected my lifestyle.” Another participant (P3) was able to incorporate her secondary partner on a daily basis by having her live with the family. By doing this, there was a distribution of the various roles between three parenting partners after the birth of her second child: this facilitated being able to engage in their sexual lifestyle with each other, which happened in the home. Behind closed doors, they did partake in “bedroom switching” (Participant P3) in the evenings. Unlike other participants, this triad focused on intimacy and closeness in their relationship as well as sexual play outside of their three-way relationship. However, this did cause some difficulties when extended family attended the home as the secondary partner was treated as a roommate.

Four participants used another strategy in order to pursue CMN which focused on compromise. These four participants noticed a decrease in the duration of and opportunities for sexual activity and intimacy after having children. One participant (P2) described sexual activity post children with his partner was “short and quick right... not as tantric”. Some chose to take turns going out to play with others and/or be more selective about which activities to attend. It also required taking time to go to local bathhouses if they wanted to be more adventurous (make noise or pursue activities on the BDSM spectrum). Another participant (P3) mentioned that prior to having children, there was the following:

“a lot more kinky kind of stuff... not as serious. I think when we had the 2 kids, it became more settled down...more... and more like a deeper intimacy whereas before it was very... no strings attached, not a whole lot of commitment, a lot of play... um... and until we found our partner that we brought into our lives. That is pretty much how it stayed.” (Participant P3).

Communication was key to the success of prioritization for the participants. They mentioned that because of their lifestyle they needed to be able to communicate effectively with each other, a skill that they honed during the integration of CNM as a lifestyle. Prior to becoming parents, most of the participants did regular check-ins with their partners concerning their comfort in pursuing their sexual style. This allowed two participants (P5 and P6) to better communicate when it came to other aspects of their lives:

“so is part of our, an integral part of our relationship as a couple... opened us to be able to communicate in a way that we did not do before [...] So we've had to develop that communication side uh more so because of the lifestyle that we live and as a result that has made us far more intimate uh and close in our relationship.” (Participant P6).

Having a close social network helped some participants not feel isolated (three) as well communicating with other parents who were also CNM helped with reconciliation of roles because they were able to discuss situations that were unique to CNMPCs.

The last subcategory featured each other's expectations as parenting partner, conjugal partner and sexual partner and expectations of oneself. When these expectations were not met, this made finding a balance or reconciling the various roles during the transition to parenthood more difficult. Participant P1 illustrated this:

“There was a lot breakdown of communication there so, there was a lot of unmet expectations of me thinking that he was going to...sacrifice some of his needs such as going out and going to yoga and exercising and putting himself first where I wasn’t even getting to shower. And I would, it was never offered to me. I mean...I I...need to have a shower today and then he goes, “well you didn’t shower every day before” and I’m like, well I really have to now and he was like “well, why do you want to automatically start doing that every day?” and I’m like because I am covered in baby pee.” (Participant P1).

Another participant (P3) highlighted having unrealistic expectations of herself that made the conciliation of roles more difficult. This participant initially compartmentalized her various roles. She had a hard time identifying as a mother and as a lover, reconciling between being a parent and still being sexy. After counseling (cognitive behavioral therapy and dialectical behavioral therapy), she was able to bring these roles together and integrate them. Once she was able to see herself as a whole person with “different hats”, she was better able to be a parent, a partner, and a lover, and to take part fully in her sexual role in CNM. She explains, “so sexy, and still be mom, and you know be... you know, I can integrate all those parts of my life.”

4.6.2 Impact of Sexual Style on Parenting

The second category of this fourth theme involves *the impact of the sexual lifestyle on parenting*. Initially, the participants had a hard time being able to understand how their sexuality was influenced by their parenting because their sexuality was an integral part of how they identified as people. All of the participants explained how the openness that is so much a part of their sexual style would spill over into the openness of communication with their children. One participant shared an example of this, which involved taking their child to purchase their first transgender outfit. They were also more open if their child would choose an alternative sexual style.

“I think we’re a lot more understanding because, because of what we’ve been, and the people we’ve met, the amazing people we’ve met that were totally supportive of whatever our kids choose to do, whether it be marry one person, marry 5 people. Whatever they want to do.” (Participant P4).

The participants made sure to use the correct terminology for body parts and answer questions directly about sexuality and sex at an age appropriate level. The following participant explained this in the following two quotes:

“...it started age, age appropriately like even when they were little. I always wanted my kids to have sexually, sexually positive outlook because intimacy and sex do a play a huge role in relationships. I believe. Um that if you are not sexually necessarily compatible, it’s going to have a huge impact on everything in your life.” (Participant P3).

“My children and their friends call me the sex lady because I don’t sugar-coat things.” (Participant P3).

Three participants also had less of an issue with nudity. Two participants (P1 and P2) showered or bathed with their daughter. Another participant stated that her children knew that she was “part nudist” and that they were protective of that part of her sexuality. One of the reasons that these parents did not mind that their children saw them naked was so that their children would know what a normal human body looks like and be comfortable in their own skin.

4.6.3 The PRSRCS Results

The conciliation of roles was measured by using the Parenting Role-Sexual Role Conciliation Scale (PRSRCS) (see Table 5 on p. 131). This scale containing 13 items assesses parenting and sexual role balance, childcare arrangements and social network reactions. Items #2, #3 and #8 were reversed scored. A mean score was obtained for each participant by adding

the total individual items and then dividing this total score by the total number of items (13). Final scores range from 2.31 to 4.69; a higher score indicates a greater conciliation between the parenting role and the sexual role during the transition to parenthood. The mean range in this sample was from 2.31 to 4.69 ($M=3.58$; $SD=0.83$). Participants P3, P4, P5, and P6 had the highest conciliation score, meaning that they were better able to reconcile their parenting role and their sexual lifestyle.

A deeper analysis was conducted on the individual items and on the couples in the sample (see Appendix 19). The following four items had the highest scores (#1, #3, #5, #7): these items had the highest scores if at least five of six participants (83%) scored the item as 4 or more on the five-point Likert scale. The lowest score was observed on item #9, 'My child(ren) is(are) aware of my sexual lifestyle', as five of the six participants (83%) chose 'Never' as the answer. It was interesting to note that all participants (100%) scored the same for Item #7, 'I feel

Table 5 - Participants' Scores for the Parenting Role-Sexual Role Conciliation Scale

Participant	P1	P2	P3	P4	P5	P6
Mean (Score) (1-5)	3.15	2.31	4.24	4.69	3.46	3.61
Range	2.31 - 4.69					
<i>Mean and SD</i>	3.58 (.83)					

that I am a better sexual partner because my partner(s) is/are supportive of my sexual lifestyle'. When an analysis was conducted on the *couples* in the sample (P1 and P2, P5 and P6), there was less similarity in the scores for the individual items for the first couple (Participants P1 and P2): there was less similarity if there was a difference of 2 points or more for the same individual item.

The mean scores obtained for this scale for each of the participants reflected the qualitative data in a number of ways. The two participants (P1 and P2) with the lowest scores who were in the same relationship stated in the qualitative data that they were having a hard time reconciling their sexual style and parenting. They had less time for sexual intimacy, as well as having a breakdown in communication in the first year of their child's life, which they are starting to rebuild. The participants with the highest scores (P3 and P4) were the participants who were able to be more open about their sexual identity with their friends and family (Items #10 to #13) which was reflected in their answers during their interviews. These participants also had a greater support network for childcare, which reflects the high score on item #5. The other participants (P1, P2, P5, P6), viewed non-disclosure to friends and family as a priority, which could explain their lower scores when compared to the rest of the participants (P3, P4). In that same regard, these participants without having disclosed their lifestyle were aware that their families were not accepting of their chosen sexual lifestyle (Items #10 and #13). These same participants were very careful to whom they disclosed their lifestyle, which explains the range of responses obtained in Items #11 and #12. One participant (P6) explained it well, "it feels like I have a dual personality because I am not able to express myself fully in all aspects of my life."

4.6.4 Summary for this Section

The results for the theme, *Conciliation of Roles*, were presented in this section. Various categories emerged including family functioning and impact of sexual style on parenting. Under family functioning, participants viewed household chores as a shared responsibility. The transition to parenthood appeared to go more smoothly as opposed to when it remained unchanged. For the most part, the female participants stayed home in the first year and provided most of the childcare responsibilities. However, this changed once they returned to work wherein it became more of a shared responsibility. When it came time for the participants to be able to attend lifestyle events, finding childcare and having a support network greatly

facilitated this process. Other factors were being able to communicate and compromise with each other, and deciding who was able to attend as well as which events to attend. When participants had unrealistic expectation of themselves or of the other parent, the transition to parenthood was more difficult. Looking more closely at the impact of sexual style on parenting, they were more open with their children about sexuality, which also extended to discussing other more difficult topics. The PRSRCS results that were presented revealed that the quantitative data supported the qualitative data.

4.7 Relationship with Health Care Providers

The *final* theme that emerged from the qualitative data analysis was *the relationship with health care providers*. This theme contains four categories: *fear of judgement*, *health risk awareness*, *health care providers' lack of training*, and finally, *factors facilitating and hindering this relationship*. The results in relation to this section correspond to various parts of the Research Questions #2 (see p. 18).

4.7.1 Fear of Judgment

The first category presented in this category is *fear of judgement*. This theme is divided into three subcategories: heteronormative assumptions, perceived judgment and fear of the repercussions of lifestyle on parenting.

Healthcare providers who assumed that participants were monogamous and heterosexual (in five of six cases) demonstrated heteromononormative assumptions. When Participant P4's primary care provider asked her why she wanted STI testing when she was married reinforced such a mononormative assumption. This made the participant uncomfortable, to the point that she did not disclose her lifestyle to that primary care provider. This provider claimed that she thought that the participant's partner was cheating on her. A similar situation occurred with another participant when she was seeking health care. She

(Participant P1) was questioned about the frequency of STBBI testing and was told that she should not need to be tested that often as she was married. This made the client feel very uncomfortable, as the STBBI testing was not related to the reason she was seeking health care at that point in time. Another participant (P3) with her experience in the delivery room echoed this sentiment with her second child. During this delivery, she had both her primary and secondary partners with her and was asked very rudely, "who the partner was." This same participant, after the birth of her third child, felt like the PHN was focusing all of her attention on the risks associated with being CNM, instead of finding out what her concerns were. The PHN in question did not seem to know how to react when her secondary partner was present after the birth of her third child. Due to this perceived judgment, she delayed seeking healthcare and treatment for her PPD, which eventually led to psychosis. This affected her access to mental health care.

Because of perceived judgment, four participants did not disclose their sexual style to their health care providers. These participants preferred more anonymous STBBI testing, and they believed that details of their sexual lifestyle were on a "need to know basis" (Participant P2). They did not need the judgment that would ensue. Another participant (P4) who had an unfortunate encounter when seeking an abortion after an unwanted pregnancy following a swinging episode demonstrated perceived judgment in the following quote:

"...it was met with, you know, almost a, well you know, this was a decision that you made to do and this kind of the consequence of your decisions and it's like, well, you know it was an accident just like it would have been between a normal couple but I don't think they would have come at us with that sort of mentality, if it was just my partner and I going in and saying, you know : "We're young, we're in school, this is an accident and

you know this is not what we are looking for” vs “I am might be pregnant with my husband’s best friend’s kid.” (Participant P4).

This same participant (P4) also feared the repercussions of her lifestyle on her parenting. Child and Family Services conducted an investigation after she was reported for her choice of sexual lifestyle. This investigation was subsequently halted when the supervisor was informed; however, it did make an impact as to whom she chose to disclose her lifestyle.

4.7.2 Health Risk Awareness

The second category presented in this theme is *health risk awareness*. This category is separated in two subcategories: informed consumer, and pregnancy and STI prevention.

All the participants understood the implications of their chosen sexual style and were well informed about STBBI and pregnancy prevention. They went for regular screening and chose to inform themselves prior to their engagement in CNM. One participant (P4) highlighted the need to “having a voice, standing by her lifestyle”, especially when living with stigma. Other participants reinforced this during their interviews. They stated that living an alternative sexual lifestyle requires them to advocate for themselves because they you cannot count on the HCPs being educated about it.

All participants chose to be more careful during their pregnancies as they understood the implications of contracting certain STIs to their unborn children. Five participants were monogamous while trying to conceive in order to ensure paternity of their child. People who participate in the lifestyle and are not aware of the risks will have a harder time with their HCPs because they will not know what to ask for.

4.7.3 Health Care Providers' Lack of Training

The third category, *health care providers' lack of training*, is presented in this section and is divided into two subcategories: lack of sexual education in schools, and providers' lack of training during the prenatal period.

One participant (P6) did not believe that health care providers were prepared in their initial training to deal with sexuality, and more particularly, border sexualities. All the other participants alluded to this also. She (Participant P6) mentioned that she does not always get the support for her particular sexual concerns that she needs because of this. This could be related to their lack of knowledge about the correct terminology that is used.

"...they are interested but they don't know what it means. So then you have to get into, delve into an explanation um and with lifestyle there always needs to be a definition anyways, because my definition of a full swap might not be the same thing as what someone else might consider a full swap is in the lifestyle. But you do need to know what the basic terminology means. What is the risk, what does it refer to and that doesn't seem to be the case." (Participant P6).

She continues by stating how an open-minded HCP can make a difference.

"Where do I go where someone has expertise to know what to do, what to say and where to refer me if I need additional assistance beyond that which isn't available at all. Not that I'm aware of, unless you divulge things and you happen to be sitting with somebody who is also open uh, on the primary care side of your health care team, but you know you're guessing, you don't know that. It's not something that people say. Like you know, ah, certain people are trained in oncology and that's something that they wear

proudly. I'm an oncologist, meanwhile there's nobody out there saying, I specialize in open relationships." (Participant P6).

The participants also spoke specifically of the health care they received during the prenatal period. Of the six participants, only one went to prenatal classes, two used a doula and the other three preferred not taking prenatal classes because they felt that these classes were "rudimentary at best" (Participant P2). All participants agreed that the doulas, the prenatal classes and the reference books pertaining to pregnancy had little or no information on sexuality during the transition to parenthood. The only participant who attended prenatal classes noted that communication was discussed in terms of its importance during the transition to parenthood, however, the prenatal classes lacked information on what to expect during the first 6 weeks after childbirth and the challenges of being a parent. All participants felt that there should be more information given about sexuality in prenatal classes and that resources should be developed or made available for different levels of education.

4.7.4 Factors Influencing the Relationship

The last category presented in this theme pertains to *factors facilitating and hindering the relationship*. The factors facilitating the relationship between the HCP and clients are first presented followed by those that hinder it.

There are three factors that facilitated the relationship between the participants and their health care providers. The first one involved the family. One participant (P4) mentioned that including all parenting partners in the care of the family when possible is beneficial, as happened after the birth of her second child. She had a paraprofessional who came to the house after the birth of her second child who included her secondary partner during the visit. During this visit, education was carried out, and videos were recommended. This helped to build a relationship of trust between them. She also gave the example of the prenatal class instructor

who encouraged her to have both of her partners attend the sessions with her. The PHN who visited the home was aware of her lifestyle and included all the parenting partners. This participant also suffered from PPD, however, she was able to seek treatment in a timely manner because of the non-judgmental treatment that she had received.

All participants mentioned that CNM families are the same as other families: they put families first.

“The people in it (CNM) are normal people who do put family first, who just happen to live an alternative sexual lifestyle that does not hurt anybody and can be done safely.” (Participant P1).

Secondly, they also wanted healthcare providers to know that they take their safety and the safety of their partners and that of their children seriously. The participants wanted reassurance that their sexual lifestyle would not affect their children in any way and that they could live a complete and rewarding life free of discrimination. The following participant expressed this in the following way:

“The important thing there, I mean, if you are going to become a parent and you are going to birth a child, you need to have some, um... reassurance that your lifestyle has not unduly affected or negatively affected that possibility.” (Participant P6).

Thirdly, the participants mentioned other strategies that would be helpful or beneficial. Participant P5 suggested that HCPs who build a relationship with their clients and conduct a complete intake interview with a questionnaire that has inclusive language on it, that is neither heteronormative nor mononormative, could be beneficial.

“...verifying if the person leads an alternative sexual lifestyle of some form, would probably help open a conversation, without actually asking, just questionnaires would open doors for them.” (Participant P5).

By doing this, the participants mentioned that sexuality would be normalized and would increase clients' disclosure about their lifestyle to their primary care providers. All participants emphasized how it is important for the HCPs to take their time to get to know their clients, to not make assumptions, and to take a harm reduction approach. Five of the six participants encouraged HCPs to assess their clients' knowledge prior to 'lecturing' them on STIs or other risks in which they partake with their chosen lifestyle. They want to be able to come in and see their healthcare provider by asking for STBBI testing without judgment. They also want a partner in health care that will work with them.

“Don't just sit there and wait for me to disclose my life story. It's not going to happen... When they go to the doctor's they're sick and they want to know what's wrong. They're not going to bring in all kinds of things which might have been factors in what's happened to them but if you're not disclosing that you are open to ah... hearing what might happened and truly find a solution to what's happened um that's appropriate and fitting to their lifestyle and their sexuality, then, that makes it complicated... You know your partner happens to be infected so that could have happened.” (Participant P6).

Another solution proposed by a participant was having healthcare providers specialized in border sexualities and being better versed in sexuality. This latter solution could be extended in another way involving the bathhouses. One participant (P5) gave a very good example of catering to their specific population by being accessible at one of the local bathhouses to provide care.

On the more negative side, there was only one factor that hindered the relationship between the participants and the HCPS. All participants shared that there are differences amongst the CNMPCs. When health care providers assume that all CNMPCs are the same, it can cause harm to the relationship. Participant P4 expressed it as follows:

“Every non-monogamous relationship is different... whether there is an extra partner or not... or however the dynamic is, ask questions respectfully.... So that you know... who to address and how to address. How they play a role in... Cause I mean I believe now, very holistically that everything in your life has to work together. So it... my biggest advice would ask respectful questions. And don't be afraid to... If they're sharing that they are in a non-monogamous relationship with you, they have already opened up to you.” (Participant P4).

4.7.5 Summary for this Section

In this last section, the theme *Relationship with health care providers*, was presented. All participants expressed concerns about fear of judgment including, heteronormative assumptions, perceived judgment and potential repercussions on the ability to continue parenting because of the health care providers' perceptions of their lifestyle. They expressed how their families come first and their lifestyles second. The participants in this sample were well versed with the potential impact of their lifestyle on their health (STBBIs and pregnancy prevention), yet they expressed concerns about health care providers' lack of education in border sexualities, which has hindered their relationships in the past.

4.8 Summary of the Chapter

The results presented in this chapter were based on both qualitative and quantitative data obtained from the sample of six participants. The participants' profile and beliefs were first featured followed by the various themes, categories and subcategories that emerged during the

qualitative data analysis. The results from the quantitative data obtained from the PSOC Scale, the emotional and sexual intimacy subscales of the PAIR Inventory, and the PRSRCS were presented after the qualitative data in their respective sections. Overall, the participants in this sample experienced challenges in regard to their transition to parenthood as many other parents do. This transition was more harmonious for some participants compared to others. CNM was a chosen sexual lifestyle either before or during this transition. However, the lifestyle did stop during conception and pregnancy, and was resumed several months after childbirth. Relationship breakdown may occur, but not always associated with CNM. The conciliation of parenting and sexual roles is possible if communication is present. Indeed, for this sample, family was first while sexual lifestyle was secondary. The relationship with health care providers is critical for parents who practice consensual non-monogamy, as this relationship can affect their desire to seek health care or disclose their lifestyle. This is even more important during the transition to parenthood.

Chapter 5 - Discussion

This last chapter which presents the discussion of the research findings is divided into ten sections. The first section compares CNMCs' characteristics in the present study with previously published studies. The second section looks more closely at the present study's research findings related to the perceptions of CNMPCs during their transition to parenthood. The third section looks more closely at communication and intimacy during the transition to parenthood. The fourth section discusses the findings related to parenting with an alternative sexual style. The fifth section takes a closer look at the conciliation of the parenting role and the sexual lifestyle during the transition to parenthood. The sixth section discusses the findings related to CNMPCs' experiences with HCPs. The seventh section consists of reflections about the conceptual framework that was used for the present study, and proposes the *Model of CNMPCs' resilience during the incorporation of CNM as a lifestyle*. The eighth section presents the implications of the present study for nursing education, nursing practice, and nursing research. The ninth and tenth sections present the strengths and limitations of the present study as well as a conclusion.

5.1 Comparison of the CNMCs in this Study with Previously Published

This section pertains to the first research question: How do CNMCs living in the Winnipeg and surrounding areas compare in regards to sociodemographic, relational, professional and parenting characteristics to the other CNMCs already studied. The discussion for this question follows.

