Review

Re-examining the effectiveness of monogamy as an STI-preventive strategy

Terri D. Conley a,⁎, Jes L. Matsick b, Amy C. Moors a, Ali Ziegler b, Jennifer D. Rubin a

a Department of Psychology and Women’s Studies, University of Michigan, Ann Arbor, MI, USA
b Social Sciences Department, University of Alaska Southeast, Ketchikan, AK, USA

ABSTRACT

The utility of monogamy (in practice) as a strategy for preventing sexually transmitted infections (STIs) was investigated. By reviewing recent literature surrounding monogamous relationships and sexual behaviors, the authors determined that monogamy might not prevent against STIs as expected. First, the authors elucidate the ways in which public health officials and the general public define and interpret monogamy and discuss how this contributes to monogamy as an ineffectual STI prevention strategy. Second, the authors provide evidence that individuals’ compliance with monogamy is likely to be low, similar to rates of compliance with other medical advice. Lastly, the authors draw upon recent research findings suggesting that people who label themselves as monogamous are less likely to engage in safer sex behaviors than people who have an explicit agreement with their partner to be non-monogamous. Future research and clinical directions to promote sexual health and destigmatize sexual behaviors are considered.

© 2015 Published by Elsevier Inc.

Mutual monogamy means that you agree to be sexually active with only one person, who has agreed to be sexually active only with you.

The above definition of “mutual monogamy” from the Centers for Disease Control (CDC) has been a bedrock of sexually transmitted infection (STI) prevention for several decades (National Center for HIV/AIDS et al., 2012a). Health practitioners and public health agencies promote “monogamy” (often not explicitly defined) as a
low-risk form of partnered sex. Current research, however, challenges conclusions about the utility of monogamy as an STI-prevention strategy. Monogamy may not be as definitive a means of reducing STIs as previously assumed.

In this article, we consider definitions of monogamy and their potential implications for disease prevention, address challenges in monogamy compliance, and review empirical findings that document weaknesses in monogamy as a disease-prevention strategy. Ample bias exists against those who are not monogamous (Conley et al., 2013a; Conley et al., 2012a), making these discussions challenging. Still, to provide comprehensive knowledge about preventative care in research and clinical settings, an evaluation of the effectiveness of monogamy as an STI-prevention strategy is crucial.

Definitions of monogamy and implications for disease prevention

Considering definitions of monogamy obviates several problems with “monogamy” implementation. First, although most people understand the benefits of monogamy, their perceptions of “being monogamous” are often inconsistent with the CDC’s definition of mutual monogamy (which itself suffers from ambiguities—discussed below) (Conley et al., 2013a). Men in one study identified themselves as monogamous as long as they were not having intercourse with more than one person—despite engaging in other risky sexual activities with multiple partners (Anderson, 2010). Participants in another study made comments such as “I’m monogamous with whomever I’m with”—suggesting that some individuals define monogamy as a transient arrangement between two people, which could be followed by a potentially limitless number of other momentary “monogamous” relationships across a lifetime (Stevens, 1994). Thus, many people, though they are aware of the importance of monogamy, are not precisely adopting or implementing the CDC definition of mutual monogamy.

One possible reason for such lack of compliance with “monogamy” is that the CDC definition itself is difficult to translate into medical advice or health policy. For example, consider a hypothetical couple—one partner could be sexually active with only the other member of the couple. The other partner might be having multiple sexual relationships in addition to the relationship with the other member of the couple (while, perhaps, claiming to be “monogamous”). Therefore, for clarity, a situation in which one member of a dyad is monogamous while the other is not should be termed one-sided monogamy. Only if two people both engage in monogamy can the arrangement accurately be described as mutual monogamy.