5.1.1 Participants' Profile

The participants who were part of the current study were compared to samples reported in previous published studies (Fernandes 2009; Jenks 2014; Rubin, Moors, Matsick, Zeigler, & Conley, 2014; Sheff, 2011; Sheff & Hammers, 2011). The findings from the present study

indicate that the sample was more diverse than published samples when considering their sociodemographic, professional, and sexual characteristics, and their beliefs. Previous research conducted on CNMCs indicates that the CNM population is relatively homogeneous as they tend to be of Caucasian descent, upper-middle class (higher among swingers than those identifying as polyamorous), and between the ages of 30 and 40. In the past, CNMs identified as having grown up in a religious family but were no longer practicing their religion, and having a conservative political mindset that was slowly changing to a more non-conservative one. These findings are similar to those of more recent studies published by Balzarini and colleagues (2019) and Fairbrother, Hart and Fairbrother (2019).

For the current sample, the majority of the participants were of Caucasian descent and 50% of participants spoke more than one language. When it came to their age range, 67% of them were over the age of 40. They did not fall into the upper middle-class, as only 50 % had an income of less than 60 000\$ a year. Half of the participants worked only part time, while 83.3 % of them held non-professional jobs. These participants appear to be more in line with a more recent study conducted by Kimberly and McGinley (2019) and by Balzarini and colleagues (2019).

Unlike previous research conducted on the swinging population wherein the majority of participants identified as heterosexual (Barker & Langdrige 2011; O'Byrne & Watts, 2011), the participants in the current sample indicate that 83 % of them identified as either pansexual or bisexual. These findings line up more closely with the findings from the demographic comparison done between monogamous and polyamorous couples in the Balzarini and colleagues' study (2019). On the one hand, they presented a more liberal mindset when considering their continuum of political affiliations, and their beliefs in same-sex marriage, marriage and divorce. They were not very religious with 67 % believing in a higher power. On

the other hand, 67% were for the death penalty which is of a more conservative mindset. This sample was more heterogeneous than previous reported samples (Jenks, 2014).

The differences found in the sample of the present study can be partially explained by the evolution in the swinging culture as explained by Kimberly and McGinley (2019) in their study on the changes in the swinging lifestyle from 1980 to the present day. These changes can be explained by a cultural shift, with a general acceptance of sexual variety in more recent times (Kimberly & McGinley (2019). It would also appear that swingers have a greater variety of political viewpoints and differences due to their educational backgrounds with the majority holding a bachelor's degree (Kimberly & McGinley, 2019) which the participants in the present study also demonstrated.

These differences could be further explained by Rubin et al. (2014), who describe the impact of having used a variety of recruitment strategies, thereby negating “the artifact effect of community based-strategies that have created an inaccurate reflection of people who engage in CNM” (p. 1). For example, the student researcher in the present study took the time during a clinical placement in NSG5610 to meet key informants in the local community and identify local hangouts of CNMCs in the city of Winnipeg. This helped during the recruitment phase of the present study to better diffuse the invitation letters, such as using the Fetlife platform.

The differences between the current sample and samples reported in the literature can also be based on geographic location, in which the previous studies had been conducted in the United States or in larger urban centers such as the Ottawa region in Canada (Conley et al., 2013; Jenks, 2014; O’Byrne and Watts, 2011). The current sample came from the greater Winnipeg region which appears to be a more diverse group in terms of their sociodemographic and professional characteristics (slightly older, less income, working at blue collar jobs), and of their beliefs and values (more variety for political affiliation, religious values and societal values

for marriage and divorce). Lastly, the more diverse group in the current sample could also be explained by the fact that the culture in Canada in regard to sexuality and sexual practices is based on previous legislation in which ‘the government has no place in the bedroom’ (R v. Labaye, 2005), perhaps permitting more people from different backgrounds to more freely engage in such practices.

5.1.2 Summary for this Section

In summary, these findings indicate that CNMCs in the present study do not appear to be as homogenous as seen in previous studies conducted on CNMCs. CNMCs in the lower socioeconomic classes would also appear less likely to divulge their sexualities if it diverges from the expected heteronormative norm, giving place to the somewhat privilege of ‘perversity’ to people of higher socioeconomic classes. People, already stigmatized in other ways be it race, gender or socioeconomic status, would therefore be less likely to be willing to participate in studies that do not take into account their added vulnerability (Sheff & Hammers, 2011).

5.2 CNMPCs and their Perceptions of the Transition to Parenthood

This section which presents the findings associated with CNMPCs’ perceptions of the transition to parenthood is partially related to the second, third and fourth research questions. The findings are first discussed according to how the participants reacted to each of the four identified phases of this transition: the decision to become a parent, pregnancy, childbirth, and from birth to two years postpartum. The findings from the PSCS are then discussed towards the end of this section followed by a summary for this section.

5.2.1 Decision to Become Parent

For the first identified phase of the transition to parenthood, which involves the decision to become a parent, this decision was either a conscious or an unconscious one for the participants in the present study. It would appear that the majority of the participants (66.67 %)

put a lot of thought into the decision to become parents. This is corroborated by a report published by the Vanier Institute of the Family in 2002, “those respondents who are under the age of forty and childless were asked how likely they felt it was that they would have children in the future. Fully 80% of those who currently have no children indicate that it is “very” (46%) or “somewhat” (34%) likely that they will still have children at some point” (p. 30). Thus, the participants in the present study demonstrated a high desire to have children, as expressed by so many Canadian adults (Vanier Institute of the Family, 2002).

5.2.2 Pregnancy

For the second identified phase involving pregnancy, the participants experienced both positive and negative reactions, and for some of them, had complications develop during pregnancy. Expectant couples experience a range of emotions during pregnancy which are related to the multiple changes that are part of pregnancy (Cowan & Cowan, 2010; Polomeno, 2000a). Also, certain women will develop complications during pregnancy: according to Lowdermilk and colleagues (2012), 10 to 20% of women will be classified as having a high-risk pregnancy. The participants shared how social support was important for them in order to deal with these complications. The support that conjugal partners can offer each other is important during pregnancy (Cowan & Cowan, 2000; Polomeno, 2000a), however, this may be different during high-risk pregnancy (Polomeno, 2001). The findings from the present study reveal how these complications can bring couples closer to each other, as shared by participants P5 and P6, yet participants P1 and P2 experienced relationship breakdown.

Another interesting finding was the following: distinct to this study was the aspect of taking into account more than one partner during the pregnancy phase of the transition to parenthood, especially in a polyamorous relationship. Each partner needed to become more aware of how he or she was feeling in regard to all the relationships involved in such a conjugal

situation. For example, one participant who was limited due to pregnancy complications felt jealous of both primary and secondary partners as they could do things that she could not. This is an original finding and has not been reported in the literature up to now. Communication is so critical during any phase of the transition to parenthood (Cowan & Cowan, 2010; Polomeno, 2000a), even more when multiple partners are involved. According to Balzarini and colleagues (2017), polyamorous partners appear to be more adept at communication. Polyamorous relationship communication may continue and be extended during pregnancy and the other phases of the transition to parenthood. This warrants further investigation in the context of CNMPCs.

5.5.3 Childbirth

During the third identified phase of childbirth, the female participants and their partners experienced a range of reactions, both positive and negative. Complications that developed during childbirth had an impact afterwards on the women, on their relationships, and on the attachment with their babies. Some of the female participants did have sexual difficulties in the postpartum period which was a consequence of difficult childbirth experiences. According to Bryanton and colleagues (2008), the stronger predictors of women's perceptions in regard to their childbirth experience were: the type of birth, the degree of awareness, relaxation, and control; the helpfulness of partner support; and being together with the infant following birth. It should be noted that women and their partners who have very negative childbirth experiences may consequently experience birth trauma. This did not occur in this sample, but it is important to mention this at this point, as this possibility can exist. According to Beck (2004), birth trauma is defined as: "...an event occurring during the labour and delivery process that involves actual or threatened serious injury or death to the mother or her infant. The birthing woman experiences intense fear, helplessness, loss of control, and horror" (p. 28). Some of the

troubling effects of birth trauma are detrimental relationships with partners, sexual dysfunction, fear of childbirth, and difficulties with mother–infant relationships. This aspect may need to be considered in future research in relation to CNMPCs and their childbirth experiences.

5.2.4 Postpartum Period

In the last identified phase which was the period from birth to two years postpartum, the participants or their partners experienced postpartum depression (five out of six participants) and had special needs children (five out of six participants). The first two postnatal years appear to be more difficult for this sample, but eventually, the participants did adjust to their new circumstances. This high level of difficulty experienced by the sample is unusual and not typical of the population of new parents. This is another distinct characteristic of this particular sample. The Winnipeg Regional Health Authority (2016b) reports that perinatal mental health includes postpartum blues, postpartum depression, postpartum anxiety, and postpartum psychosis. According to the Public Health Agency of Canada (2009), 7.5% of women reported depressive symptoms in the postpartum period. Yet, the Postpartum Depression Association of Manitoba (n.d.) reports that 15% of families are affected by this complication. The current sample had more mental health postnatal issues as compared to what is reported in the literature. In the Jenks study (2014), the sample consisted of 1 400 individuals responding to an online questionnaire; of these, 174 identified as swingers and 34 as polyamorists. When asked the question, “Have you had severe enough personal, emotional, behavioural, or mental problems (for example, depression or anxiety) during the past year that you felt you needed help?”, the general sample was much more likely to say “Yes” (60.5%), while the results for the swingers and the polyamorists were respectively 30.3% and 48.5%. However, the polyamorists were much more likely to seek help. In fact, over 81% of the polyamorists and about 77% of the swingers who answered “Yes” actually sought help. Of the 60% of the general sample who

answered “Yes”, only 35% sought help. Jenks explains that polyamorists and swingers “often face new situations for which no norm currently exists and that sometimes one or all those involved in the relationship just need advice or suggestions as how to proceed. As a result, they not only have a greater likelihood of saying that they not only need help but proceed to see someone. If they have sought, and received, competent counselling, they are better able to handle the relationships” (p. 13). All the participants in the Jenks (2014) study did seek, and depending on the quality of help received, were able to recover from their ailment. This will be further discussed in the health care providers’ section later on in this chapter.

The participants’ lives in this sample were compounded by having special needs children. According to Cousino and Hazen (2013), parents of special needs children experience stress and this can a strain on their relationship. Parents who faired the best had developed coping strategies such as being a team, good communication, and receiving social support. Indeed, the participants in the present study did eventually adjust to their new circumstances despite the presence of these difficulties. The explanation offered by Jenks (2014) is interesting in that polyamorists and swingers are continually exposed to new situations where no norms exist. This pushed them to communicate and to find new ways of coping. Indeed, the participants in the present study had found their own ways of dealing with their situations, and using strategies to reach a new level of adjustment.

5.2.5 Parenting Sense of Competence Scale

The participants completed the Parenting Sense of Competence Scale (PSCS) which measures parental efficacy and satisfaction. The PSCS was complementary to the questions asked during the interviews with the participants in regard to their perceptions of the transition to parenthood. The higher the total score, the higher is the parent’s level of confidence in his or her parenting. In this study, most of the participants’ total scores were on the higher side, however, the two male participants had the lowest total scores for parenting sense of competence as well

as one female participant. For the efficacy subscale, the only item that produced the lowest score was #7, 'Being a parent is manageable and any problems are easily solved'. For the couples in the sample (P1 and P2, P5 and P6), the scores for parental efficacy were similar. For the parental satisfaction subscale, the participants felt that they were doing a good job as a parent. There were greater differences in the satisfaction score for Participants P1 and P2 compared to Participants P5 and P6.

Participants generally had higher efficacy and satisfaction scores in the PCSC than other samples (Johnston & Mash, 1989; Ohan, Leung, & Johnston, 2000). The findings from the Ohan, Leung and Johnston study (2000) indicate that partners' marital satisfaction does significantly affect their parenting efficacy but can significantly reduce parenting satisfaction which can be noted in the levels of satisfaction of Participants P1 and P2. Another indicator of decreased satisfaction could be differences in parenting styles as well as having a 'special needs child' which are present in the current findings. Having an easygoing parenting style (Ohan, Leun, & Johnston, 2000) appears to increase parental satisfaction, which could be noted in the scores of Participants P3 and P4.

The lower PSCS scores for the fathers in the present study can be explained when looking at the qualitative data. Both fathers started identifying with their parental roles after their children were born or when their child/children were around a year of age. These findings are similar to those reported by Condon, Boyce and Corkingdale (2004). These authors also found that the pregnancy period was the most stressful for the fathers in their study, which hindered their relationships to a certain degree with their partners. Contrary to Johnston and Mash (1989), the fathers in the present study had a lower sense of satisfaction for their parenting sense of competence, however, they were more similar with those from the Ohan, Leung and Johnston study (2000). Although the participants in the present study answered the PCSC in terms of what they remembered from their transition to parenthood, parenting satisfaction for the

fathers (Participants P2 and P5) in the sample was lower. According to Condon, Boyce and Corkingdale (2004), when fathers feel like better partners, they are better able to integrate the parental role and the opposite of this is also true. The father participants had to contend with sleep deprivation and providing for their families, while their female partners took time off to look after the children. Comparatively in Sweden where non-transferable parental leave exists, Hass and Hwang (2006) found that fathers who took their parental leave participated more in their children's care and were more satisfied with the interactions with their children. The fathers in the present study did not have that opportunity which could have influenced their PCSC scores. The role of parent takes time to integrate, thus the more time he or she spends with the child, the greater efficacy develops. There have been changes to the national parental leave program in Canada since March 17, 2019, including extended paternity leave. It remains to be seen how this will impact fathers' parenting sense of competence.

In regard to the participants who were couples (Participants P1 and P2, P5 and P6), different coping strategies were used by them. By working as a team and having more effective communication, Participants P5 and P6 were able to come together more quickly as partners and parents, whereas Participants P1 and P2 took longer to do so, sharing the parental role more evenly when their child was a year of age. Sharp and Gable (n.d) highlighted the need of co-parenting and requiring a team effort for increasing marital satisfaction and general family functioning. The sooner parents start communicating and working as a team during the transition to parenthood, the sooner, they are able to come together and regain the levels of intimacy seen prior to this transition (Morrill, Hines, Mahmood, & Cordova, 2010).

5.2.6 Summary for this Section

In summary for this section, the findings in the current study indicate that the CNMPCs in the Winnipeg and surrounding area do compare with other couples who go through the

transition to parenthood, yet they did encounter difficulties associated with it. The findings that are distinct to the present study indicate a higher prevalence of PPD, which seems to corroborate those found in the Jenks study (2014). However, five out of the six participants experienced having a 'high needs' child, which could have contributed to increasing the risk of PPD. The findings further indicate that participants had higher scores for the parenting efficacy subscale on the PCSC, but were slightly lower in the parenting satisfaction subscale, that can be attributed to the stage of parenting in which the participants found themselves in.

5.3 Communication and Intimacy during the Transition to Parenthood

This section presents the findings related to communication and intimacy during the transition to parenthood for the participants in this study and is partially related to the second, third and fourth research questions. Communication and intimacy were found to be very important for this sample's transition to parenthood. Thus, communication will first be discussed followed by what is distinct to CNMPCs. Next, sexual intimacy and what is distinct to the study's sample are considered. This will be followed by emotional intimacy. Finally, communication and sexual and emotional intimacy will be tied together to try to illustrate how CNMPCs appear to have resilience during the transition to parenthood. The resilience demonstrated by this particular sample of participants is an underlying theme that emerges from these findings. A summary for this section is presented at the end.

5.3.1 Communication

Changes in communication in this sample were similar to the changes experienced by other parents during the transition to parenthood (Cowan & Cowan 2000; de Pierrepont et al. 2016b; Sharp & Gable, n.d). These communication changes can be influenced by the stress and period of disorganization that parents experience after the arrival of their child. This can then affect partners' capacity to reconcile their various roles (Briggs et al. 2005; Cowan &

Cowan 2000; de Pierrepont & Polomeno, 2015). Some participants noted a decrease in communication (a disconnect) related to a decreased desire to communicate during the initial postpartum phase, while other participants made it a priority to communicate more. It would appear that communication appears to be important under such circumstances, more so in the context of parenthood (Halford, Petch, & Creedy, 2010).

According to Lowdermilk et al. (2012), the transition to parenthood is more difficult when parents are affected by PPD or are raising a high needs child. Each of these two aspects will be discussed. Parents who experience postpartum depression can experience a loss of interest in activities and relationships, which can cause them to withdraw from their partners and loved ones (PPDAM, n.d.). This was noted in all participants initially after they experienced PPD. The lack of desire to communicate was further compounded when postpartum psychosis was involved as it did for one participant. The risk of PPD is increased if parents have a child that is high needs (PPDAM, n.d.). When parenting a high needs child, all the focus can be turned into meeting the child's needs to the detriment of the parents' needs (Briggs et al., 2005; Polomeno, 2007; Sharp & Gable, n.d.). Parents under such circumstances are forced to turn inward, and in turn, this will affect communication as noted by the majority of participants in this study. The findings in this study would suggest that the participants noted a change in communication during the transition to parenthood that was either improved or further compounded by PPD and/or parenting a high needs child.

Despite the higher presence of PPD and high needs children, for the majority of participants, their communication was distinct in a number of ways both directly and indirectly. Firstly, CNMPCs appear to be distinct in that they potentially have a certain resilience during the transition to parenthood. The term 'resilience' was intentionally chosen to describe this sample. Resilience theories gather around two critical components: the first component is the presence

of a significant threat or stressor, while the second is a positive adaptation to the situation despite the threat or stressor (Young, Roberts, & Ward, 2019). Resilience is applicable during the transition to parenthood, as it is a unifying concept that incorporates many of the skills linked to this very same transition (Young, Roberts, & Ward, 2019). Other researchers (Gabidia-Payne et al., 2015; Hill, Stafford, Seaman, Ross, & Daniel, 2007, as cited by Young, Roberts, & Ward, 2019), seem to agree that the transition to parenthood itself is a sufficient threat without any extra stressors involved to justify the application of resilience theory.

It would appear that under such circumstances, the participants in the present study did demonstrate resilience. They generally noted a positive adaptation to the transition to parenthood as they had the “capacity to deliver competent, quality parenting to children despite adverse circumstances” (Gabidia-Payne et al., 2015, p. 111, as cited by Young, Roberts, & Ward, 2019). The adverse circumstances that the participants were exposed to involved PPD and having a high needs child. Those who had been affected by PPD and sought professional help demonstrated resilience. This, although distinct from other couples, seems to be the norm of CNMCs as mentioned above in the Jenks (2014) study. CNMCs, when faced with mental health challenges, appear to more willing to seek help when needed, which was demonstrated by the participants who experienced the transition to parenthood. They also made a point of reaching out to their social network when they needed breaks from their high needs children. Thus, communication and resilience are indirectly linked in such a situation.

Furthermore, the participants recognized the importance of communication during the transition to parenthood. The participants appeared to be more aware of their communication skills. Putting advanced communication skills into practice empowered these parents to overcome the challenges when faced with PPD and/or high needs children. These advanced communication skills could have stemmed directly from their ‘lifestyle’. The participants

mentioned how they were better able to read their partners' emotional needs during lifestyle events in order to gauge whether they were comfortable

or not; this could have assisted them to be better able to recognize each other's needs while parenting. The participants made it a regular practice to do regular check-ins with one another, to make sure that their partner's body language matched how they were feeling, and to tell each other what they desired and needed. These skills all combined together appear to have better equipped CNMPCs as parenting partners: they seem to go into the transition to parenthood with better-developed communication skills when it comes to conflict resolution and to the use of compromise. These more advanced communication skills help them to navigate more than one person as a partner and more than one relationship. Thus, resilience and communication are directly linked for this sample of participants.

The protective factors just identified fit with the following component of resilience (Sheff, 2011; Young, Roberts, & Ward, 2019) in the following ways. The participants demonstrated self-efficacy by understanding and communicating to what extent their personal resources were required, and by doing regular check-ins and realizing when their stressor surpassed their capacities. They proved cognitive flexibility in having realistic expectations of each other as parents, partners and lovers. They demonstrated emotional regulation by being able to appraise and discuss the stressors facing their family during the transition so that they could cope better (Young, Roberts, & Ward, 2019). Although the participants also had a social support network, prioritized family relationships including extended family, and asked for support when needed, they did mention that they lacked a peer group (Young, Roberts, & Ward, 2019), or other CNMPCs going through the same situation. Asking questions of other CNMPCs would enable them to forge their own relationship structures (Sheff, 2016). Another finding was that the

participants were better at negotiating co-parenting after divorce or separation as expressed by Participants P3 and P4.

Interestingly, from a sexual viewpoint, it would appear that the end of the sexual relationship did not mean the end of a relationship per se, as a certain polyaffectivity is present; in other words, it is the capacity for the former partners to sustain a relationship beyond the point when it ceases to be sexual (Sheff, 2016). This is important as this part of the participants' resilience comes from being able to be more emotionally intimate with another person, as noted by Participant P1; this emotional intimacy helped all the relationships. For the participants who identified as swingers, emotional attachment was not permitted, yet they still viewed some members of their social network as 'kin' as they had developed relationships with them.