Mutual monogamy, of course, is the intended advice behind the CDC definition, but even the wording of the message belies the difficulty in maintaining mutual monogamy. That is, the CDC provides a definition of “mutual monogamy”—yet it adopts language of “agreement” between sexual partners. “Agreements” themselves do not prevent STI transmission—only behaviors can prevent the spread of STIs. Many situations emerge in which people are following the CDC definition and yet are unprotected from STIs (i.e., when one member of the monogamous couple is faithful and the other is not despite the partners’ agreement to be monogamous). The CDC definition of so-called “mutual monogamy,” therefore, is inaccurate—it is necessary to make a distinction between monogamy agreements and monogamous behaviors. Mutual monogamy does not fall in the realm of “agreements” but requires behavioral compliance of both partners. Because an agreement to be monogamous with another person (in absence of correspondent behaviors from that person) does not prevent STIs, the utility of the CDC definition for safer sex promotion is worthy of further investigation. Mutual monogamy, as defined for the remainder of this article, is having sexual relations with only one person, who has sex exclusively with that partner (irrespective of any “agreements”).

In sum, definitions of monogamy are indistinct, both for professionals and the general public. More attention to individuals’ use of monogamy in order to promote safer sex is needed. Given the high rates of sexual infidelity, researchers should address how many people are practicing one-sided monogamy with a partner who has agreed to be monogamous but is not—and the implications of such arrangements for STIs.

Efficacy and effectiveness of monogamy as a tool for STI-prevention

In the wake of the HIV/AIDS epidemic, public health officials actively promoted monogamy (often not precisely defined) to protect against STIs (National Center for HIV/AIDS et al., 2012a; Koop, 1987; Misovich et al., 1997a). Sexual education programs treat monogamy as a primary means of avoiding STIs (Santelli et al., 2006; Anon., 2014). One reason for the widespread public health and clinical focus on monogamy is that mutual monogamy (with the definition established above and perfectly implemented) is ipso facto efficacious for preventing STI transmission. Undeniably, if lifelong monogamous lifestyles were widely adopted (i.e., two people are only sexually active with one another throughout their lifetimes), the spread of STIs could be eliminated almost entirely.

Given that the perfect implementation of mutual monogamy would eradicate STIs, it may seem peculiar to critically analyze advice to “be monogamous.” However, for any treatment, it is important to distinguish between efficacy and effectiveness. There is no dispute that monogamy is efficacious at preventing STIs (i.e., it prevents STIs when it is implemented perfectly). More attention should be paid, however, to the effectiveness of monogamy (i.e., whether it prevents STIs as it is implemented in real-world settings) (Gartlehner et al., 2006). Although monogamy has been promoted for decades, STIs are still quite prevalent—20 million new STIs occur every year in the US (National Center for HIV/AIDS et al., 2012b). One assumption might be that the continued spread of STIs results from the public’s lack of awareness of the health benefits of a monogamous lifestyle. However, recent research indicates that monogamous relationships are overwhelmingly perceived by the public to prevent the spread of STIs (Conley et al., 2012a; Stevens, 1994; Moors et al., 2013; Aral and Leichliter, 2010; Markham et al., 2009; Helweg-Larsen and Collins, 1997). As such, the public recognizes that a monogamous lifestyle largely prevents STIs. Unfortunately, having knowledge about lifestyle choices that can prevent STIs (e.g., abstaining from sexual intercourse or using condoms) may have limited utility—indeed, providing individuals with more information about broad health practices often has little association with behavioral change (Helweg-Larsen and Collins, 1997). Similarly, among adolescent populations, abstinence-only education (i.e., an approach that advocates no sexual contact until marriage) was previously viewed as a plausible STI-prevention measure (McClelland and Fine, 2008). Abstinence is undeniable efficacious for eliminating pregnancy and STI transmission (Community Preventive Services Task Force, 2012). If adolescents uniformly abstained from sex, STI transmission and pregnancy would quickly cease in that population. However, researchers in the fields of public health and policy, psychology, and education now reject the implementation of traditional abstinence-only education because it is overwhelmingly ineffective (McClelland and Fine, 2008; Community Preventive Services Task Force, 2012; Chin et al., 2012; Trenholm et al., 2008). Adolescents exposed to abstinence-only curricula are aware that sexual intercourse before marriage is condemned, yet they often fail to implement this directive. Thus, abstinence-only education is efficacious, but ineffective.

Potential parallels to monogamy are obvious; the practice of having only one sexual partner across the lifetime prevents STIs in theory. However, reluctance or inability to adhere to monogamy may mean that monogamy is untenable in practice. Current monogamy promotion efforts assume that monogamy will reliably prevent STI transmission (National Center for HIV/AIDS et al., 2012a), yet little attention has been given to whether monogamy is effective at reducing STI transmission.
Compliance with monogamy advice

Rates of compliance with medical advice are known to be low, even for simple behaviors such as taking a pill or reducing behaviors that have clear, detrimental health consequences (e.g., smoking) (Claxton et al., 2001; Feinstein, 1990; Burnier, 2006; Prochaska and DiClemente, 1983). Adherence to a monogamy regimen may be as low, or lower, than adherence to other medical advice. We consider this issue below.

Monogamy maintenance requires abstaining from extradyadic sex

Extradyadic sexual intercourse is appealing to many people. Avoidance of the highly desirable activity of sexual intercourse with new partners (when available) may be more taxing for some than many daily medical procedures (e.g., taking a pill). The basic perceptual process of habituation means that sexual partners become less sexually attractive over time (Rankin et al., 2009; Ferreira et al., 2012). Even in cultures and circumstances in which consequences of infidelity are dire (e.g., cultures wherein the death penalty is enforced for extramarital sexual encounters), non-monogamy still occurs (Barash and Lipton, 2001). Likewise, sufficient evidence that humans are naturally monogamous or that monogamy is the ideal type of relationship for every individual is lacking (Conley et al., 2013a). Instead, previous research across 48 cultures documented that monogamy is not a universal aspect of human nature (Schmitt, 2005). Rather, a strong predictor of monogamy is the lack of opportunity to have extradyadic sex (Christopher and Sprecher, 2000).

Similarly, many people who have entered a monogamy agreement still have extradyadic encounters (i.e., they “cheat” or are “unfaithful”). Infidelity occurs frequently among couples. In undergraduate student samples, roughly between 20% and 40% of participants had oral, vaginal, or anal sexual intercourse outside of their relationships (Emmert-Sommer et al., 2010; Owen et al., 2010; Vail-Smith et al., 2010). Among national probability samples of married couples, estimates range from 21% to 57% of cheating among married men and 11%–35% among married women (Greeley, 1994). Obviously, an even higher percentage of dyads have been affected by infidelity, knowingly or unknowingly. Thus, ample evidence suggests that compliance with mutual monogamy may be lower than already low rates of compliance with standard medical advice (Claxton et al., 2001; Feinstein, 1990; Burnier, 2006; Prochaska and DiClemente, 1983).

Monogamy maintenance requires cooperative compliance

Another facet of monogamy complicates its effectiveness in preventing STIs: monogamy, as defined by the CDC, is not an individually driven behavior; rather, monogamy requires cooperation of two individuals. The fact that monogamy requires compliance from two people makes medical advice provided to individuals incomplete. Given that controlling another’s behavior is impossible and monitoring another’s behaviors is very difficult, an individual can never be completely assured that mutual monogamy will be maintained within the context of a relationship. That is, it is never possible for a relationship partner to confirm mutual monogamy with absolute certainty—partners are almost never together constantly to monitor one another’s behaviors.

Most recommended health behaviors, such as refraining from smoking or eating healthier, are under the conscious control of a single individual. Yet even these behaviors are notoriously difficult to regulate. Because mutual monogamy requires the full participation of two people, it is much more challenging to address than most medical or public health advice that promotes positive health outcomes.

Incidentally, we acknowledge that condom use also generally requires the cooperation of both partners. For this reason, advice to use condoms also would be better prescribed to couples than to individuals. However, partners are not required to rely on each other’s trust that each person will enact agreed-upon behaviors that occur when they are not together. That is, an individual is aware of whether she or he is being protected by condoms because condom use happens in the presence of both individuals. This is not the case for monogamy.