5.3.2 Sexual Intimacy

The qualitative findings in this present study are similar to those found by de Pierrepont and collaborators (2016a, 2016b) when it came to the physiological factors that affect sexual intimacy. Sexual libido varied for the female participants during pregnancy and remained the same for the male participants. The participants in this study indicated that complications related to childbirth delayed the return to coitus in the postnatal period; however, other ways of intimacy were retained by them as well as a greater ability to adapt to the other partner(s) to suit their sexual needs. The fathers in the study, by tailoring their needs according to what their partners needed or wanted, acted in the way as those in the MacAdam, Huuva and Berterö study (2011). Indeed, this did not prevent them from expressing their needs and desires for sexual intimacy. The findings in the present study indicate that CNMPCs have an earlier return to sexual intimacy than most parents during the first year postpartum (de Pierrepont et al., 2016b).

Some psychological factors played a role in sexual intimacy. A decrease in the number of opportunities for sexual intimacy related to fatigue (de Pierrepont et al., 2016b), especially

when combined with lack of sleep or having multiples, decreased the opportunity and variety of sexual practices. The female participants also expressed concerns related to their physical appearance that affected sexual intimacy. Also, the participants were more aware of the physiological effects of breastfeeding on sexual libido than most new parents. They were able to communicate 'touch fatigue', which decreased two of the female participants' desire for sexual intimacy. Touch fatigue can be especially difficult for new mothers that are breastfeeding and/or have a high needs child (Breimer, 2016). Two participants (Participants 2 and 6) described not wanting to be touched because of having to hold on to their high needs child not only for breastfeeding but to constantly console them. It would appear, therefore, that participants who had all their attachment and closeness needs met by their infant did not seek out as much physical intimacy with their partners. When partners recognized touch fatigue was an issue, they gave their partners breaks. Touch fatigue appeared to play less of a role for the majority of partners through the use of these strategies (Breimer, 2016)

According to literature (Barker & Langdrige, 2010; Fernandes, 2009), CNMCs have a higher level of sexual satisfaction than the general population. It would appear that this holds true during the transition to parenthood when looking more closely at the participants' perceived levels of sexual intimacy scores which are higher than those reported in published studies (Olsen & Schaefer, 2000). When compared to the general population and taking into account certain psychological factors, the participants did not notice a decline in sexual intimacy, especially when it related to PPD. This is contrary to the findings in the de Pierrepont and colleagues' study (2016b). The potential decline as would be expected for most partners during the postnatal period would either appear not to have happened, or could have happened but still remained higher than the average, when considering the participants' sexual intimacy scores. The participants, however, noted that sex during the first year was more 'vanilla' with less incorporation of BDSM practises in the home. They did not participate in the lifestyle in the initial

postpartum period, concentrating instead on their primary and secondary partners. The two participants who were the most affected by PPD, Participants P1 and P2, did present with the lowest scores on the perceived level of sexual intimacy subscale: these two participants shared how their sex life had become 'routine' during that time. However, even if their sex life was routine, it still continued. This is contrary to how new parents and their postnatal sex life usually are (de Pierrepont et al., 2016b).

To reiterate, some findings would appear to be distinct for this study's sample. Contrary to the literature (de Pierrepont et al, 2016b; von Sydow, 1999), it would appear that CNMPCs do not have a period of nonsexuality during the first postnatal months, followed by a gradual return for up to 12 months. CNMPCs, although limited by certain normal physical discomforts related to childbirth, and a decreased libido due to breastfeeding, put a greater emphasis on the importance of sexual intimacy during the transition to parenthood. PPD did affect sexual intimacy but it would appear to be of a lesser degree than the general population. CNMPCs also prioritized their primary relationships during the transition, focusing on reconnecting sexually with each other prior to a return to other lifestyle events. Could sexual intimacy be more important than emotional intimacy for these parents or at least equally important? This appears to have been demonstrated for Participants P1, P2, P3, P5 and P6, as they used sexual intimacy to reconnect emotionally. Participants who had no clear role models as Sheff (2016) mentioned, were able to use sexual intimacy as a protective factor that helped increase their emotional intimacy, demonstrating a certain resilience to overcome the typical period of nonsexuality as mentioned by de Pierrepont and colleagues (2016b). It is noteworthy to connect the participants' resilience with their sexual intimacy.

5.3.3 Emotional intimacy

Emotional intimacy is directly related to the ability for partners to openly communicate thoughts and feelings with one another (Timmerman as cited by Polomeno, 2013). This ability directly influences how couples come together as partners and parents (Polomeno, 2013). CNMPCs in the present study encountered some of the same stressors as other parents, while trying to integrate their roles and getting used to their new tasks as parents, partners and lovers. However, the participants in the present study seem to have encountered more stressors, as they had to deal with multiple gestation, multiple pregnancy losses, PPD and high needs children. When parenting couples encounter these stressors, certain behaviours can occur: they may turn inwards or reach towards their parenting partners (Polomeno, 2013). The participants demonstrated these same behaviours, especially after the birth of their first child. The partners who took longer to rebuild emotional intimacy did express feelings of bitterness and unhappiness, similar to those described by Polomeno (2013). Most of the participants recognized the emotional disconnect and chose to reach out to their partners in order to rebuild, putting time and effort into their relationship throughout the first postnatal year. This is another way that the participants demonstrate resilience in relation to their parenting.

The findings from the present study also suggest that once the transition to become a parent is successful after the birth of the first child, the subsequent transitions are easier, due to the skills learned during the primary transition. That being said, the successful transition to parenthood can sometimes be derailed if a parent has PPD, pregnancy complications or a high needs child following the birth of the first child. If the transition is not successful, and emotional intimacy is not regained, as described by Polomeno (2007), coupleship breakdown can occur, as was seen with one participant in the study. There was only one relationship breakdown in this sample, representing about 17%. This is still lower than the divorce rates reported by Heincke et al. (1997) and by Cowan and Cowan (2010), respectively 18% and 25%.

The quantitative findings from the present study indicate that the participants had a greater level of conjugal satisfaction as demonstrated by their emotional intimacy scores. These findings are similar to those as presented by Fernandes (2009) and Barker and Langdrige (2010), but greater than those reported by Olsen and Schaeffer in their study (2000), in which the averages for the emotional intimacy scores ranged from 48 to 58. Indeed, the level of emotional intimacy for the participants in the present study did dip slightly in the initial postpartum period followed by a gradual return over time: this pattern is similar to that found by Cowan and Cowan (2000), but not as much.

The emotional intimacy scores were the lowest (24, 36) for Participants P1 and P2, which could be explained by the qualitative data. Their scores could be attributed to the difficulties they encountered with multiple pregnancy losses and having a high-risk pregnancy. These difficulties hindered their relationship during the pregnancy, leading to a breakdown in communication. It is difficult to tell whether, the difference in parenting styles, having a high needs child, or the other preceding factors, influenced their lower emotional intimacy scores. Participant P1 also had significant differences in perceived emotional and sexual intimacy scores for both her primary and secondary partners. These differences could be reflected in the different dynamics between her and her secondary partner: when she spends time with her secondary partner, who lives out of the province, she does not have her daughter with her, so is able to better connect with her secondary partner and gets a certain amount of respite from dealing with her high needs child.

The scores for perceived emotional intimacy for both Participant P3's primary and secondary partners (84, 80) did not seem to reflect the qualitative data. The psychological factors (postpartum depression, high needs child) as described by de Pierrepont and collaborators (2016b) could have influenced this participant's emotional intimacy. When parents

suffer from PPD, they can turn inwards, and/or have negative thought processes, can be more irritable and lash out at their partners and be more fatigued among other things (PPDAM, n.,d.). When a partner sees these behaviours, and does not understand the illness, it can create a rift in the relationship and a decreased desire to help (PPDAM, n.d.). This in turn can influence a couple's level of emotional intimacy when professional help is not provided or is not adequate. Participant P3 described how she was "feeling like a third wheel" prior to the birth of her second child and into the early postpartum period, as well as a breakdown in the relationship and communication with her primary partner after the birth of her third child. When adequate outside help for the PPD was provided after the birth of her second child, the emotional intimacy was able to be rebuilt. After the birth of her third child, PPD combined with a high needs child, and no longer having a secondary partner, led to an eventual marital breakdown. The presence of a secondary partner appears to be more important for emotional intimacy.

Distinct to the present study is the extra resilience noted when a secondary partner was involved. Participant P1 noted that, because of the emotional connection she had with her secondary partner, she was better able to invest in her primary relationship due to the support she received from her secondary partner. Without this extra support, she was unsure if she could have handled the transition to parenthood as well, and have been able to rebuild the intimacy in her primary relationship. Another participant, P3, noted that the transition to parenthood after the birth of her second child was easier because of the extra hands involved. By being able to divide the tasks between three parenting partners, they had more energy to concentrate on their emotional intimacy after the birth of their second child.

Another element distinct to this sample was that it would appear that sexual intimacy came before emotional intimacy. De Pierrepont and colleagues (2016a, 2016b) in their scoping review do indicate that sexual intimacy and emotional intimacy are important during the

transition to parenthood by they do not mention if one is more important than the other. The findings in the study also indicate that the various changes in communication during the transition to parenthood were influenced by the participants' level of conjugal intimacy. When communication was present and partners took on the various obstacles as a united front, it would appear that their conjugal satisfaction and parental sense of competence were also greater, for example, as demonstrated by Participants P5 and P6. Most couples would appear to start rebuilding the emotional intimacy first and then sexual intimacy (Cowan & Cowan, 2000); this was not the case for this sample. The resilience of CNMPCs appear to be in their recognition of the drift in emotional intimacy combined with a greater understanding of the physiological changes brought on by pregnancy, childbirth and breastfeeding, and their effects on sexual intimacy. This allows CNMPCs to use sexual intimacy and communication as strategies to rebuild their relationships and present a united front in parenting. This resilience can only go so far, meaning that there are limits to it: for certain couples, even with these strategies in place, saw a breakdown in their relationship. This could be partially attributed to the lack of support received by health care professionals (HCPs), when they sought aid, which led to untreated mental health conditions. Somehow, the participants in the study were able to use communication as a way to increase or regain intimacy in their relationships, first sexually and then emotionally, thus, increasing their resilience with time.

5.3.4 Summary for this Section

It would appear that CNMPCs are similar to other parents in a number of ways. Although they experienced the same physiological factors as other parents, they demonstrated resilience in appearing to have a better understanding of how these physiological factors could affect their communication and intimacy (sexual and emotional). CNMPCs in this sample also had added stressors to the general stressors encountered during the transition to parenthood. They were again able to demonstrate resilience, in being able to adapt to their current situations, despite

having PPD and high needs children. Because of the various components of resilience, they mastered the transition to parenthood, as they seemed to be able to maintain greater sexual and emotional intimacy. The participants in this study were similar to those described by Sheff (2016) and Young, Roberts and Ward (2019), demonstrating resilience by using positive communication skills and family cohesiveness. This concept of family cohesiveness is discussed next.

Family cohesiveness was revealed not only by the participants identifying as polyamorous, but for those who identified as swingers. Family cohesiveness is defined as, “the emotional bonding that family members have toward one another” (Olsen, Russel, & Spengel, 1982 as cited by Riviera, Guarnaccia, Mulvaney-Day, Lin, Torres, & Alegria, 2008). These various open relationships were often ‘in transition’ from swinging to polyamory. Their motto would appear to be ‘Family First’ as all participants demonstrated resilience by including extended family as well as ‘chosen family’ as needed, especially when they needed extra support. This ‘chosen family’ was developed by establishing close kinships with their partners outside of their primary relationships incorporating them as ‘Aunties’ and ‘Uncles’. This held true as well even after marital breakdown as was the case for Participant P3: although the secondary partner acted as an ‘Auntie’ to the children after she was no longer a sexual partner, she still remained as an emotional support to both parenting partners even after they legally divorced. Thus, family cohesiveness was revealed through these various relationships.

One of the highlights demonstrating resilience during the transition to parenthood as presented by Sheff (2016) is that CNMPCs appear to recognize the importance of communication during the transition to parenthood and are able to apply their advanced communication skills learned from their sexual lifestyle in other aspects of their lives. They were able to recognize when they needed outside help when it came to PPD, high needs children,

and having perinatal complications. CNMPCs used sexual intimacy as a tool to increase emotional intimacy, which is contrary to most couples during the transition to parenthood.

5.4 Parenting with an Alternative Sexual Style

There is little insight on how CNMCs differ from those who choose a monogamous lifestyle and what process parents in non-monogamy follow when incorporating CNM. The findings in the present study reveal three phases that the participants followed, leading to the eventual integration of this lifestyle with parenting. The first phase which highlights 'Contemplating CNM' will illustrate how the process was started and the different characteristics that the participants held, leading them to consider CNM as a viable lifestyle. The second phase, 'Acting on CNM', will reveal the process in which CNMCs go through as to when deciding whether or not CNM is for them. The findings from the third phase, 'Incorporating CNM as a Lifestyle' are also discussed. These phases are comparable in some ways and distinct in others as described by Jenks (1998) and Kimberly and Hans (2015) (see Appendix 23). The last section will feature reflections on how CNM influences parenting followed by a summary for this section. This present section partially contributes to the discussion involving the second, third and fourth research questions.

5.4.1 Contemplating CNM

The first aspect to consider for 'Contemplating CNM' is how the process is initiated. It would appear that this initial phase of 'contemplation' can apply to all CNMCs. The findings in the present study put special emphasis on the initiation of the discussion on CNM as well as the comparison with social norms, yet distinct to it is who is the initiator of the conversation on CNM. All the female participants in the study were the ones to initiate the conversations or identified as CNM at the beginning of their relationship. This is contrary to previous studies (Fernandes, 2009; Jenks 2014) in which two thirds of the initiators of the discussion on CNM were the male

partners. Such conversations included discussion about a desire to explore and increase sexual satisfaction (not only with others but with each other), and on defying social norms. All of the participants questioned the social norm of mononormativity and were more willing to create their own sexual and relationship scripts

The second aspect to consider for this first stage is how the participants in the present study appear to have certain personality traits that are similar to those of the swingers and other people who identify as CNM (Conley, Zeighler, Moors, Matsick, & Valentine, 2013; Jenks, 1998; Kimberly & Hans, 2015; Sheff, 2016). First, the majority of participants seem to be extroverted, which is a personality trait that may be of value with the success of maintaining CNM (Kimberly & Hans 2015). Second, they presented a certain level of agreeableness and a seemingly higher than average compassion and concern for others as demonstrated by the use of their advanced communication skills. These latter personality traits are usually seen in those identifying as polyamorous (Pallotta-Chiarolli, 2010), however, in the present study, those identifying as swingers also demonstrated these traits. Third, the participants who identified as being polyamorous had a desire for close emotional and romantic relationships, by recognizing that their partners could not fulfil all of their needs. Fourth, the participants were amenable to “abstractions, ambiguities and complexities” (Conley et al., 2013, p. 134). This means that the participants were curious and adventurous. Conley and collaborators suggest that these personality traits might make a person more amenable or more successful at a CNM lifestyle. However, not all people with these traits will choose CNM as a lifestyle or even explore it. Indeed, if these traits are not present, then it is the reasons for such a choice that will drive people to choose such a lifestyle. The reasons that are given for swinging or engaging in CNM include the following: for pleasure, for excitement, to overcome certain sexual inhibitions, voyeurism, playing out sexual fantasies, sexual variety and defying social norms (Fernandes, 2009; Jenks 1998; Kimberly & Hans 2015). These reasons are similar the ones given by the

participants in the present study. For certain people, it is a combination of their personality traits and their reasons for engaging in CNM that can lead to 'Contemplating CNM'.

Certain authors have proposed the different stages on how people begin the process of considering such a lifestyle. Jenks (1998) and Kimberly and Hans (2017) looked at the process in which people engage in and find satisfaction with the swinging lifestyle. According to Jenks (1998), the first three steps would be: "1. Strong interest and/or early involvement in sex; 2. Personal characteristics (liberal sexual orientation, low degree of jealousy); 3. Passive phase characterized by learning about and talking about swinging" (p.525). These three steps as suggested by Jenks (1998) can be incorporated into what Kimberly and Hans (2017) have labelled as the phase of 'transition', characterized by vocalizing fantasies and assessing self-esteem. Indeed, the findings in the present study uphold all of these proposed notions, as they are similar to what the participants revealed during their interviews. The explanation of the process under which the participants considered this lifestyle continues in the next subsection.

5.4.2 Acting on CNM

The findings in the present study indicate that there is a second stage, 'Acting on CNM', in the process of making CNM as a lifestyle. This second stage is similar to Jenk's (1998) fourth step, called 'Active Phase', which is characterized by contact with swingers and the possibility for withdrawal. It is also similar to Kimberly and Hans' (2017) phase entitled 'Experiences'. All of these phases pertain not only to swinging but also to CNMCs. This second stage is characterized by exploring the CNM lifestyle. This includes arriving at a consensus followed by exploration of various sexual styles, and the importance of communication throughout this process.

The findings surrounding arriving at a consensus appear to be distinct from the other two models presented, or perhaps implied, that prior to acting on CNM, a consensus or an

agreement was made. However, the findings from the present study indicate that arriving at a consensus was the first part of the stage 'Acting on CNM'. This was done through self-reflection on their beliefs and societal norms and then, arriving at a consensus on how to begin acting on CNM as described as follows. Contrary to previous studies (Jenks, 1998; Kimberly & Hans, 2015), where most participants acted on CNM either prior to children or after their children were grown, the present findings indicate that arriving at a consensus and acting on CNM can occur as well at any point during the transition to parenthood as demonstrated by half of study's participants.

Similarly to Kimberly and Hans (2017), most participants engaged in a greater variety of sexual practices prior to engaging in CNM, demonstrating an interest in having a variety of sexual experiences which characterized the 'Experience' phase (Kimberly & Hans, 2017). This is different from the O'Byrne and Watts (2011) and Fernandes (2009) studies in which swingers focused only on heterosexual contact and more 'vanilla' type sexual practices, while shying away from bondage-discipline/dominance-submission/sadism-masochism (BDSM), and avoiding homosexual contact as this was frowned upon. It is difficult to determine whether these differences were in part due to the evolution seen in the swinging culture (Kimberly & Hans, 2015), or if the participants in the present study did not identify as swingers. Sheff and Hammers (2011) explain that the privilege of perversities was found with 'kinksters' and those identifying as polyamorous, but they did not note this with those identifying as swingers. Unlike other samples (Fernandes, 2009; Jenks 2014; O'Byrne & Watts 2011), 83% of the present study's participants identified as either bisexual or pansexual. Another factor that can play a role is that in Winnipeg, swingers do not appear to keep themselves separated from other 'sexual deviants', as they attend fetish events and the events put on by their own swinging clubs.

All participants wanted their first encounter with CNM to be non-threatening: some of them chose to engage with friends or people they trusted initially, while others sought out

mentors in the lifestyle to show them the ropes. They also actively sought out learning about the new language of CNM subculture. This engaging and learning took on a variety of forms including Fetlife or other online platforms as well as attending fetish events in the city of Winnipeg or taking part in a swingers' club. Fetish events and swingers' events are considered safe places which have the same underlying rules of "No means No; Aggression Not Tolerated" (Kimberly & Hans, 2015, p. 792). The participants who identified as swingers wanted to keep the sexual play as 'strictly sex on the side' as expressed by Participant P5, and limiting emotional attachment. This is very different for those who identified as polyamorous as they actively sought out meaningful emotional connections. On the other hand, there are participants who did not have that 'safe' experiences during the initial phase of exploration. Participant P2 expressed concern for those who initially engage in CNM, do not have a voice or are being taken advantage of. This poses some concerns when looking closer into the swinging subculture as the self-imposed rules of 'No means no' and 'Aggression not tolerated' (Kimberly & Hans, 2015) are not always respected.

Communication appears again to be important during this second stage. The findings reveal that the participants during this stage of exploration require enhanced communication skills, as they conducted regular check-ins with their partner(s) as well as their ability to deal with abstractions, ambiguities and complexities. This is similar to what was reported by Jenks (1998) and Kimberly and Hans (2017). The participants were better equipped to navigate the second stage as they were able to create their own rules of conduct when engaging in CNM. This led them to move to the next stage of 'Incorporating CNM as a lifestyle'. These rules of conduct were created by arriving at a consensus of what these rules were to entail.

5.4.3 Incorporating CNM as a Lifestyle

'Incorporating CNM as a Lifestyle' would appear to involve a significant amount of time

and energy, and at a potential cost to their families (Jenks, 1998; Kimberly & Hans, 2015). Although many personality traits and reasons characterize those who start contemplating CNM, the process per se would appear to be an iterative one that can either enhance existing positive relationships or destroy negative ones. Some people may exit from such a lifestyle as it can potentially expose insecurities including personality traits that are not conducive to the lifestyle such as jealousy (Jenks, 1998). Not all people who enter the first two stages of the process leading to the integration of CNM as a lifestyle are successful. However, in the present study, all of the participants did reach the third stage of 'Incorporating CNM as a Lifestyle'. During this third stage, the participants experienced the following three aspects: a sexual identity evolution, better sexual and health-related practices, and the effects of gender on their sexual expression.