In sum, monogamy, as a potentially undesirable behavior and one that requires cooperative compliance, is uniquely difficult to implement—a factor that should be considered when recommending monogamy as medical advice. It is therefore sensible for researchers to evaluate the effectiveness of monogamy relative to other recommendations for STI prevention (e.g., using condoms for every act of intercourse).

Monogamous identity labels inhibit safer sex practices

Another problematic aspect of monogamy is its apparent power to motivate individuals to refrain from behaviors as “monogamous.” The pressure to be monogamous is intense. Those who adopt consensually non-monogamous lifestyles (CNM; relationships in which all partners agree that having sexual and/or romantic relationships outside of a committed relationship is permissible) are perceived in an exceedingly negative light (e.g., as irresponsible and having low-quality relationships) (Conley et al., 2012a; Moore et al., 2013; Matsick et al., 2014). Stigma against non-monogamy may promote dangerous sexual practices in several ways, considered below.

Serial monogamy and safer sex practices

One way in which individuals can maintain a monogamous identity while having sexual intercourse with large numbers of partners over the lifespan is through serial monogamy. The practice of serial monogamy (i.e., transitioning, often rapidly, from one monogamous relationship to the next) is a far more common sexual trajectory for an individual than CNM or lifetime mutual monogamy (Britton et al., 1998; Pinkerton and Abramson, 1993; Pinkerton and Abramson, 1994). In other words, to most people, “monogamy” does not mean that a partner is and always will be an individual’s only sex partner in life—it merely means that a person will be having sexual contact with only one person at a time. This practice is in fact in accordance with the CDC definition of monogamy: an individual could be leading a lifestyle characterized by a high number of sexual partners and (concurrently) following the CDC advice faithfully. Engaging in either serial monogamy or casual sexual relationships will lead to more sexual partners than true lifelong monogamy. However, monogamous individuals in relationships, including serially monogamous individuals, are less likely to practice safer sex with their primary relationship partners than with secondary/casual partners (Catania et al., 1995; Choi et al., 1994; Fisher et al., 1996; Grimley et al., 1995; Misovich et al., 1997b). After the first few months of dating, partners frequently replace condoms with oral contraceptives (which provide no STI prevention), often without any STI testing or discussion of monogamy prior to this shift. (Misovich et al., 1997b; Civic, 2000; Critelli and Surr, 1998).

Patients often believe that they are being safe when they engage in serial monogamy because they are living up to medical advice to “be monogamous.” However, serial monogamists acquire significant risk because they forego condom use with an equivalent or greater number of partners than those who have casual encounters—notably, among adolescents in a longitudinal study, serial monogamy was related to the acquisition of STIs (Ott et al., 2011). Moreover, just by labeling oneself as “monogamous” (as serially monogamous people do), a person is less likely to adhere to standard safer sex practices that prevent STIs, such as using condoms (Britton et al., 1998).

Counter-intuitively, then, pursuing short-term relationships may be, in practice, a better way to protect oneself from STIs than serial monogamy. Because abandoning condoms is a stable concomitant of labeling a relationship monogamous, the monogamy label may put people (whose partners are not monogamous) at greater risk than people who use condoms with many sexual partners (Pinkerton and
Afram, 1993; Pinkerton and Abramson, 1997). That is, the label of “monogamy” heightens STI-risk by providing an unwarranted veneer of safety. Researchers could highlight the risks involved with serial monogamy and practitioners could consistently promote condom use regardless of relationship status. Clinicians should advise patients to thoroughly screen for STIs before reducing condom use within monogamous relationships, even if patients believe they know their partner well (Fisher et al., 1996).