The first aspect to consider is the evolution of the participants' sexual identity. This third stage is similar to that of Jenks' (1998) last step entitled, 'Commitment Phase', which is characterized by actual involvement, socializing into swinging and developing a rationale for swinging. This stage is also similar to the phase of 'Satisfaction' as noted by Kimberly and Hans (2017). However, it appears to go one step further for the participants, characterized in a number of ways. To begin, they see their sexual style as being an integral piece of their identity as well as that of being parents. One of the ways of reconciling their sexual style and being parents were to eventually integrate their sexual partners after friendships developed at various family activities, which is similar to what Kimberly and Hans (2017) describe in their study. Distinct, however, from one of the self-imposed rules found by these authors, was the fact that the participants in this study developed emotional attachments with long-term sexual partners over time even though they tried to maintain the 'strictly sex on the side' which added another complexity to those identifying as swingers. The participants also established long-term friendships with like-minded people that increased their social network, but also provided for better support during the transition to parenthood. This enhanced social network increased their

resilience during this period of stress, as they were able to talk to other CNMPCs who had undergone the same transition. The findings indicate that the participants used their shared activity of engaging in CNM as a tool to connect with one another and as a means to completely integrate their sexual identity. One participant (Participant 1) expressed it this way, “to avoid complacency”. This in turn enhanced trust and open communication between partners.

The literature indicates that non-disclosure is an important aspect to the people who identify as swingers. Kimberly and Hans (2017) refer to this as ‘privacy’ in their model whereas Jenks (1998) refers to ‘disclosure/non-disclosure’. The findings in the present study indicate that there are three patterns of responses that CNMPCs have to disclosure. The decision to disclose or not to disclose their lifestyle appears to have come after much deliberation and an arrival at a consensus with a set of ground rules to guide them. Each of these patterns influences the expression of their sexual identity in their various roles. The findings indicate that similar to those of Kimberly and Hans, some participants (P5, P6) chose to conceal their lifestyle to outsiders, meaning, those who did not participate in the swinging lifestyle (*first pattern*). The findings indicate that other participants (P1, P2) did disclose their lifestyle to those who did not participate in their lifestyle, but were selective in doing so making sure to arrive at a consensus prior to divulging their lifestyle (*second pattern*). The rest of the participants were distinct from that of previous studies done on swingers, yet similar to those who identify with polyamory in that they were open to all their social network if the subject matter came up (*third pattern*).

It would appear, therefore, that even for those who identify as swingers, although privacy or non-disclosure is an important aspect, the decision to whom and what to disclose remains as unique as each parenting couple. Common reasons for non-disclosure did emerge that were similar to those found by other researchers (Jenks, 1998; Kimberly & Hans, 2015; Pallota-Chiarolli, Hayden, & Hunter, 2013). The participants did not want to be treated any differently

when it came to job opportunities or career advancement. They also did not want their lifestyles to negatively affect the lives of their children. The findings seem to indicate that Participants P3 and P4, who chose to disclose their sexual identity to most or all of their social network, appeared to have to live with the social stigma, which added significant stress to their lives. This is similar to other research findings (Arbona & Jimenez, 2014; French & Chavez, 2010).

For the second aspect in regard to sexual and health-related practices, the findings would indicate that the participants were well versed in the risks they undertook with the lifestyle and took measures to prevent the lifestyle from affecting their health or that of their offspring. In order to be able to be safer, the participants would disclose their lifestyle to health care providers and ask for advice on how to be 'safer' during their lifestyle sexual encounters, especially during the transition to parenthood. They were diligent with condom usage with each sexual encounter in the lifestyle. Furthermore, the participants were very careful when it came to pregnancy prevention by using oral contraceptives or an IUD. These tendencies are all contrary to what has been published in previous studies (Fernandes, 2009; Kimberly & Hans, 2015; O'Byrne & Watts, 2011). However, distinct to this study, is the finding that all the female participants chose not to engage in CNM during their pregnancies, and the male partners only engaged with partners known to be safe, as evidenced by recent STBBI panels. This is a new development for the literature in regard to CNMPCs.

For the last aspect on the effects of gender on the participants' sexual expression, it would appear that gender and sexual identity influence the incorporation of CNM as a lifestyle. The male participants who identified as bisexual had a harder time fully expressing themselves when participating in strictly swinging events that were put on by the swingers' clubs or when trying to attend fetish events held in the city of Winnipeg. This finding is similar to what has been previously reported (Fernandes, 2009; O'Byrne & Watts, 2011), However, the following finding is

new and distinct and has not been reported in the literature. The female participants in the study had difficulty to reconcile their higher sexual drives and their femininity. According to Kimberley and Hans (2015), women have the ultimate power when deciding to engage in any sexual acts, yet, if they were to aggressively pursue sexual acts, this would go against most heterosexual scripts (Gagnon & Simon, 2005). The male is usually the initiator of sexual activity, while the female is considered as the recipient. It would appear from the findings in this study that even with CNMCs, females are more limited in their sexual expression, or in the scripts that they can play to engage in sexual activity. This may be considered as gender inequality in this regard which a paradox in itself is.

5.4.4 Reflections on CNM on Parenting

This present study appears to be one of the first studies to consider the incorporation of CNM during the transition to parenthood, with a renegotiation of what CNM means to the parenting couple. The findings from previous findings (Jenks 1998; Jenks 2014) reveal that most CNMCs decided to stop CNM when they became parents or started it after their children were fully grown. There are three ways in how CNM influences parenting: the greater need for individual autonomy, how such parents discuss sexuality with their children, and resilience in the face of the challenges associated with CNM and parenting.

The greater need for individual autonomy was the first way that CNM influenced parenting. The participants in the present study looked at different strategies on how to allow for greater individual autonomy. This aspect is supported by Sheff (2016). The participants who incorporate CNM as a lifestyle appear to be more vocal of their needs and desires as individuals, which in turn helped, solidify their relationships and assisted with their parenting. For the participants who were polyamorists, one relationship did not have to end for another to begin. Participant 2 was able to receive emotional support from her secondary partner, which

allowed her to be a better partner to her primary partner and a better mother to her daughter.

The second way that CNM influences parenting is how the participants in this present study were more considerate of their children's sexuality and how to discuss sex and sexuality with them. It would appear that the openness with such communication extends to their children in all subject matters including sex and sexuality. According to Grossman, Jenkins, and Richer (2018), parents' and children's backgrounds influence the content of sexuality and how communication has an impact on it. These same authors also mention that many parents express discomfort in having to talk about sex or sexuality with their children (50% for male children, 27 % for female children), whereas all of the participants in this study (100%) expressed little or no discomfort about talking about sex or sexuality with their children. Contrary to the findings in the Grossman, Jenkins and Richer's study (2018), the participants started earlier to discuss sex and sexuality with their children, and had a greater appreciation of different sexual identities and expressions. They also seemed be more comfortable with their children's lifestyle choices that did not necessarily follow social conventions.

For the last way involving resilience, the same traits that are conducive to considering non-monogamy and incorporating it as lifestyle as previously mentioned in section 5.4.1 appear to also offer a certain resilience during the transition to parenthood. A person who is more extroverted tends to have a larger social support network, so having a greater variety of relationships will help that person to better fare during times of stress, for example, during the transition to parenthood (Conley et al., 2013). Therefore, CNMPCs would be more resilient as they are not relying on only one person, potentially leading to an eventual relationship fallout. The participants were able to recognize that their primary parenting partner could not always fulfill all of their needs and were better able to look outward when needed. They appeared to be better able to reinvent themselves as parents according to their needs and those of their

children.

5.4.5 Summary for this Section

Incorporating CNM as a lifestyle is an iterative process comprised of three stages, namely, 'Contemplating CNM', 'Acting on CNM', and 'Incorporating CNM as a Lifestyle'. These stages are similar yet distinct from those previously proposed by Jenks (1998) and Kimberly and Hans (2015). Although certain personality traits may be present in the first stage, the women were more often the initiators of the lifestyle rather than the men. Having a greater variety in sexual practices and a greater interest in sexual experiences was part of the second stage for the study's participants, yet their first encounters had to be non-threatening. Reaching the third stage where the lifestyle was fully incorporated, the participants all actualized progress in their sexual identity and in their sexual practices while understanding the effects of gender on their sexual expression. Having an established social network and enhanced communications skills spilled over into the participants' life situations when stress was very present. The participants in the present study were also very well versed in sexuality, health conscious and aware of the potential implications of their lifestyle on their health and that of their children, demonstrating the following, 'Family first, lifestyle second'. The three identified stages continue to nurture the participants' underlying resilience that was demonstrated by the findings in this section.

5.5 Conciliation of Parenting and Sexual Roles

This section presents the findings that are similar, different, and distinct to those of previous studies (Brotherson, 2007; Cowan & Cowan, 2000; de Pierrepont et al., 2016a, 2016b; Lowdermilk et al., 2012; Polomeno, 2014), in regard the conciliation of the participants' parenting and sexual roles. Three aspects are considered in the conciliation of these two roles: finding a balance amongst the various roles, the factors that influence this conciliation, and finally, how the findings from the PSCRSC contribute to the conciliation of the two roles. The

summary for this section can be found at the end. This present section partially contributes to the discussion involving the second, third and fourth research questions.

5.5.1 Balancing Roles

For the first aspect relating to the balance of the various roles, the participants had to balance their roles of partner, lover, and parent. Marks and MacDermid (1996) conducted a study on balancing multiples roles and the self. Their findings suggest that people who maintain more of a balance between their different roles and the self would have less role strain and less incidences of depression, and have higher levels of self-esteem and role ease. The findings in the present study are similar to those in the Marks and MacDermid's study (1996) in that the participants who appeared to have found a better balance between their roles of partner, lover and parent seemed to have fared better during the transition to parenthood. The new role of parent has a significant impact on the partner (Cowan & Cowan 2000; de Pierrepont et al., 2016b). All of these findings, both from the previous studies and from the present one, would indicate that once the role of parent is mastered, then the other two roles of partner and lover follow suit.

5.5.2 Factors Influencing Conciliation of Roles

The second aspect involves the many factors that seem to influence the conciliation of the parenting and sexual roles. The first group of factors are gender specific while the second group of factors pertains to the context in which this conciliation occurs.

The first group of factors that are gender specific will be first presented for the female participants and then for the male ones. The factors that affected the female participants' conciliation of their roles were: lack of sleep and being tired, body image changes, doubts in their parental capacity in the initial postpartum period, increased workload, mood changes, and anxiety. These factors have been corroborated by Brotherson (2007), de Pierrepont et al.

(2016b), and Polomeno (2013). It is noteworthy that the changes in the women's body image did not appear to have influenced their capacity to fulfill their role of lover. The literature (Brotherson, 2007; de Pierrepont et al., 2016b; Polomeno, 2013) has identified other factors, however, the female participants did not mention them during their interviews: stress associated with changes in their work situation, increased workload, and financial strains. On the other hand, the male participants were more stressed in the initial three months postpartum compared to the women: they mentioned being stressed about providing for their family, altered sleep patterns, needing to navigate a new normal for sexual activity in the initial postpartum period, and having less free time for social activities. These findings are similar to those presented by Condon, Boyce and Corkindale (2004). However, the male participants did not notice as much of a change in the workload around the house, as they viewed household chores as a shared responsibility. Indeed, they were more prepared for the changes in their sexual roles, and were very understanding of their partners during their pregnancies and the initial postpartum phase, by adapting to their partners' sexual needs and still being able to voice their own sexual desires and needs.

The second group of factors affecting the participants' conciliation of their parenting and sexual roles is related to the context in which the conciliation occurs. Firstly, having a fussy or a high needs child usually affects the ability of people to reconcile the role of lover and partner in the parenting context, potentially leading to a breakdown in the relationship (Lowdermilk, Perry, Cashion, & Rhodes, 2012), however, this did not occur for the participants' sexual intimacy. Previous studies (Briggs et al., 2005; Polomeno, 2007) indicate that a decrease in sexual intimacy is one factor that can put a strain on the parenting couple's relationship, eventually leading to separation and divorce. The participants in the present study would appear to have put a greater emphasis on their sexual role during the transition to parenthood, using their sexual intimacy as a way to reconnect as partners. Secondly, managing expectations in regards

to household chores, parenting styles as well as sexual activity frequency, appears to have assisted most of the participants' abilities to reconcile their various roles. When expectations are not met, this can influence one partner's desire to come together with the other partner(s) as demonstrated by the qualitative data from P1, P2 and P3. For one participant (P4), she compartmentalized various aspects of herself in reaction to trying to meet the different expectations and this led to increased difficulties for her.

Up to this point, the factors that influence the conciliation of the parenting and sexual roles are considered on how they are similar or how they differ for the participants. Now the factors that make the participants' context distinct are presented and these are all in relation to their resilience, as they manage the transition to parenthood. The factors will initially be discussed followed by how they are related to their resilience.

Firstly, household chores were viewed as a shared responsibility. This aspect continued for childcare: although the female participants stayed home with the children in the first postnatal year, by the age of one, the participants (whether male or female) took on full childcare responsibilities with their partners. They would take turns caring for their children according to work schedules and for social engagements. Secondly, the majority of the participants had high needs children. Sometimes with high needs children or dealing with other stressors, one of the partners can back off or withdraw from the parenting role (Cowan & Cowan, 2000): this can lead to increased tension in the conjugal relationship and less shared childcare responsibilities, which in turn can lead to decreased time in the role of lover. De Pierrepont et al. (2016b) indicated that when this happens, the emphasis can be placed more on the child and the parenting role, to the detriment of the role of partner or lover; on the other hand, both parents can come together to meet the needs of their child and create a more harmonious bond between them. The participants reacted with a range of reactions, with the

majority coming together as partners, lovers and parents to surmount the added stressors, while for one participant; this led to separation and divorce related to having a high needs child.

Thirdly, CNMPCs appear to prioritize their sexual role. The participants in the study took longer to rebuild their emotional intimacy, using sexual intimacy as a tool to come together as partners. The participants also integrated their role and identity as CNMPCs. What this means is that they were more aware of the changes in their sexual lifestyle: just as for monogamous couples, there was a decrease in the duration and opportunity for sexual intimacy. However, they quickly adapted to these changes and were able to determine how often they went out to pursue their lifestyle.

Certain factors were present to support and buffer the context in which the conciliation of parenting and sexual roles occurred. Having a supportive social support network was important (Neff, Broady, & Simpson, 2011), as this facilitated getting childcare when the participants were pursuing lifestyle events. This in turn decreased their social isolation, which many new parents may experience during the transition to parenthood (PPDAM, n.d.). Certain participants, after a lifestyle event, would take turns to fully recuperate and recover while encouraging the children to seek out the designated parent. In regard to the functioning of the household, the majority of the participants came together with their partners to decide which household tasks were priorities and needed to be carried out, before a lifestyle event could take place. For other participants, they chose to fully incorporate their partners in co-parenting, especially when dealing with high needs children so that they could take turns in order to respond to the needs of these children. Others had a secondary partner live with them in the home, which allowed for more flexibility to pursue their lifestyle. Two approaches were utilized for the lifestyle events. In one approach, certain participants chose to pursue the lifestyle solo, leaving one parent at home, while the other went out, and then taking turns. In the other approach, the participants

used the strategy of compromise, when deciding which lifestyle event they were to attend together due to the decrease in duration and frequency of opportunities to do so.

In all of these circumstances, communication was the key to better reconcile their roles of partner, lover and parent. Although they did value their sexual lifestyle by making it a top priority, all participants were adept at prioritizing household, childcare and other aspects of their relationships. Indeed, a greater emphasis was placed on family and their primary relationships.

5.5.3 Findings from the PRSRCS

The findings from the PRSRCS support those from the qualitative ones as follows. Four of the participants appeared to have better reconciled their parental role and their sexual style. This is in part due to having a greater support network when it came to childcare. Two of the highest scoring participants, also were open about their lifestyle to their social network. Another factor that might have played a role is that these four participants all experienced higher levels of stress, with successful resolution in the earlier stages of their relationships. Neff, Broady and Simpson (2013) found that: "Spouses who experienced moderate stress during the early months of marriage and had good initial relationship resources (i.e., observed support behaviors) reported greater marital adjustment following the transition to parenthood than did spouses who had good initial resources but less prior experience coping with stress." (p. 1050). However, for the others, when there was a breakdown in communication the postpartum period, there was less time for sexual intimacy. This findings from this scale also bring to light, that the participants who had multiple stressors to deal with, such as having a high needs child, seemed to have taken a little bit longer to reconcile their various roles. But they did do so eventually. This is similar to previous studies mentioned above (Jenks, 1998; Kimberly & Hans 2015). Disclosure also had an impact for the participants: it would appear that those who were more willing to be open with their lifestyle with family and friends were better able to reconcile their

parenting role and their sexual style. At this point, it could be posited that the stigma associated with the participants' lifestyle, as mentioned in Section 5.4., although real for them, might not have as much of an impact as the findings are suggesting. If CNMPCs are willing to be open about their lifestyle to more people, the stigma associated with the lifestyle is reduced or can be less. This warrants further investigation.

5.5.4 Resilience and Conciliation of Roles

Many factors appeared to contribute to the extra resilience noted with the conciliation of roles during the transition to parenthood. According to Neff, Broady and Simpson (2011), stress inoculation when combined with advanced problem resolution skills possibly resulted in a better conciliation of roles. The problem solving and advanced communication skills would yet again appear to add to these couples' resilience during the transition to parenthood. Secondly, the participants appeared to have a larger social network (Neff, Broady, & Simpson, 2011), which added to their resilience, allowing them to focus not only on the parenting role but on their roles as partners and lovers (including in the sexual lifestyle). Thirdly, CNMPCs in this particular study did not appear to conform to the normal gender roles when it came to household chores and childcare responsibilities, viewing these as a shared responsibility. Finally, distinct to this study is the fact that the participants focused on their sexual role as a means to bring them together as partners which appears to have added to their resilience as well.

5.5.5 Summary for this Section

Although the participants had a transition to parenthood similar to other parents (Brotherson, 2007; Cowan & Cowan, 2000; Lowdermilk et al. 2012; Polomeno, 2014), their unique situation made them distinct on how they reconciled their parenting and sexual roles. The majority of them appeared to better reconcile their roles compared to monogamous parents. Their sexual lifestyle was a priority for them, however, they did not involve themselves

in any lifestyle event unless household and childcare responsibilities were discussed and organized, who attended the events was negotiated, and their social network was often utilized if they attended the events. Once the parenting role was mastered, it was easier for the participants to quickly adapt their sexual role, leading to a better reconciliation between both roles (parenting and sexual). The PRSRCS findings supported those from the interviews. The Participants P3, P4, P5 and P6 were able to communicate their needs with their partners, therefore, better able to be intimate in a variety of ways. Communication and advanced problems solving skills in periods of stress continue to be key for these participants' resilience as they reconcile their parenting role and their sexual lifestyle.

5.6 CNMPCs' Experiences with the Health Care System

This section presents a discussion of the findings in terms of the participants and their relationship with health care professionals (HCPs). In this section, HCPs include nurses unless otherwise specified. Particular attention will be placed on nurses, as they play an integral role in the care provided to the participants during the transition to parenthood. Four aspects are considered: the HCPs' including nurses' discomfort levels and lack of education, fear of disclosure, health risk awareness, and factors affecting participants' relationships with HCPs. A summary for this section is presented at the end. This present section partially contributes to the discussion involving the second, third and fourth research questions.

5.6.1 Discomfort and Lack of Education

Previous studies (Leonardi-Warren, Neff, Mancuso, Wenger, Galbraith, & Fink, 2016; Polomeno & Dubeau, 2009) highlight that HCPs receive very little education and training in sexuality during their undergraduate studies, and even less about alternative lifestyles (Barker & Langdridge, 2010). This lack of education translates in that most HCPs are uncomfortable discussing sexuality and sexual health concerns with their clients, regardless of the health care

setting (Leonardi-Warren et al., 2016; Polomeno & Dubeau, 2009). Although sexual education is a crucial aspect to be addressed during the prenatal period (Allen & Fountain, 2007; de Pierrepont et al., 2016a), the participants in the present study received little or no education from nurses on sexuality during their prenatal classes.

When HCPs are uncomfortable discussing sexuality, it can be posited that it is more difficult for them to move beyond society's heteronormative assumptions. The HCPs' discomfort and their lack of education in sexuality translates into starting discussions about sexuality with their clients with heteronormative assumptions. These assumptions can lead to non-disclosure on the part of the clients, which can be especially problematic during the transition to parenthood. Miscommunication can ensue, especially when the HCPs do not understand the terminology being used when discussing the lifestyle, or they can present themselves as being curious without having the appropriate tools to help their clients.

5.6.2 Fear of Disclosure

In this study, certain participants did disclose their lifestyle to HCPs, while others did not. The ones who did not are first discussed, followed by those who did.

According to the literature (Politi, Clark, Armstrong, McGarry, & Sciamanna, 2009), sexual minorities are more hesitant to share information related to prior negative experiences with HCPs, and providers lack education and training on relevant sexual issues in regard to these sexual minorities. In general, CNMCs have a tendency of not divulging their lifestyles to HCPs (Barker & Langdrige, 2010), which can put them more at risk for STBBI (O'Byrne & Watts, 2011). The findings from the present study indicate that the majority of the participants (66.7%) did not disclose their lifestyles to their primary physicians. Many reasons were given for this, including the fear of judgement and the repercussions of their lifestyles on their children. Although the participants did not appear to routinely disclose their lifestyle to their HCPs

(Fernandes, 2009; O'Byrne & Watts, 2011), they did seek out sexual health care and counselling when required. The participants chose to attend nurse-led sexual health clinics, and were more open to speak with certain public health nurses. These nurses presented themselves as non-judgmental and included all parenting partners during their home visits after the arrival of the children. In this regard, these findings are similar to those presented by the study conducted by Politi, Clark, Armstrong, McGarry, and Sciamanna (2009). The participants felt that HCPs should ask about sexual health concerns if they were directly related to the matter at hand, and, if the questions were related to the health concern at hand, they would be more than willing to disclose their lifestyle.

The other participants (37.3 %) chose to disclose their lifestyle to their primary HCPs, and regularly discussed issues with them, as needed. These participants were persistent in finding HCPs who were open to their lifestyle and were willing to listen to them. This finding is contrary to what Saewyk (2015) found, indicating that this is not a behavior commonly seen by sexual minorities. Sexual minorities have a tendency to not seek out primary care and wait longer before seeking health care due to their fear of being discriminated against. This combined with the stigma associated with a sexual minority lifestyle can lead to health disparities (Saewyk, 2015).

5.6.3 Health Risk Awareness

The participants in the present study were well aware of the health risks associated with their lifestyle and preferred to take a more anonymous STBBI testing approach, attending clinics specializing in sexual health. These findings are different from those presented by Knapp (1975) and O'Byrne and Watts (2011): the participants sought out sexual health care and counselling as needed. The findings in the present study suggest that CNMPCs are very well aware of the health risks associated with their lifestyle during the transition to parenthood, go for regular

screening, and educate themselves prior to engaging in CNM, yet they are more careful at the time of conception and during their pregnancies by choosing not to engage in risky sexual behaviors.

5.6.4 Factors that Influenced CNMPCs' Relationship with HCPs

The findings from the present study indicate that certain factors facilitated CNMPCs and their relationship with their HCPs, while others hindered it. The findings from the present study that facilitated their relationship will first be discussed, followed by the ones that hindered their relationship.

5.6.4.1 Factors that Facilitate CNMPCs' Relationship with their HCPs

The findings from the present study reveal two interconnected factors that can facilitate CNMPCs' relationships with their HCPs. The first factor stems from HCPs being aware of emerging family structures and their implication on social institutions including health care. The second factor involves being well versed in sexuality and harm reduction approaches and/or being able to direct CNMPCs towards a HCP if needed.

The findings indicate that the first factor that can facilitate CNMPCs relationships with their HCPs is being aware of emerging family structures in Canada. If and when HCPs are aware of the potential economic and legal implications faced by CNMPCs when they encounter social institutions that are based on mononormativity, they can gain a better appreciation of the challenges faced by these families and better serve them. HCPs who are more aware are more likely to use inclusive language and use a non-judgmental approach at all points of care. By using an inclusive language and a non-judgmental approach, sexual minorities will feel more comfortable disclosing their lifestyle to HCPs (Leonardi-Warren et al., 2019). This factor includes taking a closer look at institutional policies that define family. This is especially important because including family in the care received during the transition to parenthood can

greatly facilitate CNMPCs' relationship with HCPs, the family's well-being, and HCPs' understanding that CNMPCs are just like any other families. They put their families first. This is similar to Pallota-Chiarolli, Hayden and Hunter's (2013) findings stressing the importance of recognizing CNMPCs' strengths as families, all while acknowledging their differences. Unfortunately, this facilitating factor demonstrated by HCPs appears to be the exception as opposed to the norm when CNMPCs seek health care as the findings in the present study indicated that the majority of participants received care from HCPs who had heteromononormative assumptions.

The second factor that facilitates CNMPCs' relationships with HCPs is for HCPs to be well versed in sexuality and normalizing it. The findings indicate that, contrary to previous studies (Fernandes, 2009; O'Byrne & Watts, 2011) this population might be better versed in health risk awareness than previously presumed. This would indicate that HCPs including nurses need to meet CNMPCs where they are at and very carefully assess their knowledge, prior to giving any education using a sex-positive approach. This approach means "respecting the wide range of human sexuality. It involves talking with your clients openly and without judgement about their sexuality" (Canadian Public Health Association, 2017, p.1). It also involves taking special considerations for dialogue using clarification and a common language (CPHA, 2017). It is important for nurses and other HCPs not to make assumptions based on age, gender, race, relationship status, ability, socioeconomic status, and other aspects (CPHA, 2017). During a health visit, the nurse should be asking questions pertinent to what the visit is for. When HCPs ask questions about a client's sexuality when it has nothing to do with the care sought, it can hinder the relationship with HCPs.

5.6.4.2 Factors that Hindered CNMPCs' Relationship with HCPs

The findings from the present study highlight two major factors that hindered CNMPCs' relationships with nurses and other HCPs.

The first identified factor that hindered CNMPCs' relationships with HCPs was HCPs' lack of awareness of general sexuality and border sexualities as well as a lack of undergraduate training in general sexuality. The findings reinforce that a lack of education and awareness can lead to non-disclosure of sexual identity and lifestyle, which can be detrimental for CNMPCs (Leonardi-Warren et al., 2019). The findings reveal that their HCPs' lack of knowledge about their sexual lifestyle and sexuality sometimes frustrated the participants, as they had to choose when to disclose; this had the consequence of leading them to move towards seeking care from HCPs who were specialized in border sexualities. The participants mentioned being challenged by nurses after the delivery of their child, requesting that the father of the baby remain while removing other parenting partners from the room because the other patients were uncomfortable. This lack of understanding of the diversity of Canadian families could greatly affect the care received by CNMPCs during their transition to parenthood.

The second factor that hindered CNMPCs' relationships with their HCPs appears to be the judgment perceived from HCPs during their encounters with the health care system. The qualitative findings reveal that CNMPCs appeared to be viewed less favorably than their heteronormative counterparts. One example to illustrate this point was when a HCP was more accepting of a partner 'cheating' on the participant, than her disclosing her swinging lifestyle. Another example involved the judgement that a participant received when seeking an abortion related to a pregnancy that occurred during a swinging encounter. HCPs taking on heteronormative assumptions would negatively impact the relationship between them and their clients identifying as CNM including during the transition to parenthood. Some of the qualitative

findings in the present study reveal how this changed once the participants were identified as 'family'. Nurses and other HCPs, by not making heteronormative assumptions and by normalizing sexuality, would appear to increase their clients' trust with the HCP relationship. More research needs to be done in this area in relation to these aspects.

5.6.5 Summary for this Section

This section presented the discussion of the findings in relation to nurses and other HCPs and their relationship with CNMPCs. The participants were very much aware of the health risks associated with their sexual lifestyle during the transition to parenthood, yet utilized different strategies to deal with them. Some of the participants did seek health care services, while others did not. This was in part influenced by health care providers including nurses who were comfortable with the lifestyle of CNMPCs and who knew about it. Some of the findings are contrary to those presented in the literature as specified above, however, other findings are new and distinct and have not yet been reported. CNMPCs do appear to seek out health care providers including nurses who are familiar with sexual minorities and want them to know that their families are very important to them. For CNMPCs, family is first, sexual lifestyle is secondary.

5.7 Reflections about the Conceptual Framework

This section presents reflections about the conceptual framework that was used for the present study and considers a new model that highlights the resilience developed by CNMPCs during the incorporation of CNM as a lifestyle during the transition to parenthood.

5.7.1 Applicability of the Adapted EMERJ Model to the Present Study

From the findings, it would appear that the EMERJ Lens (EMERJ, 2008), combined with Cowan and Cowan's Ecological Model (Cowan & Cowan, 2000) to create the conceptual framework used to guide the present study, was beneficial in two ways.

Firstly, the EMERJ Lens is grounded in social justice, which aligns very well with critical social theory. This means that the conceptual framework allowed the student researcher to identify the CNMPCs as a vulnerable population who may experience stigma or challenges associated with their gender bodies and sexuality (EMERJ, 2008). When conducting research with a sexual minority, it is important to choose a framework that is grounded in social justice: such a framework looks more closely at the ways in which the general society might systemically influence sexual minorities' ability to live fully in all aspects of their lives, and to be able to have self-determination over their gender, bodies and sexuality. By focusing on the CNMPC community in Winnipeg with this lens, several key aspects that are related to the conceptual framework that were used for this present study emerged as important. These aspects can help to guide nurses when working with this subpopulation of parents. These key aspects are connected with three arenas of the reproductive justice model, namely, the family, health and safety, and access and opportunity. For the *family*, four reproductive justice issues were identified: a) the findings indicate that the participants worry about repercussions of their lifestyle on their children; b) there appears to be a lack of legal recognition of children in polyamorous families, which can potentially result in difficulties in custody battles in the event of a divorce; c) CNMPCS, if already part of a visible sexual minority, would be even less likely to divulge their relationships to HCPs; and d) they put families first, sexual lifestyle second. Three issues in relation to *health and safety* were also identified: a) CNMPCs are faced with potential threats and harassment because of their sexual lifestyle; b) they do not appear to be equipped with tools in the initial exploration phase to affirm themselves, and to say no to unwanted sexual contact; and c) they are very aware of the health risks involved with their lifestyle. For the last part in regard to *access and opportunity*, CNMPCs have very limited access to HCPs who are well versed in sexuality minorities.

Secondly, as noted with the challenges identified above, this part of the conceptual framework that guided the research questions did allow the student researcher to identify particular challenges faced by CNMPCs during the transition to parenthood. It appears that by adapting the EMERJ Lens by the addition of the Cowan and Cowan's Ecological Model (2000), the present study was better able to explore the transition to parenthood from the viewpoint of the CNMPCs. If only the EMERJ Lens had been used, it might not have picked up on particular areas of interest during this timeframe. This allowed a further exploration in the part of the framework that is related to family under the EMERJ Lens. By adding the Cowan and Cowan's Ecological Model (2000) to the conceptual framework, more data were able to be collected that focused particularly on the five central aspects of family life, as according to these authors (see Section 2.9.2). A better picture of the CNMPCs' perceptions in regard to their transition to parenthood, their sexual style, the conciliation of the parenting role and sexual style, and their relationship with health care providers were obtained from both qualitative and quantitative data that were then triangulated for analysis and interpretation.

5.7.2 Model of CNMPCs' Resilience during the Incorporation of CNM as a Lifestyle While Parenting

As previously stated, the conceptual framework that was used for this study integrated the EMERJ Lens with the Cowan and Cowan's Ecological Model (2000). The EMERJ Lens was useful as it was needed to consider sexual minorities, while the Cowan and Cowan model enhanced the family aspect in the EMERJ Lens. Yet, the Cowan and Cowan model was created with a focus more on heteromononormative couples. By using the EMERJ Lens, this compensated for the heteromononormativity of the Cowan and Cowan model.

Although CNMPCs may not experience as many issues as other members of sexual minorities, it would appear that the challenges they encounter are unique and require action.

The Model of CNMPCs' Resilience during the Incorporation of CNM as a Lifestyle While Parenting was developed to help nurses and other HCPs working with this sexuality minority in order for them to better focus their attention on the challenges unique to the situation of CNMPCs. Nurses and other HCPs need to be more understanding of where their clients who identify with CNM are on the continuum of incorporating CNM as a lifestyle while parenting (as noted in Figure 4 on p. 192). The transition to parenthood is the context in which this is all occurring.

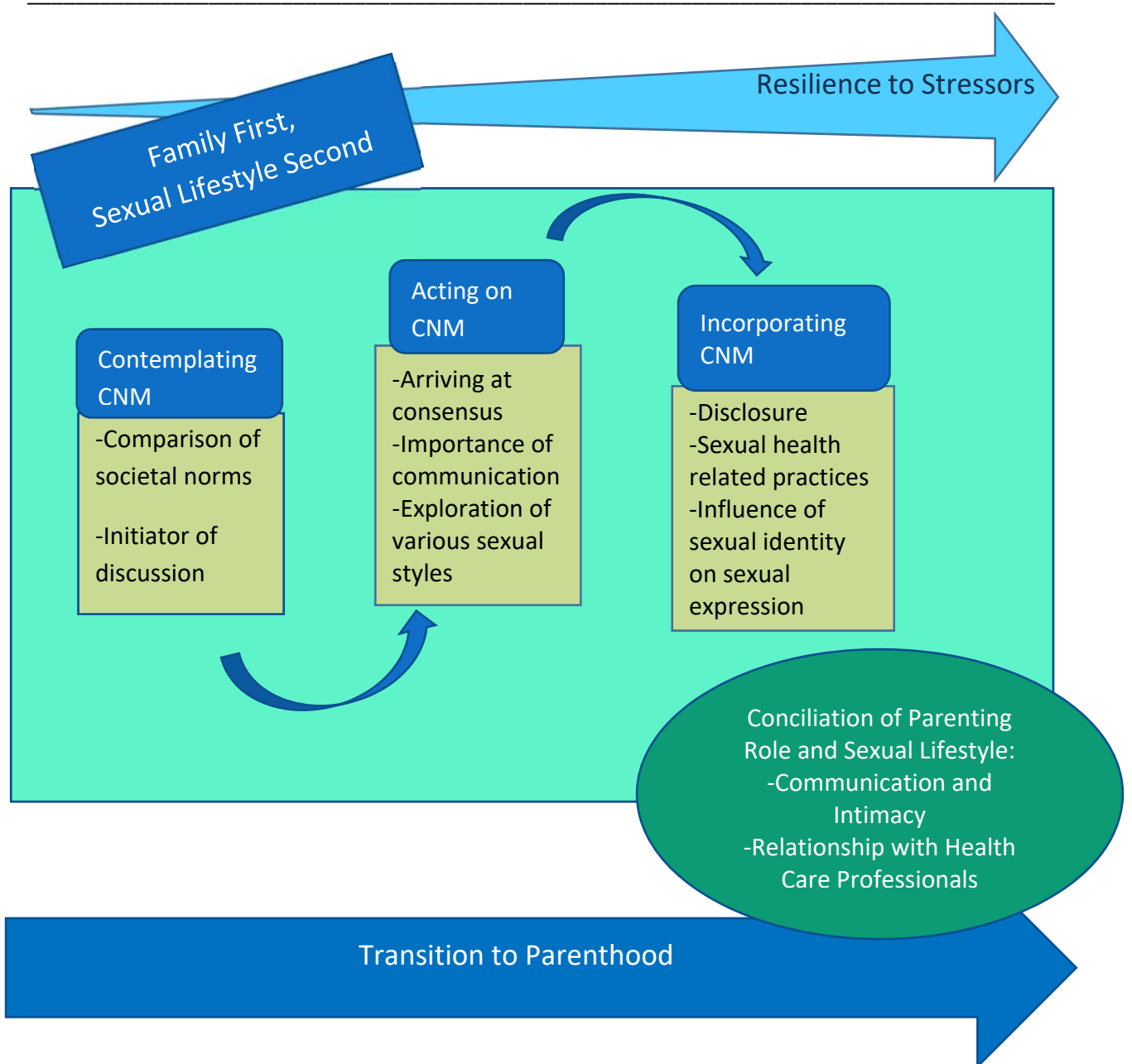
This was not an easy process for the student researcher, and it required much time and reflection. Although the original conceptual framework had been created and used for the present study, once the research findings had been analyzed and interpreted, something else was needed. The student knew that she wanted to have a focus for nurses and other HCPs. Also, it was important to include the three phases of the incorporation of CNM as a lifestyle within the context of the transition to parenthood. As time went on, she continued by adding the challenges, and at the heart of all this, the resilience that is present in couples who are CNM and parents.

This is the model that emerged from the research findings. The model is divided into five parts. In the first part, in the upper left hand corner, is the major impact of this new proposed model which is, 'Family First, Sexual Lifestyle Second'. The lowest part represents the continuum of the transition to parenthood. The middle part represents the three phases of incorporating CNM as a lifestyle while parenting. The major challenges that are part of each of the three phases are presented in the model. In the first phase, the two challenges are the comparison of societal norms and who is to initiate the discussion, while for the second phase, the three challenges are arriving at a consensus, recognizing the importance of communication, and an exploration of various sexual styles. The third phase contains three challenges: whether

to disclose their lifestyle or not, deciding on sexual health related practices as well as identifying the influence of sexual identity on sexual expression. It is in and around the third phase that CNMPCs demonstrate the most resilience, depicted by the circular image. It is during this phase that CNMPCs are most likely to find a conciliation between their parenting role and their sexual lifestyle, a greater level of communication and intimacy, and a greater capacity to navigate their health care needs with the various health care providers. The higher part of the model is represented as an arrow that increases from left to right, with resilience to internal and external stressors being encompassed in it.

Nurses and other HCPs can use this model to gain a better appreciation of the various phases of incorporating CNM as a sexual lifestyle within the context of parenthood. Having an understanding that the incorporation of CNM comes in phases, allows nurses and other HCPs to be better prepared during the health encounters with CNMPCs. In the first phase, 'Contemplating CNM,' it is very unlikely that a client would disclose that he or she is contemplating this incorporation. However, during this first phase, a nurse would expect to be able to openly answer any question related to sexuality and other questions related to having more than one sexual partner. During the second phase, clients may choose or not to disclose their sexuality to nurses and other HCPs but may approach their needs in different ways, such as stating that their partner was unfaithful as Participant P4 did. During this phase, it is important for the nurse to normalize having more than one sexual partner at a time when the partners are trying to be open and honest with each other as they are managing their sexual lifestyle and parenting. During this phase, the nurse can use a harm reduction approach and speak more openly about various sexual styles and practices as well as speak to the importance of maintaining communication and intimacy in the couple's relationship. During the third phase, a nurse can expect CNMPCs to openly disclose their lifestyle, if a therapeutic relationship has been established. It is most likely during the second and third phases that

Figure 4 - Model of CNMPCs' Resilience during the Incorporation of CNM as a Lifestyle While Parenting



CNMCs will start contemplating having children and will have more questions in that regard but this may happen earlier in the process. They may also have more questions about sexual health related practices. CNMPCs who have children in the third phase, Incorporation of CNM as Lifestyle, appear to be more resilient to the stressors of parenting than those who become parents in the first phase. It is during this third phase that the resilience factors enumerated in the circular image of the conciliation of roles (parenting and sexual) of the figure come to light.

5.8 Implications for Nursing Education, Nursing Practice, and Nursing Research

This section presents the implications from the findings of the present study on CNMPCs during the transition to parenthood in regard for nursing education, nursing practice, and nursing research.

5.8.1 Implications for Nursing Education

The implications for nursing education are considered at two levels: undergraduate education and continuing education.

5.8.1.1 Undergraduate Education

There are three implications for nursing education at the undergraduate level. The first implication for nursing education is that educators need to be well versed in sexuality and sexual minorities, and in the context of parenthood. In doing so, they can transmit this type of knowledge to students throughout their undergraduate programme: students need to not only be taught that sexuality is as much a part of a person's life as any other aspect, but also on how to integrate discussion about sexuality with their clients. By integrating sexuality and sexual identity, future nurses can focus on the person in a more holistic way. Research (Landry & Kensler, 2019) has demonstrated that gaining a better understanding of sexual minorities starts with being more familiar with the correct terminology. Nursing students can gain a broader perspective on alternative sexual styles and their connection to parenthood in their

undergraduate nursing course and practicum, as well as to how to assess these families and how to intervene with them. Nursing students can gain a better understanding of the stages of coming out with a sexual identity that doesn't follow the norm (Landry & Kensler, 2019) and familiarize themselves with the *Model of CNMPCs' Resilience during the Incorporation of CNM as a Lifestyle While Parenting* during the transition to parenthood. This would also include on having a better understanding of the challenges and the resilience factors might present themselves during CNMPCS' transition to parenthood.

The second implication involves the need for cultural safety in nursing education (McGibbon & Mbugua, 2020). According to the Aboriginal Nurses Association of Canada (ANAC), "Cultural safety takes on beyond cultural awareness, cultural sensitivity and cultural competence" (p. 2). This concept goes beyond cultural awareness, cultural sensitivity and cultural competence (ANAC, 2009). Cultural safety looks at the power differential that takes place during health care delivery and compensating for any health inequities that may occur because of this (ANAC, 2009). To address health inequities through the lens of cultural safety, nurses and other HCPS must "acknowledge that we are all bearers of culture, expose the social, political and historical contexts of health care" (ANAC, 2009, p. 2) and look at "difficult concepts such as racism discrimination and prejudice" (ANAC, 2009, p. 2). Although nurses strive to provide culturally sensitive and high-quality care regardless of race, religion, sexual practices, or gender identity, the findings of the present study would indicate that CNMPCs did not always receive culturally safe care at a time when they really needed it.

How can future nurses be better prepared in their undergraduate studies to better serve their clients including sexual minorities? Awareness of sexual minorities is an integral part of being able to provide culturally safe nursing care to this population. This implication reinforces the need to include historical and legal issues related to sexual minorities and those to

CNMPCs, as well as the effects of stigma and social isolation on their health. Part of providing culturally safe care is the awareness of how nurses' personal values and beliefs can influence the care they provide to their clients (Landry & Kensler, 2019). Nursing instructors need to help the student nurses to gain insight on their own values and beliefs, by using reflective practice (ANAC, 2009) and how this can influence the relationships with their clients. By gaining a better understanding on how they view sexuality, sexual practices and the transition to parenthood, they can better understand how their unconscious actions and language, can influence the therapeutic relationship with their clients. Instructors can reinforce certain key aspects. For starters, students need to understand and be taught that when a sexual minority receives culturally safe care, health outcomes are improved. Students also need to be taught the tools to create a culture of inclusion in their workplaces, starting in their own educational institutions. Most importantly, students need to be taught effective communication that is non-judgmental to foster a climate of trust and confidence (Landry & Kensler, 2019), especially for CNMPCS.

The third implication revolves around the need to empower students with the tools they require to assist their clients to be able to understand and analyse the issues that their CNMPC clients face. This can be done by gaining a better understanding of all the ways of knowing, but especially the sociopolitical and emancipatory ways of knowing (Pépin, Kerouac, & Ducharme, 2010). The students would then be able to understand that solutions to the issues faced by sexual minorities including CNMPCs are resolvable. However, there are still a number of barriers to the resolution of the health inequities faced by sexual minorities: nurses are best placed to articulate the issues, and to analyse them. This requires students to be trained to advocate for change, including indirect and direct ways of lobbying, and how to apply tools to do this.

These three implications, if put into practice, can have a great impact on the care received by sexual minorities by these future nurses, and can potentially lead to a reduction in the health disparities by making health care more accessible and inclusive. By integrating these concepts in nursing education, it will also benefit the general population as, in general, nurses do not appear to be comfortable discussing matters related to sexuality.

5.8.1.2 Continuing Nursing Education

The findings indicated similarly to previous studies (for example, Magnan & Reynolds, 2006) that nurses are generally not well versed in human sexuality and are not aware of how to integrate sexuality in their day to day nursing practice. To remedy this situation, nurses require more training and this training can come in many forms. First of all, the training requires a sex-positive approach (Landry & Kensler, 2019) and needs to include lived experiences of CNMPCs during their transition to parenthood with the health care system. McDonald (2019) indicates that including knowledge regarding the everyday lives of people who do not follow the heteromononormativity is key to be able to influence curriculum development and health care practice. A sexual sex-positive approach involves being accepting of individuals' preferences and differences when it comes to their sexual lifestyles and identities (Landry & Kensler, 2019). This can begin by integrating real life stories of a variety of the emerging family structures in these workshops, nurses can better understand the needs of this particular sexual minority. This can be done at health conferences and in training workshops. It can also be done at the graduate level, with more nurses specializing in sexuality and sexual minorities, particularly during the transition to parenthood. Content to include in this training would be the following: the basics of sexuality, how to use inclusive language, and how to create social and relational spaces for clients who do not identify with the heteromononormative reality that society upholds.

5.8.2 Implications for Nursing Practice

The implications for nursing practice are considered for frontline nursing practice and advanced nursing practice.

5.8.2.1 Frontline Nursing Practice

There are three implications for frontline nursing practice. The first implication applies to both the hospital and community settings. Nurses need to be better versed in sexuality and sexual health, as presently, they are not so. This has been shown to be detrimental to their clinical practice, especially during the perinatal period, or when caring for families during their transition to parenthood, as a couple's sexuality is greatly affected (Polomeno & Dubeau, 2009). The present study highlighted the need for more psychosexual training for nurses (Landry & Kensler, 2019; Magnan & Reynolds, 2006), especially when working in these areas. By having more education related to sexuality and sexual minorities, nurses' comfort level with sexuality will increase. This is imperative as sexual minorities have more physical and mental health disparities when compared to other groups of clients (Landry & Kensler, 2019). Perinatal nurses' knowledge would be particularly enhanced through perinatal specific psychosexual education.

The second implication is that this study reinforces the need for culturally safe care with sexual minorities including CNMPCs in the hospital and community settings. Sexual minorities, according to the literature, experience health disparities (Landry & Kensler, 2019). No literature appears to be available on whether CNMCs also experience these same health disparities. One could posit however, with the present research findings, that CNMPCs experience these same disparities to a certain degree. By teaching cultural safety in the context of sexual minorities and raising awareness of border sexualities, CNMPCs will hopefully receive the appropriate level of care needed, without fear of stigmatization. Cultural safety "involves empowerment of the healthcare practitioner and the patient. The determinants of 'safe' care are defined by the

recipient of care“ (Richardson & William, 2007, p. 699). A large part of cultural safety is that nurses are able to assess their own values and beliefs and how they have the potential to impact the person in front of them (Richardson & William, 2007). It involves recognizing the power inequalities in each interaction with their clients and the potential for health inequities (Richardson & William, 2007). Having more healthcare providers especially nurses practicing in a culturally safe manner with all of their clients as well as being well versed in the language used by CNMCs would facilitate the conversation with CNMPCs.

The third implication highlights the need to use a different approach with clients who identify as CNM because for the most part, couples who engage in consensual non-monogamy according to the research findings are well aware of the risks involved with their lifestyle. It also highlights the importance of having an open and honest, inclusive intake interview when seeing new clients that does not use heteromononormative language (Landry & Kensler, 2019). The level of education required using the harm reduction approach (Canadian Public Health Association, 2017) appears to be directly related to which phase the CNMCs are in while incorporating CNM as a lifestyle. Nurses and other HCPs need to recognize that CNMPCs, much like any other families, put their families first and their sexual lifestyle second. Their sexual lifestyle does not interfere with their abilities as parents.

5.8.2.2 Advanced Nursing Practice

Advanced practice nursing is defined in the following way by the Canadian Nurses Association.

“Advanced practice nursing (APN) is an umbrella term for registered nurses (RNs) and nurse practitioners (NPs) who integrate graduate nursing educational preparation with in-depth, specialized clinical nursing knowledge and expertise in complex decision-making to meet the health needs of individuals, families, groups, communities and populations.

Advanced practice nurses (CNSs and NPs): analyze and synthesize knowledge; critique, interpret and apply theory; participate in and lead research from nursing and other disciplines; use their advanced clinical competencies; and develop and accelerate nursing knowledge and the profession as a whole. In addition, NPs have regulatory authority to autonomously diagnose, prescribe and order and interpret tests for their clients.” (CNA, 2019, p. 13).

There are two implications for advanced nursing practice. The first implication is the need for nurses in leadership positions to identify the issues that come with the changing fabric of society. This is especially important for those working in perinatal health. They need to recognize and be able to get their staff to understand and be aware how the work environment and organizational culture can affect sexual minorities including CNMPCs, and advocate for change (McDonald, 2019). This can include, for example, modifying paperwork to be more inclusive, providing lunch and learns with staff on inclusive LGBTQ* language, and looking at the various policies in hospitals or community settings that may perpetuate societal heteromononormative assumptions.

The second implication is the need for nurses in advanced practice to become well versed in sexuality and be comfortable discussing with other staff and their clients this integral component of their identity. Advanced practice nurses are leaders in their workplaces and need to be able to mentor and coach the staff that they are working with in order for them to be able to provide their clients a cultural safe environment. They also need to models for change and lead by example, such as using inclusive language and including all family members during the continuum of care in perinatal health. They can be involved in writing position statements for professional organizations on gender and sexual diversity (McDonald, 2019), by including and sharing knowledge of families who do not follow the heteromononormative normality. They can

initiate policy reform in their clinical programs and workplaces to create supportive environments (McDonald, 2019). Finally, they also have the obligation to “influence public policy related to the provision of safe and dignified care, access to employment and housing” (McDonald, p. 385), to help to decrease health disparities that may be associated with CNMPCs.

5.8.3 Implications for Nursing Research

There are five implications for nursing research. The first is that it reinforces the need to use social critical theory (Mill, Allen, & Morrow, 2001) when doing research with sexual minorities. This is important because minority populations need to be active participants in the research studies. By grounding the research in social critical theory, the present study was able to explore not only the research questions identified by the student researcher but also other areas of interest to this population.

The second implication for the present study would be to continue using a mixed methods approach (Creswell & Plano Clark, 2007) when conducting this type of research. This approach is very useful because people who experience stigma might have a tendency to try to figure out what the researcher is asking and answer according to what the researcher wants to hear; this is called social desirability (Sheff & Hammers, 2011). One of the solutions to this is to use the mixed methods approach: by gathering data on the same concepts in multiple forms, it can help safeguard against that possibility.

The third implication involves the research methods used. It is important when conducting research with at-risk populations to be flexible in the use of the research methods (Fortin & Gagnon, 2016). Semi-structured interviews were beneficial because there was flexibility for the participants who could add more information as they wanted and needed to. It is important for researchers to assess the quantitative tools that they use and ascertain how and by whom they were used, prior to their utilization, especially with sexual minorities including

CNMPCs. These tools need to have been applied with heteromononormative and non-heteromononormative samples. These tools may need to be adapted to include more inclusive language or to accommodate more than one parenting partner.

The fourth implication is in regard to the replication of this study. Although the participants in this study were somewhat similar to other participants identifying as CNM in previous studies (Kimberly & Hans, 2015), more studies on a larger scale that focus on CNMPCs are not only needed in Winnipeg and the surrounding area, but also in other parts of Canada, and elsewhere.

The last implication is the future directions that can be taken with CNMPCs. Although this study appears to be the first of its kind, more research needs to be done. It would be interesting to try to test certain hypotheses enumerated below in the forms of questions that were suggested by the research findings. Many questions still remain unanswered and would warrant further study. Is the '*Model of CNMPCs' Resilience during the Incorporation of CNM as a Lifestyle While Parenting*' created by the student researcher applicable to all CNMCs? Do all CNMPCs demonstrate resilience during the transition to parenthood due to the lifestyle? Do the personality traits that make people more amenable or more successful at a CNM lifestyle facilitate their transition to parenthood? Do CNMPCs experience stigma to the same extent as other sexual minorities? When nurses and other HCPs are in stressful clinical situations, is it more difficult for them to move beyond society's heteronormative assumptions and achieve cultural safety for sexual minorities? All of these questions warrant further investigation in order to pursue our beginning understanding of this particular sexuality minority.

5.8.4 Summary for this Section

Many implications were presented for nursing education, nursing practice, and nursing research. The theme that appears to cross through all of these areas is the lack of

psychosexual education for students in undergraduate nursing programmes as well as for nurses who are in practice, be it frontline or advanced. All nurses in education, practice and research need to be conscious of the heteromononormative assumptions that pervade the health care system and in society. To override these assumptions, sexuality-related nursing must include sexuality minorities such as CMNPCS as part of holistic nursing care. Resilience under such circumstances warrants further consideration.

5.9 Strengths and Limitations

The strengths and limitations of the present study will be presented in the following section.

5.9.1 Strengths

There are seven strengths for this research study.

The first strength is that it is the first of its kind to explore the conciliation of the parenting role and the sexual lifestyle for CMNPCs during their transition to parenthood. This adds to the body of knowledge in regard to a particular sexual minority in the context of parenthood.

The second strength of the present study is that the concept of resilience emerged from the research findings for CNMPCs during the transition to parenthood. It has been previously considered in relation to polyamorists, but it is now being expanded to polyamorists and swingers who are parents.

The third strength is that the present study was able to identify factors that facilitate and hinder the relationship between CNMPCs and health care providers. This is especially important for nurses as frontline workers, especially during the transition to parenthood. They will make it easier for CNMPCs as sexual minorities seeking health care with confidence and transparency.

The fourth strength is the development to of a model that looks at how the CNMPCs incorporate their sexual lifestyle while parenting, and offers resilience to certain external

stressors. This model can be used by nurses and other HCPs to better situate where their clients may be, as the challenges experienced by them during the various phases appear to be different. It can also assist the nurses in identifying potential strengths that can add to their clients' resilience during the transition to parenthood.

The fifth strength is that the present study used a mixed methods approach. Data saturation was obtained with the qualitative data after six participants. By triangulating the quantitative data with the qualitative data, the student researcher was able to corroborate the research findings and add more rigor to the findings presented in this study.

The sixth strength was the creation of a new research instrument that can help to measure the conciliation of the parenting role and the sexual lifestyle of CNMPCs, namely the PRSRCS. This tool appears to measure what it was intended to do, however, it would require further validity and reliability testing with a larger sample size.

The last strength involves ethics. There was flexibility associated with the research process, especially when it came to the online questionnaire and the interview. The participants gave implicit informed consent at the beginning of the online questionnaire. They did not have to use their real names, rather they were able to use their Fetlife monikers. This allowed the participants to feel more secure in what they were sharing. An oversea secure online platform called *Qualtrics* was chosen for the online questionnaire: the use of this platform prevents the data from being used for any other means.

5.9.2 Limitations

There are six limitations to the present study.

The first limitation is the small sample size. The criteria for sample size when applied in the context of mixed methods research were respected, yet despite this, only six participants could be obtained. Also, Kimberly and Hans (2015) indicate that when working with people who

identify as a border sexuality, a smaller number of participants is to be expected. However, data saturation was obtained for this research study.

The second limitation involves that the study was limited to a certain geographical area. Recruitment posed some difficulty which partially contributed to the small sample size. Indeed, the student researcher was not a member of the CNM community in Winnipeg and surrounding area, and required using more indirect means of recruitment, such as using Fetlife.

A third limitation concerns the generalization of the research findings. The study was limited to a certain geographic area and as such, the results cannot be generalized to other parts of the province and the rest of the country. Also, due to the small sample size, to be able to generalize research findings normally requires collecting data on a large sample size (Fortin & Gagnon, 2016). It is also easier to generalize findings when conducting quantitative or experimental research. However, these findings did provide a rich, and contextualized understanding of CNMPCs' conciliation of their parenting role and their sexual lifestyle during the transition to parenthood due to the amount of simultaneous quantitative and qualitative data that had been obtained (Fortin & Gagnon, 2016).

A fourth limitation concerns a linguistic one. The availability of the research materials was mainly in English. Also, one participant was Francophone and was invited to answer the questions to the interview guide in her language of choice. She chose to answer most of the questions in English. This is, however, representative of the linguistic reality of Winnipeg and its surrounding area. Although Winnipeg is multicultural, most Winnipeggers speak English and choose this language when interacting in public according to the 2016 census profile (Statistics Canada, 2016b).

The fifth limitation was in regard to nurses and HCPs. Most of the obtained findings were mainly on HCPs, with some of them focusing on nurses. This is a consequence to how the questions in that part of the interview guide were formulated and how the participants responded to those questions. In hindsight, the student researcher could have pushed the participants' comments in regard to the nurses in order to get more information about them. In the future, more research needs to be done with nurses, as they encompass a larger number of HCPs that CNMPCs will and do encounter.

The last limitation is that since this is a first step in understanding sexuality in this particular context, no direct comparison of the findings is possible. Because it is an initial exploration, participants were asked to describe their sexual lifestyle and they were then placed in two different subcategories: swinger or polyamorous. By asking them to describe their sexual style, each participant did not necessarily fall into a distinct category and as such, were in between predefined categories. These limitations were remedied by giving participants a choice to self-identify.

Parenthood and sexuality is a combination that needs further research, especially when considering different sexual lifestyles and sexual contexts. This is also the beginning of the student researcher's research program and her training in human sexuality and sexual minorities. She is not an expert in these fields, so this research study permitted her to start the process of training in these areas, not only as a nurse but also as a researcher. More studies that focus on sexuality and the transition to parenthood with sexual minorities including CNMPCs are needed to better equip nurses and HCPs to care for these patients who could be more at risk for health disparities.

5.10 Conclusion

The present study was the first of its kind focusing on CNMPCs and their conciliation of the parenting role and their chosen sexual lifestyle during the transition to parenthood. This study highlights a number of different aspects. Firstly, this study demonstrates that CNMCs do not appear to be as homogenous as in previous studies. Secondly, CNMPCs experience the same challenges as others parents, but they would appear to have a certain resilience which is in part due to their sexual lifestyle. This resilience was demonstrated in a number of ways such as including advanced communication skills, having certain personality traits that help during this transition, using sexual intimacy as a means to increase their intimacy, and being more open to ask for help and request help when needed, whether for their own health or help with childcare. Thirdly, it would appear that CNMCs go through three different phases (contemplation, acting and incorporating) leading towards the incorporation of CNM as a lifestyle while parenting. The challenges encountered during these various phases seem to be very different, depending on which phase CNMPCs were during the transition to parenthood. Fourthly, a new model that highlights the challenges faced by CNMCs during the incorporation of CNM as a lifestyle as well as the resilience was created to better understand this process. Fifthly, this study highlighted the CNMPCS' capacity to come together in periods of stress, especially when they are dealing with stressful life events at the beginning of their relationships. Lastly, nurses and other HCPS do not appear to be well versed in sexuality, and do not seem to be able to understand how parents could choose non-monogamy as a lifestyle. Although the present study had a number of strengths and limitations, it did serve to highlight the resilience of CNMPCs during the transition to parenthood as well as how they put families first before their sexual lifestyle.

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Appendices

Appendix 1: Information Letter for Club Executives to Disseminate to Membership

Consensual Non-monogamous Couples' Conciliation of their Parental Role and their Sexual Style during the Transition to Parenthood

Information Sheet for Participants

You are being approached because you are involved in a consensual non-monogamous relationship. We are conducting a study to explore how partners in consensual non-monogamous relationships reconcile their parenting role with their sexual style.

Background of the Study

Many research studies have been published on sexuality and the transition to parenthood. The transition to parenthood is defined as the period of time starting with the decision to have a child or upon conception and terminating once the child is two years old. However, little is known about how this transition can affect couples that are engaged in consensual non-monogamous relationships and how they reconcile their parenting role and their sexual style. On the other hand, many health care professionals in perinatal health are not comfortable with the discussion of sexuality, and have not had any training in it. Parents would prefer that the perinatal health care professionals initiate discussion about sexuality. Indeed, nursing, by its very nature, entails engagement with human sexuality especially during the transition to parenthood. No study has been conducted to explore the conciliation between the parental role and the sexual lifestyle of consensual non-monogamy. Nurses and other perinatal health care professionals need to better understand this conciliation of roles so that they can improve health care being delivered to these clients.

Purpose and Design

The purpose of this study is to understand the conciliation between the parental role and the sexual style associated with consensual non-monogamy in Winnipeg and surrounding areas.

Study Procedures

If you agree to participate in this study, please complete this online survey. Your decision to complete and submit this online survey will be interpreted as an indication of your consent to participate. This will take about 15-30 minutes of your time. In the first section of the questionnaire, you will be asked questions relating to sociodemographic information as well as that of professional and relational information (Sociodemographic, Professional, Relational and Parenting Characteristics Questionnaire). In the second section, there are questions on how you feel about your parenting capabilities and confidence (Parenting Sense of Competence Scale). In the third section, there are questions pertaining to emotional and sexual intimacy (The PAIR Inventory, emotional and sexual intimacy subscales only). The last section contains questions on the conciliation of the parenting role and the sexual role (The Parenting Role-Sexual Role Conciliation Scale).

You may skip any questions you do not feel comfortable answering.

Once the data are collected and analyzed, you may be contacted after the data collection period is completed and analyzed to provide any feedback on data collected.

Risks

You may experience some discomfort with the content of certain questions relating to the research topic; in any case, you may refuse to answer any of these questions. A list of counselling resources in the community will be provided.

Benefits of the Study

There are some benefits in participating in this study. By exploring your experience in regards to the conciliation of your parental role and your sexual style, you will help perinatal health care professionals gain more knowledge and understanding about this conciliation. This will hopefully lead to more continuing education for these providers, and for them to provide better care for consensual non-monogamous parents during their encounters with the health care system

Withdrawal from the Study

Your participation in the study is voluntary and you are free to withdraw from the study at any time and, for any reason. You also may have any data collected about you withdrawn from the study. We recommend that you discuss any concerns you have about the study, with the principal investigator who is the student researcher, at the earliest opportunity, at any point during the study.

Confidentiality

All results of the study will be kept confidential. Your name will not be mentioned in any written or verbal report of the study results. The questionnaire is anonymous. A research code will be used. No information that identifies you will be provided to anyone. Once the recorded interviews are transcribed, they will be destroyed in accordance to the University of Ottawa policies and procedures. After which, any reference material to you will be under the research code.

Questions about the Study

If you have any questions concerning this study, please do not hesitate to call Jacqueline Avanthay, R.N., B. Sc. N., IBCLC, M.Sc.N. (cand.), the principal investigator for this study, at, or by sending her an email at:

The University of Ottawa Research Ethics Board has approved this study. This committee considers the ethical aspects of all research projects using human subjects. If you should have any questions regarding the ethical conduct of this study, you may contact the Protocol Officer for

Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154,
Ottawa, ON K1N 6N5 Tel.: (613) 562-5387. Email: ethics@uottawa.ca

We thank you for your participation.

Appendix 2: Recruitment: Fetlife Page

I am a registered nurse and a master's student in nursing at the University of Ottawa. I am conducting a research study to understand the conciliation between the parental role and the sexual style associated with consensual non-mongamy in Winnipeg and surrounding areas.

If you are a parent and also consensually non-monogamous and would like to share your experiences of the transition to parenthood, you will help health care professionals gain more knowledge and understanding about this conciliation. This will hopefully lead to more continuing education for these providers, and for them to provide better care for consensual non-monogamous parents during their encounters with the health care system.

This study will take from one to two hours. At the beginning, you will be asked to fill in a questionnaire containing sociodemographic information, parenting sense of competence, sexual, emotional and sexual intimacy as well as the conciliation of the parental and sexual role. The second part comprises an audio recorded interview made up of semi-structured questions. This interview can be done in person or via teleconference such as Skype.

This study has been approved by the Research and Ethics Board of the University of Ottawa.

If you are Interested, you can directly message me on Fetlife at this account to obtain more information. Or email me at

Thank you,

*** the same moniker that was used for the clinical placement will be used to recruit participants. Once participants message to the moniker provided. More information will be given

Appendix 3: Poster Example

ARE YOU IN A CONSENSUAL NON-MONOGAMOUS
RELATIONSHIP?

ARE YOU ALSO A PARENT?

WOULD YOU LIKE TO HELP IN IMPROVING HEALTH
CARE FOR OTHER CONSENSUAL MONOGAMOUS
PARENTING COUPLES?

I am conducting a research study to understand the conciliation between the parental role and the sexual style associated with consensual non-monogamy in Winnipeg and surrounding areas. I am a registered nurse and a master's student in nursing at the University of Ottawa.

If you are a parent and also consensually non-monogamous and would like to share your experiences of the transition to parenthood, you will help health care professionals gain more knowledge and understanding about this conciliation. This will hopefully lead to more continuing education for these providers, and for them to provide better care for consensual non-monogamous parents during their encounters with the health care system.

This study has been approved by the Research and Ethics Board of the University of Ottawa.

If you are Interested, you can directly message me on Fetlife at this account to obtain more information. Or email me at [\[redacted\]](#)

Thank you,

*** The same moniker that was used for the clinical placement will be used to recruit participants. Once participants message to the moniker provided. More information will be given to their email provided.

Appendix 4: Recruitment Email Sent to Swingers Clubs

Dear Club Executive,

I am conducting a research study to understand the conciliation between the parental role and the sexual style associated with consensual non-mongamy in Winnipeg and surrounding areas. I am a registered nurse and a master's student in nursing at the University of Ottawa.

I am looking to recruit club members who are parents and would like to share their experiences of the transition to parenthood. By sharing this with your club members, you will help health care professionals gain more knowledge and understanding about this conciliation. This will hopefully lead to more continuing education for these providers, and for them to provide better care for consensual non-monogamous parents during their encounters with the health care system.

This study will take from one to two hours. At the beginning, the club member will be asked to fill in a questionnaire containing questions about sociodemographic information, parenting sense of competence, sexual, emotional and sexual intimacy as well as the conciliation of the parental and sexual role. The second part comprises an audio recorded interview made up of semi-structured questions. This interview can be done in person or via teleconference such as Skype.

This study has been approved by the Research and Ethics Board of the University of Ottawa.

If you are willing to forward this information to your club membership, please contact me at

Jacqueline Avanthay, RN, B. Sc. N., IBLCLC, M Sc. N. (cand.)

**Appendix 5: Sociodemographic, Professional, Relational and Parenting Characteristics
Questionnaire**

Characteristic	Answer
1) How old are you? (years)	
2) What is your civil status? Single, separated, divorced, common-law, other	
3) Are you a Canadian citizen? Yes ___ No ___	
4) If no, what is your current status?	
5) How long have you been in Canada?	
6) Where were you born?	
7) With which cultural group do you identify yourself?	
8) Which language(s) do you speak? English ___ French ___ Other _____	
9) What is your employment status? - Full time - Part time - Seeking employment - Unemployed	
10) What is your profession?	
11) What is your annual income? < 19,000 20,000-39,000 40,000-59,000 >60,000	
12) What is your gender?	
13) What is your sexual orientation?	
14) How would you describe the relationship that you are currently in?	
15) Do you have children? Yes ___ No ___	
16) How many do you have?	
17) How old are they?	
18) What is the child care arrangement for them?	
19) What is your political affiliation? - Conservative - Liberal - Environmentalist	

<ul style="list-style-type: none"> - Green Party - Neo-democrat - Other : 	
<p>20) Do you believe in a higher power? Yes ___ No ___</p>	
<p>21) What is your religious affiliation?</p> <ul style="list-style-type: none"> - Catholic/Christian - Buddhist - Islam - Jew - Atheist - Spiritual - Other: 	
<p>22) Do you attend church or another type of religious place? Yes ___ No ___</p>	
<p>23) If yes, how often do you attend per month? (Number of times per month).</p>	
<p>24) Are you for or against :</p> <ul style="list-style-type: none"> - Marriage - Divorce - Death penalty - Same-sex marriage 	<p>Yes ___ No ___ Yes ___ No ___ Yes ___ No ___ Yes ___ No ___</p>

Appendix 6: Interview Guide

This interview guide contains 4 different sections covering a range of themes that pertain to the conciliation of the parental role with that of a consensual non-monogamous sexual style during the transition to parenthood. The themes covered will start with more neutral questions. The first section covers the transition to parenthood followed by the one on sexual style/sexuality. After these two, the conciliation of roles is explored followed by the experience with health care providers.

Section 1. Transition to Parenthood

- 1) How did you make the decision to become a parent?
- 2) Would you consider the decision to become a parent an easy one or a difficult one? Please explain your answer.
- 3) Tell me about your pregnancy/pregnancies or about your partner's pregnancy/pregnancies.
- 4) How was/were your childbirth experience(s)?
- 5) How was the time after the birth of your child (children)?
- 6) How was your relationship:
 - Before your child(children) arrived;
 - During pregnancy;
 - And afterwards?
- 7) What good moments stand out for you:
 - Before your child (children) arrived;
 - During pregnancy;
 - And afterwards?
- 8) How has the intimacy in your relationship changed from before the arrival of your child (children) up to now?

Timmerman as cited by Polomeno (2013) defines intimacy as “a quality of a relationship in which the individuals must have reciprocal feelings of trust and emotional closeness towards each other and are able to openly communicate thoughts and feelings with each other” (p. 37).

- 9) What moments that were more challenging (difficult) stand out for you:
 - Before your children(children) arrived;

- During pregnancy
 - And afterwards?
- 10) How has the communication in your relationship changed from before the arrival of your child(children) up to now?
- 11) Did you take any prenatal classes or parenting classes? When? How were they helpful? Not helpful?
- 12) Did any of these classes discuss sexuality? If yes, please explain.

Section 2. Sexual Style:

- 13) Can you tell me more about your present sexual lifestyle?
- 14) Can you elaborate on your journey to identifying yourself as consensual non-monogamous as a sexual identity?
- How did this happen?
 - When did it happen?
- 15) How has identifying as consensually non-monogamous affected your life?
- Sexuality
 - o Have you always been able to express your sexuality in all areas of your life?
 - Gender
 - o Can you describe how you identify in regards to gender?
 - o How has this affected the expression of your sexuality?
 - Body
 - o Have you ever experienced any situations in which you did not feel like you had complete control of your body? Or the capability of making healthy choices in regards to sexual health, prenatal health etc...?
 - Safety
 - o Have you ever experienced any situations in which you have not felt safe?
 - Access and opportunity
 - o Has it affected you in any way in regards to having equal opportunities as the rest of the population?
 - Social network
 - o Have you been able to tell your family (friends/work/colleagues etc...) about your lifestyle? How has this affected your life either way?
 - Health
 - o How has your experience been with the health care professionals in perinatal health?
 - o How has your experiences with health care system in general?

Section 3. Conciliation of Roles

- 16) How has the sexual part of your relationship changed from before the arrival of your child(children) up to now?
- 17) How have you come together with your “partner(s)” in regard to your sexual style?
 - How did this happen?
 - When did this happen?
- 18) How has pregnancy affected your sexual style?
- 19) How has childbirth affected your sexual style?
- 20) How has the parenting affected your sexual style?
- 21) How has breastfeeding affected your sexual style?
- 22) How has your sexual style affected your parenting?
- 23) How do you organize yourselves on the home front in order to pursue your sexual style?
 - Roles
 - Child care
 - Household chores
 - Etc.
- 24) How have you reconciled (or found a balance between) your parenting role and your sexual style?
 - What are the factors that help/have helped the conciliation of your parenting role and your sexual style?
 - What are the factors that hinder/have hindered the conciliation of parenting role and your sexual style?
- 25) Please think of other people who have your sexual style and who are parents. How have they found a balance between the two (parenting and sexual style)?
- 26) When you look back on your situation, would you do the same (make the same choices)? Or different? Please explain your answer.
 - What have you learned from all of this?

Part 4. Health Care Professionals

27) Have you shared your sexual style with health care professionals up to now? If no, go to Question #28. If Yes, go to Question #29.

28) If no :

What are the reasons that have prevented you from sharing your situation?

29) If yes:

- What parts have you shared with health care professionals and why?
- How has your experience with health care professionals been up to now?
- What factors have helped your situation and what factors have hindered your situation?

30) How have health care professionals reacted up to now?

31) In an ideal situation, what would you like to tell health care professionals who work with clients during the transition to parenthood, what would you like to tell them?

32) Are there other comments or thoughts that you would like to share with me?

Thank you very much for taking the time to answer these questions.

It is very much appreciated.

Appendix 7: Face and Content Validity: Assessment Form for Interview Guide

Face Validity Assessment		
Overall, do the items contained in the interview guide relate to the conciliation of the parental role with that of a consensual non-monogamous sexual style during the transition to parenthood?	Yes _____ No _____	Please explain your answer:
Content Validity Assessment Form		
Interview Guide Question	Is the question well written, clear and concise? Please indicate "Yes" or "No".	Comments about the interview question.
Part 1: Transition to Parenthood		
1) How did you make the decision to become a parent?		
2) Would you consider the decision to become a parent an easy one or a difficult one? Please explain your answer.		
3) Tell me about your pregnancy (pregnancies) or about your partner's pregnancy (pregnancies).		
4) How was your childbirth experience(s)?		
5) How was the time after the birth of your child (children)?		
6) How was your relationship -before your child(children) arrived; -during pregnancy; -and afterwards?		
7) What good moments stand out for you - before your child (children) arrived; - during pregnancy; - and afterwards?		
8) How has the intimacy in your relationship changed from before the arrival of your child (children) up to now?		

<p>9) What moments that were more challenging (difficult) stand out for you:</p> <ul style="list-style-type: none"> - before your child(children) arrived; -during pregnancy; -and afterwards? 		
<p>10)How has the communication in your relationship changed from before the arrival of your child(children) up to now</p>		
<p>11) Did you take any prenatal classes or parenting classes? When? How were they helpful? Not helpful?</p>		
<p>12) Did any of these classes discuss sexuality? If yes, please describe this.</p>		
<p>Part 2. Sexual Style:</p>		
<p>13) Can you tell me more about your present sexual lifestyle?</p>		
<p>14) Can you elaborate on your journey to identifying yourself as consensual non-monogamous as a sexual identity?</p> <ul style="list-style-type: none"> -How did this happen? -When did it happen? 		
<p>15) How has identifying as consensually non-monogamous affected your life?</p> <ul style="list-style-type: none"> - Sexuality <ul style="list-style-type: none"> o Have you always been able to express your sexuality in all areas of your life? - Gender <ul style="list-style-type: none"> o Can you describe how you identify in regards to gender? o How has this affected the expression of your sexuality? - Body <ul style="list-style-type: none"> o Have you ever experienced any situations in which you did not feel like you had complete control of your body? Or the capability of making healthy choices in regards to sexual health, prenatal health etc... - Safety 		

<ul style="list-style-type: none"> ○ Have you ever experienced any situations in which you have not felt safe? - Access and opportunity <ul style="list-style-type: none"> ○ Has it affected you in any way in regards to having equal opportunities as the rest of the population? - Social network <ul style="list-style-type: none"> ○ Family ○ Friends ○ Others (work colleagues etc.) - Health <ul style="list-style-type: none"> ○ Experiences with the health care professionals in perinatal health ○ Other experiences with health care system 		
Part 3. Conciliation of Roles		
16) How has the sexual part of your relationship changed from before the arrival of your child(children) up to now?		
17) How have you come together with your "partners" in regard to your sexual style? <ul style="list-style-type: none"> ○ How did this happen? ○ When did this happen? 		
18) How has pregnancy affected your sexual style?		
19) How has childbirth affected your sexual style?		
20) How has the parenting affected your sexual style?		
21) How has breastfeeding affected your sexual style?		
22) How has your sexual style affected your parenting?		
23) How do you organize yourselves on the home front in order to pursue your sexual style? <ul style="list-style-type: none"> -roles -child care -household chores -etc. 		

<p>24) How have you reconciled (or found a balance between) your parenting role and your sexual style?</p> <ul style="list-style-type: none"> ○ What are the factors that help/have helped the conciliation of your parenting role and your sexual style? ○ What are the factors that hinder/have hindered the conciliation of parenting role and your sexual style? 		
<p>25) Please think of other people who have your sexual style and who are parents. How have they found a balance between the two (parenting and sexual style)?</p>		
<p>26) When you look back on your situation, would you do the same (make the same choices)? Or different? Please explain your answer.</p> <ul style="list-style-type: none"> ○ What have you learned from all of this? 		
<p>Part 4. Health Care Professionals</p>		
<p>27) Have you shared your sexual style with health care professionals up to now?</p> <p>Yes ____ Go to question 29</p> <p>No ____ Go to question 28</p>		
<p>28) If no :</p> <p>What are the reasons that have prevented you from sharing your situation?</p>		
<p>29) If yes :</p> <p>What parts have you shared with health care professionals and why?</p> <p>How has your experience with health care professionals been up to now?</p> <p>What has helped your situation and what has hindered your situation?</p>		
<p>30) How have health care professionals reacted up to now?</p>		
<p>31) In an ideal situation, what would you like to tell health care professionals who work with</p>		

clients during the transition to parenthood, what would like to tell them?		
32) Are there other comments or thoughts that you would like to share with me?		

Appendix 8: Parental Sense of Competence

Parenting Sense of Competence Scale

(Gibaud-Wallston & Wandersman, 1978 as cited in Gilmore and Cuskelly, 2008)

Please rate the extent to which you agree or disagree with each of the following statements.

- | | Strongly
Disagree | Somewhat
Disagree | Disagree | Agree | Somewhat
Agree | Strongly
Agree |
|-------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|----------------------|----------|-------|-------------------|-------------------|
| | 1 | 2 | 3 | 4 | 5 | 6 |
| 1. The problems of taking care of a child are easy to solve once you know how your actions affect your child, an understanding I have acquired. | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. Even though being a parent could be rewarding, I am frustrated now while my child is at his / her present age. | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. I go to bed the same way I wake up in the morning, feeling I have not accomplished a whole lot. | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. I do not know why it is, but sometimes when I'm supposed to be in control, I feel more like the one being manipulated. | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. My mother was better prepared to be a good mother than I am. | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. I would make a fine model for a new mother to follow in order to learn what she would need to know in order to be a good parent. | 1 | 2 | 3 | 4 | 5 | 6 |
| 7. Being a parent is manageable, and any problems are easily solved. | 1 | 2 | 3 | 4 | 5 | 6 |

8. A difficult problem in being a parent is not knowing whether you're doing a good job or a bad one. 1 2 3 4 5 6
9. Sometimes I feel like I'm not getting anything done. 1 2 3 4 5 6
10. I meet by own personal expectations for expertise in caring for my child. 1 2 3 4 5 6
11. If anyone can find the answer to what is troubling my child, I am the one. 1 2 3 4 5 6
12. My talents and interests are in other areas, not being a parent. 1 2 3 4 5 6
13. Considering how long I've been a mother, I feel thoroughly familiar with this role. 1 2 3 4 5 6
14. If being a mother of a child were only more interesting, I would be motivated to do a better job as a parent. 1 2 3 4 5 6
15. I honestly believe I have all the skills necessary to be a good mother to my child. 1 2 3 4 5 6
16. Being a parent makes me tense and anxious. 1 2 3 4 5 6
17. Being a good mother is a reward in itself. 1 2 3 4 5 6

Appendix 9: The PAIR Inventory: Emotional and Sexual Intimacy Subscales

Permission to use the emotional and sexual intimacy subscales obtained through Enrich Canada via email in September 2017.

Emotional Intimacy

1. My partner listens to me when I need someone to talk to.
7. I can state my feelings without him/her getting defensive
13. I often feel distant from my partner.
19. My partner can really understand my hurts and joys.
25. I feel neglected at times by my partner.
31. I sometimes feel lonely when we are together.

Sexual Intimacy

3. I am satisfied with our sex life.
9. I feel our sexual activity is just routine.
15. I am able to tell my partner when I want sexual intercourse.
21. I “hold back” my sexual interest because my partner makes me feel uncomfortable.
27. Sexual expression is an essential part of our relationship.
33. My partner seems interested in sex.

Appendix 10: The Parenting Role-Sexual Role Conciliation Scale

The Parenting Role-Sexual Role Conciliation Scale					
Item	Never	Rarely	Some of the time	Most of the time	Always
	1	2	3	4	5
1) It is easy for me to strike a balance between my family life and my sexual lifestyle.					
2) I feel that my family life interferes with my sexual lifestyle.					
3) I feel that my sexual lifestyle interferes with my family life.					
4) My partner(s) say that it is					

<p>easy to strike a balance between our family life and our sexual lifestyle.</p>					
<p>5) I am comfortable with the arrangement for childcare while I am pursuing my sexual lifestyle.</p>					
<p>6) I feel that I am a better parent because I feel free to pursue my sexual lifestyle.</p>					
<p>7) I feel that I am better</p>					

sexual partner because my partner(s) is/are supportive of my sexual lifestyle.					
8) I worry about my child(ren) while I am pursuing my sexual lifestyle.					
10) My family is aware of my sexual lifestyle.					
11) My friends are aware of my sexual lifestyle.					
12) My friends are					

accepting of my sexual lifestyle.					
13) My family is accepting of my sexual lifestyle.					

The PRSRCS was modified after the Face and Content Validity was conducted (See Appendix 11 for the original scale).

Appendix 11: Face and Content Validity: Assessment Form for The Parenting Role-Sexual Role Conciliation Scale

Face Validity Assessment		
Overall, do the items contained in Parenting Role-Sexual Role Conciliation Scale relate to the conciliation of the parental role and sexual role?	Yes _____ No _____	Please explain your answer:
Content Validity Assessment Form		
Question on scale	Is the question well written, clear and concise? Please indicate "Yes" or "No".	Comments about the interview question.
1. I have a good balance between my family life and my sexual lifestyle.		
2. I feel that my family life interferes with my sexual lifestyle.		
3. I feel that my sexual lifestyle interferes with my family life.		
4. My partner(s) feel that there is good balance between our family life and our sexual lifestyle.		
5. I am comfortable with the arrangement for childcare while I am pursuing my sexual lifestyle.		
6. I am a better parent because I feel free to		

pursue my sexual lifestyle.		
7. I am a better sexual partner because my partner(s) is/are supportive of it.		
8. I worry about my child(ren) while I am pursuing my sexual lifestyle.		
9. My child(ren) is(are) aware of my sexual lifestyle.		
10. My social network (family and friends) is aware of my sexual lifestyle.		

Appendix 12: Implied Consent Form for Online Survey

Consensual Non-monogamous Couples' Conciliation of their Parental Role and their Sexual Style during the Transition to Parenthood

Thesis Supervisor

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School of Nursing

Invitation

You are being invited because you are involved in a consensual non-monogamous relationship. I am conducting a study to explore how partners in consensual non-monogamous relationships reconcile their parenting role with their sexual style.

Research Background and Context

Many research studies have been published on sexuality and the transition to parenthood. The transition to parenthood is defined as the period of time starting with the decision to have a child or upon conception and terminating once the child is two years old. However, little is known about how this transition can affect couples that are engaged in consensual non-monogamous relationships and how they reconcile their parenting role and their sexual style. On the other hand, many health care professionals in perinatal health are not comfortable with the discussion of sexuality, and have not had any training in it. Parents would prefer that the perinatal health care professionals initiate discussion about sexuality. Indeed, nursing, by its very nature, entails engagement with human sexuality especially during the transition to parenthood. No study has been conducted to explore the conciliation between the parental role and the sexual lifestyle of

consensual non-monogamy. Nurses and other perinatal health care professionals need to better understand this conciliation of roles so that they can improve health care being delivered to these clients.

Purpose and Design

The purpose of this study is to understand the conciliation between the parental role and the sexual style associated with consensual non-monogamy in Winnipeg and surrounding areas

Study Procedures

If you agree to participate in this study, please complete this online survey. Your decision to complete and submit this online survey will be interpreted as an indication of your consent to participate. This will take about 15-30 minutes of your time. In the first section of the questionnaire, you will be asked questions relating to sociodemographic information as well as that of professional and relational information (Sociodemographic, Professional, Relational and Parenting Characteristics Questionnaire). In the second section, there are questions on how you feel about your parenting capabilities and confidence (Parenting Sense of Competence Scale). In the third section, there are questions pertaining to emotional and sexual intimacy (The PAIR Inventory, emotional and sexual intimacy subscales only). The last section contains questions on the conciliation of the parenting role and the sexual role (The Parenting Role-Sexual Role Conciliation Scale).

You may skip any questions you do not feel comfortable answering.

Once the data are collected and analyzed, you may be contacted after the data collection period is completed and analyzed to provide any feedback on data collected.

Risks

You may experience some discomfort with the content of certain questions relating to the research topic; in any case, you may refuse to answer any of these questions. A list of counselling resources in the community will be provided.

Benefits of the Study

There are some benefits in participating in this study. By exploring your experience in regards to the conciliation of your parental role and your sexual style, you will help perinatal health care professionals gain more knowledge and understanding about this conciliation. This will hopefully lead to more continuing education for these providers, and for them to provide better care for consensual non-monogamous parents during their encounters with the health care system.

Withdrawal from the Study

Your participation in the study is voluntary and you are free to withdraw from the study at any time and, for any reason. You also may have any data collected about you withdrawn from the study. We recommend that you discuss any concerns you have about the study, with the principal

investigator who is the student researcher, at the earliest opportunity, at any point during the study.

Confidentiality

The information that you will share will remain strictly confidential and will be used solely for the purposes of this research. The only people who will have access to the research data are myself and my thesis supervisor. Your answers to open-ended questions may be used verbatim in presentations and publications but neither you (nor your organization) will be identified. In order to minimize the risk of security breaches and to help ensure your confidentiality we recommend that you use standard safety measures such as signing out of your account, closing your browser and locking your screen or device when you are no longer using them / when you have completed the study.

Results will be published in pooled (aggregate) format. Anonymity is guaranteed since you are not being asked to provide your name or any personal information.

Conservation of Data

The surveys will be kept in a locked filing cabinet in the office of the supervisor Viola Polomeno at the University of Ottawa for a period of 5 years at which time they will be destroyed.

Information about the Study Results

Information about the study results will be available to you upon request.

If you have any questions or require more information about the study itself, you may contact the researcher or her thesis supervisor at the numbers mentioned herein.

If you have any questions with regards to the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5, tel.: (613) 562-5387 or ethics@uottawa.ca.

Please keep this form for your records.

Thank you for your time and consideration.

Jacqueline Avanthay

Viola Polomeno

Appendix 13: Consent Form for Interview

Consensual Non-monogamous Couples' Conciliation of their Parental Role and their Sexual Style during the Transition to Parenthood

Dr. Viola Polomeno, R.N, Ph.D.

Associate Professor

University of Ottawa

Faculty of Health Sciences

School of Nursing

Student

Jacqueline Avanthay R.N., B. Sc.N, IBLCLC, M.Sc.N. (cand.)

University of Ottawa

Faculty of Health Sciences

School of Nursing

Invitation

You are being invited because you are involved in a consensual non-monogamous relationship. I am conducting a study to explore how partners in consensual non-monogamous relationships reconcile their parenting role with their sexual style.

Research Background and Context

Many research studies have been published on sexuality and the transition to parenthood. The transition to parenthood is defined as the period of time starting with the decision to have a child or upon conception and terminating once the child is two years old. However, little is known about how this transition can affect couples that are engaged in consensual non-monogamous relationships and how they reconcile their parenting role and their sexual style. On the other hand, many health care professionals in perinatal health are not comfortable with the discussion of sexuality, and have not had any training in it. Parents would prefer that the perinatal health care professionals initiate discussion about sexuality. Indeed, nursing, by its very nature, entails engagement with human sexuality especially during the transition to parenthood. No study has

been conducted to explore the conciliation between the parental role and the sexual lifestyle of consensual non-monogamy. Nurses and other perinatal health care professionals need to better understand this conciliation of roles so that they can improve health care being delivered to these clients.

Purpose and Design

The purpose of this study is to understand the conciliation between the parental role and the sexual style associated with consensual non-mongamy in Winnipeg and surrounding areas

Study Procedures

If you agree to participate in this study, you will be asked to participate in a semi-structured interview. This interview can last between up to one hour. After the interview, you will be offered a period of reflection. This period of reflection can be by yourself or with one or more partners, if desired. This period of reflection will permit the interviewer to better understand how you felt about the research process.

You may skip any questions you do not feel comfortable answering.

Once the data are collected and analyzed, you may be contacted after the data collection period is completed and analyzed to provide any feedback on the data collected.

Length of the Study

You are being asked to participate in one semi-structured interview.

Possible Side Effects and Risks

You may experience some discomfort with the content of certain questions relating to the research topic; in any case, you may refuse to answer any of these questions. You will be provided a list of counselling resources.

Benefits of the Study

There are some benefits in participating in this study. By exploring your experience in regards to the conciliation of your parental role and your sexual style, you will help perinatal health care professionals gain more knowledge and understanding about this conciliation. This will hopefully lead to more continuing education for these providers, and for them to provide better care for consensual non-monogamous parents during their encounters with the health care system.

Withdrawal from the Study

Your participation in the study is voluntary and you are free to withdraw from the study at any time and, for any reason. You also may have any data collected about you withdrawn from the study. We recommend that you discuss any concerns you have about the study, with the principal investigator who is the student researcher, at the earliest opportunity, at any point during the study.

Confidentiality

The information that you will share will remain strictly confidential and will be used solely for the purposes of this research. The only people who will have access to the research data are myself and my thesis supervisor. Your answers to the semi-structured interview may be used verbatim in presentations and publications but neither you (nor your organization) will be identified.

Results will be published in pooled (aggregate) format. Anonymity is guaranteed since you are not required to provide your name or any personal information as if desired you may give verbal consent prior to the start of the interview.

Consent Form – Interview

I agree to participate in this study conducted by Jacqueline Avanthay, a master's student in nursing at the University of Ottawa. The data from this study will help nurses gain a better understanding of consensual non-monogamy and the conciliation of the parental role and the sexual style.

My participation will involve completing one online questionnaire and participating in one semi-structured audio recorded interview. After the semi structured interview, I will be offered a period of reflection that can either be with or without my parenting partner(s). The period of reflection will be completely optional. I understand that it will be my choice to have this period audio recorded and included in the study or not. After the data are collected and analyzed, I understand that I may be contacted to provide feedback on the research findings. All information collected will be kept confidential.

I can withdraw my consent and withdraw from the study at any time and this will not affect my decision to participate or not participate in the study.

I have read the information sheet and consent form and I understand the information. I voluntarily consent to participate in this study.

There are two copies of the consent form, one of which is mine to keep.

Signature of Participant

Investigator/Delegate's Signature

Name of Participant (print)

Investigator/Delegate's Signature (print)

Date: _____ Date: _____

Verbal consent was obtained and audio recorded prior to starting the interview on this date

Appendix 14: Participants' Profile

Participant Profile	<i>N</i>	%	<i>Mean(SD)</i>
Sociodemographic/professional			
Gender			
Male	2	33.3	
Female	4	66.7	
Age			37.6 (6.37)
31	1	16.7	
34	1	16.7	
41	2	33.3	
43	1	16.7	
45	1	16.7	
Income (dollars)			
Under 19000	1	16.7	
20000 to 39000	1	16.7	
40000 to 59000	1	50	
Over 60, 000	3	33.3	
Province of Birth			
Manitoba	5	83.3	
Quebec	1	16.7	
Cultural Affiliation			
Canadian	5	83.3	
Métis	1	16.7	

Languages		
English Only	3	50
English, French	2	33.3
English, French, Hungarian and Spanish	1	16.7
Employment Status		
Full-time	3	50
Part-time	3	50
Occupation		
Administrative	4	66.7
Health Care	1	16.7
Housekeeper	1	16.7
Relational and Parenting Characteristics		
Sexual orientation		
Heterosexual	1	16.7
Bisexual or pansexual	5	83.3
Marital Status at time of Study		
Married	4	66.7
Separated	1	16.7
Common-law with new partner	1	16.7
Marital Status during Transition to Parenthood		
Married	5	83.3

Common-law	1	16.7	
Relationship Description during Transition to Parenthood			
Swinger	2	33.3	
Polyamorous	3	50	
Open relationship	1	16.7	
Number of Children (Age)			10.63 (4.36)
1	2	33.3	
2	1	16.7	
3 or more	3	66.7	
Parenting Arrangements: Childcare While Pursuing Sexual Play			
Family member or babysitter	4	66.7	
Taking turns going out individually	2	33.3	

Appendix 15: Participants' Beliefs

Political Affiliation		
Conservative	1	16.7
Neodemocrat	1	16.7
Environmentalism	1	16.7
Liberal	2	33.3
Other	1	16.7
Belief in Higher Power		
Yes	4	66.7
No	2	33.3
Church Attendance		
Yes, a few times per year	2	33.3
No	4	66.7
Marriage: For or Against		
For	6	100
Against	0	0
Divorce: For or Against		
For	6	100
Against	0	0
Death Penalty: For or Against		
For	4	66.7

Against	2	33.3
Same Sex Marriage: For or Against		
For	6	100
Against	0	0

Appendix 16: Parenting Sense of Competence Scale: Individual Results, Mean and Standard Deviation for Parenting Efficacy and Satisfaction

Participant Number:	1	2	3	4	5	6
1. The problems of taking care of a child are easy to solve once you know how your actions affect your child.	6	4	6	6	5	5
2. Even though being a parent could be rewarding. I am frustrated now while my child is at his/her present age *	2	6	6	2	4	5
3. I go to bed the same way I wake up in the morning, feeling I have not accomplished a whole lot.*	4	6	6	6	5	5
4. I do not know why it is, but sometimes when I'm supposed to be in control, I feel more like the one being manipulated*	4	6	5	6	6	5
5. My mother/father was better prepared to be good mother/father than I was.*	5	2	6	6	4	5
6. I would make a fine model for a new mother to follow in order to learn what she would need to know in order to be a good parent.	5	5	6	4	5	5
7. Being a parent is manageable, and any	5	5	5	3	3	5

problems are easily solved.						
8. A difficult problem in being a parent is not knowing whether you're doing a good job or a bad one.*	6	2	2	5	3	2
9. Sometimes I feel like I'm not getting anything done.*	2	4	6	6	3	5
10. I meet my own personal expectations for expertise in caring for my child.	5	4	6	6	5	5
11. If anyone can find the answer to what is troubling my child, I am the one	6	4	5	6	5	5
12. My talents and interests are in other areas, not being a parent.*	5	4	6	5	4	5
13. Considering how long I've been a parent, I feel thoroughly familiar with this role.	6	5	6	6	5	4
14. If being a mother of a child were only more interesting, I would be motivated to do a better job as a parent.*	4	6	6	6	5	6
15. I honestly believe I have all the skills necessary to be a good mother to my child.	5	4	6	6	5	6
16. Being a parent makes me tense and anxious*	2	3	4	6	4	5

17. Being a good parent is a reward in itself.	5	5	6	6	6	6
Satisfaction (9-54)	31	39	48	47	38	43
Efficacy (8-48)	43	36	46	43	39	41
Total (17-102)	74	75	94	90	77	84
<i>Mean (SD) Efficacy</i>	41.33 (2.77)					
<i>Mean (SD) Satisfaction</i>	41 (6.36)					
<i>Mean (SD) Total Score</i>	82.33 (8.36)					
Items with a * are reversed scored.						
Questions were rated on a six point Likert scale (1, strongly disagree; 2, somewhat disagree, 3, disagree; 4, agree; 5, somewhat agree; 6, strongly agree)						

Appendix 17: PAIR Inventory: Individual Question Results for the Sexual Intimacy Scale

Participant Number :	1	2	3	4	5	6
3. I am satisfied with our sex life	2	2	4	4	4	3
	4	-	4	4	-	-
9. I feel our sexual activity is just routine	3	1	1	1	1	0
	0	-	1	1	-	-
15. I am able to tell my partner when I want sexual intercourse	3	4	4	4	4	4
	3	-	3	4	-	-
21. I "hold back" my sexual interest because my partner makes me feel uncomfortable.	0	0	0	0	0	0
	1	-	0	0	-	-
27. Sexual expression is an essential part of our relationship	3	4	3	4	4	4
	4	-	3	4	-	-
33. My partner seems disinterested in sex.	0	0	0	0	0	0
	0	-	0	0	-	-
Perceived Level of Sexual Intimacy Score	68	88	88	92	92	92
	88	-	84	92	-	-
<i>Mean and SD for Primary Partners</i>	86.67 (9.35)					
<i>Mean and SD for Secondary Partners</i>	88 (4.0)					
Items were rated on a four point four point Likert scale (0 = Strongly disagree; 1 = Somewhat disagree; 2 = Neutral; 3 = Somewhat agree; 4 = Strongly agree)						

Appendix 18: PAIR Inventory: Individual Question Results for Emotional Intimacy Scale

Participant Number:	1	2	3	4	5	6
1. My partner listens to me when I need someone to talk to	0	2	4	4	4	4
	3	-	4	4	-	-
7. I can state my feelings without him/her getting defensive	1	1	4	4	4	3
	4	-	3	4	-	-
13. I often feel distant from my partner.	3	2	1	1	1	1
	0	-	1	0	-	-
19. My partner can really understand my hurts and joys	2	1	4	4	4	3
	2	-	3	4	-	-
25. I feel neglected at times by my partner	3	3	0	0	0	1
	1	-	0	0	-	-
31. I sometimes feel lonely when we are together.	3	2	3	0	0	1
	0	-	1	0	-	-
Perceived level of intimacy score	24	36	84	92	92	86
	80	-	80	96	-	-
<i>Mean and SD for Primary Partners</i>	69 (30.61)					
<i>Mean and SD for Secondary Partners</i>	85.33 (9.23)					
Items were rated on a four point four point Likert scale (0 = Strongly disagree; 1 = Somewhat disagree; 2 = Neutral; 3 = Somewhat agree; 4 = Strongly agree)						

Appendix 19: PRSRCS Individual Results and Range, Mean, Standard Deviation

Participant Number:	1	2	3	4	5	6
1. It is easy for me to strike a balance between my family life and my sexual lifestyle.	5	2	4	5	5	4
2. I feel that my family life interferes with my sexual lifestyle.*	3	2	5	5	4	4
3. I feel that my sexual lifestyle interferes with my family life.*	4	4	4	5	4	4
4. My partner(s) say that it is easy to strike a balance between our family life and our sexual lifestyle.	3	2	4	5	4	4
5. I am comfortable with the	5	2	5	5	4	4

arrangement for childcare while I am pursuing my sexual lifestyle.						
6. I feel that I am a better parent because I feel free to pursue my sexual lifestyle.	3	3	4	5	5	5
7. I feel that I am a better sexual partner because my partner(s) is/are supportive of my sexual lifestyle.	5	5	5	5	5	5
8. I worry about my child(ren) while I am pursuing my sexual lifestyle.*	3	2	4	5	3	2
9. My child(ren) is(are) aware of my sexual lifestyle.	1	1	3	1	1	1

10. My family is aware of my sexual lifestyle	1	1	4	5	2	2
11. My friends are aware of my sexual lifestyle	3	2	4	5	2	4
12. My friends are accepting of my sexual lifestyle	3	3	5	5	3	4
13. My family is accepting of my sexual lifestyle	1	1	4	5	3	4
<i>Mean (Score)</i>	3.15	2.31	4.24	4.69	3.46	3.61
Range	2.31-4.69					
<i>Mean and SD</i>	3.58 (0.83)					
Items 2, 3 and 8 are reversed scored						
Items are scored on a 5 point Likert scale (1, Never; 2 Rarely; 3 Some of the time; 4, Most of the time; to 5, Always)						

Appendix 20: Declaration of Sexual Rights

(Adapted from World Association for Sexual Health, 2014)

1. The right to sexual freedom.
2. The right to sexual autonomy, sexual integrity, and safety of the sexual body.
3. The right to sexual privacy.
4. The right to sexual equity.
5. The right to sexual pleasure.
6. The right to emotional sexual expression.
7. The right to sexually associate freely
8. The right to make free and responsible reproductive choices.
9. The right to sexual information based upon scientific inquiry
10. The right to comprehensive sexuality education.
11. The right to sexual health care.

Appendix 21: Ethics Approval from the University of Ottawa

File Number: H05-17-05

Date (mm/dd/yyyy): 07/21/2017



Université d'Ottawa **University of Ottawa**
 Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

Certificate of Ethics Approval Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Viola	Polomeno	Health Sciences / Nursing	Supervisor
Jacqueline	Avanthay	Health Sciences / Nursing	Student Researcher

File Number: H05-17-05

Type of Project: Master's Thesis

Title: Consensual Non Monogamous Couples' Conciliation of their Parental Role and their Sexual Style during the Transition to Parenthood

Approval Date (mm/dd/yyyy)

07/21/2017

Expiry Date (mm/dd/yyyy)

07/20/2018

Special Conditions / Comments:

N/A

File Number: H05-17-05

Date (mm/dd/yyyy): 07/21/2017



Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove participants from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at: <http://research.uottawa.ca/ethics/submissions-and-reviews>.

Please submit an annual status report to the Protocol Officer 4 weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at: <http://research.uottawa.ca/ethics/submissions-and-reviews>.

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: ethics@uOttawa.ca.

Appendix 22: Email-Permission to Use PAIR Inventory**PREPARE**  **ENRICH[®], LLC**

Jacqueline Avanthay

September 17th 2017

Permission to Use PAIR
(Personal Assessment of Intimacy in Relationships)

We are pleased to give you permission to use PAIR in your research project, teaching or clinical work with couples or families. You may either duplicate the materials directly or have them retyped for use in a new format. If they are retyped, acknowledgement should be given regarding the name of the instrument, the developers' names, and PREPARE/ENRICH, LLC.

In exchange for providing this permission, we would appreciate a copy of any papers, theses or reports that you complete using the PAIR. This will help us to stay abreast of the most recent developments and research regarding this scale. We thank you for your cooperation in this effort.

In closing, we hope you find the PAIR of value in your work with couples and families. Good luck with your project!

Appendix 23: Comparison between Jenk's Model (1998), Kimberly and Hans' Model (2015) and Avanthay's Model: CNMPCs Model of Resilience during the Incorporation of CNM as a Lifestyle While Parenting

Jenk's Model: Five Step/stages of Swinging (Jenks, 1998)	Kimberley and Hans's Model Three Phases: How Swinging Couples Enter and Navigate the Swinging Lifestyle (Kimberly & Hans, 2015)	Avanthay's Model: CNMPCs Model of Resilience during the Incorporation of CNM as a Lifestyle While Parenting Incorporation of CNM as a Lifestyle While Parenting
<p>Step 1 :</p> <p>-A strong interest or early involvement in sex</p> <p>Step 2 :</p> <p>-Personal characteristics conducive to swinging: liberal sexual orientation, low degree of jealousy</p> <p>Step 3:</p> <p>-Passive phase characterized by learning and talking about swinging, thinking about participating</p>	<p>Transition :</p> <ul style="list-style-type: none"> - Fantasies vocalized Self-esteem assessed 	<p>Phase 1- Contemplation :</p> <ul style="list-style-type: none"> - Personal characteristics - Comparison of societal norms - Process leading them to consider CNM as a viable lifestyle (initiator of discussion)
<p>Step 4:</p> <p>-Active phase characterized by contact with swingers, possibility of withdrawal</p>	<p>Experiences:</p> <ul style="list-style-type: none"> -Sexual desires fulfilled, man screens, woman decides 	<p>Phase 2-Acting :</p> <ul style="list-style-type: none"> - Arriving at consensus - Importance of communication - Exploring various sexual styles
<p>Step 5:</p> <p>-Commitment phase characterized by actual involvement,</p>	<p>Satisfaction:</p> <ul style="list-style-type: none"> - Long-term friendships - Shared activities - Enhanced trust - Open communication 	<p>Phase 3-Incorporating:</p> <ul style="list-style-type: none"> - Disclosure - Sexual health related practices - Influence of sexual identity on sexual expression
<p>Common themes throughout these three models:</p> <ul style="list-style-type: none"> - Culture of consent mentioned, does not always happen 		

- Gender influences sexual expression
- Evolution of sexual style and identity throughout the process
- Disclosure vs non-disclosure appears to be more unique to the couple than previously thought
- Greater social network that can work as a buffer on effects of stigma seen by other sexual minorities
- Limited social attachment for swinging (Jenks, 1999; Kimberly & Hans 2015), however it would appear that some emotional attachments do occur as play partners become friends and on occasion 'family members' according to findings
- Sexual health related practices varied greatly (Jenks 1998; Kimberly & Hans, 2015), however present study all used a form or barrier protection during intercourse and were very conscious of the health risks involved with their lifestyle