Infidelity and safer sex practices

Some individuals maintain a monogamous identity in a wholly deceptive fashion. They explicitly or implicitly convey to a partner that they are monogamous when actually they are engaging in extradyadic sex. This dynamic has direct implications for safer sex. Condom use has been associated with casual sex. This dynamic has direct implications for safer sex. Condom use-deceptive fashion. They explicitly or implicitly convey to a partner that they are monogamous are generally not pressed to use condoms (Misovich et al., 1997b). Thus, people may fear introducing condoms into a relationship that is assumed to be monogamous, safe, and trustworthy because condom use counters the monogamous relationship script (Conley and Rabinowitz, 2004). Unfortunately, due to high infidelity rates, even a person who identifies as monogamous and practices monogamy according to the CDC definition may be (unknowingly) involved in a one-sided monogamous relationship (i.e., an infidelity situation). Obviously, relationship infidelity increases STI risk because new partners may introduce STIs.

Expectations surrounding monogamy agreements may also serve to increase the likelihood of STI acquisition. If established couples do not use barrier methods of protection in their relationship because of the existence of monogamy agreements, it is likely unlikely that an individual who has committed infidelity will reintroduce barriers after infidelity occurred—doing so would likely raise suspicion about that person’s fidelity (Misovich et al., 1997b; Conley and Rabinowitz, 2004). Therefore, after infidelity has occurred, risk of STI acquisition for the non-cheating partner increases because of the assumption of mutual monogamy. One relationship partner may have followed all medical and public health advice to the letter—engaging in one-sided monogamy and obtaining a monogamy agreement from a partner. Yet, even perfect compliance with this advice does not necessarily protect the individual from risk of STIs. A patient who is engaging in one-sided monogamy but who happens to have a cheating partner has a heightened risk of contracting STIs.

By this logic, monogamy directives may not simply be neutral and ineffective, but by pressuring people to maintain an identity as monogamous, they may counterproductively increase risky sexual choices. That is, stigma against non-monogamy may lead individuals to conceal extradyadic sexual intercourse from an established partner, who could then be exposed to STIs. A more effective strategy than forgoing condoms with established partners would be to assume that no sexual partners are monogamous and continue with regular STI testing and safer sex behaviors.

Consensual non-monogamy and safer sex practices

We have established that labeling oneself (and/or one’s partner) as “monogamous” may encourage individuals to engage in riskier sexual behaviors under the pretense of monogamous identities. The converse must then be considered—a non-monogamous identity may promote safer sex. Some recent research has addressed the effectiveness of monogamy for STI prevention. The utility of monogamous practices in STI prevention may be indirectly ascertained by comparing the behaviors of ostensibly monogamous individuals (i.e., who are committing infidelity—they indicate that they are monogamous to their partners but then have sexual intercourse with other partners) to those of CNM individuals, who have open agreements to be non-monogamous (Klesse, 2006; Jamieson, 2004; Lano and Parry, 1995).

Among individuals who are unable or unwilling to commit to monogamy, the sexual agreements present in CNM relationships may more effectively prevent STIs than ostensibly monogamous. CNM individuals appear to practice safer sex more effectively than ostensibly monogamous individuals. CNM individuals practice safer sex with both their primary partner and with extradyadic partners more than individuals who are ostensibly monogamous (Conley et al., 2012b; Conley et al., 2013b). CNM individuals were more likely to use condoms for vaginal sexual intercourse or anal sexual intercourse in extradyadic sexual encounters and more likely to use condoms in general in their primary partnership, than cheating individuals. Likewise, CNM individuals were more likely to have been tested regularly for STIs and were more likely to have discussed the extradyadic encounter with their primary partner than unfaithful individuals. CNM individuals were also less likely to have been under the influence of drugs or alcohol during the sexual encounter compared to sexually unfaithful partners. CNM individuals also used condoms more effectively (i.e., they made fewer condom use errors) than unfaithful individuals (Conley et al., 2013b). Thus, CNM individuals more frequently and effectively practice safer sex than unfaithful individuals.

Considering CNM relationships more broadly may necessitate the reconsideration of a number of medical practices. By way of example, consider two sexually active women scheduled for a routine gynecological exam. One identifies as being in a monogamous relationship; the second indicates that she is not monogamous. A physician would likely forego STI testing for the first woman, but recommend it for the second. However, details beyond the presence of a “monogamous relationship” indicate a different picture of health risks. Perhaps the first woman has sexual contact only with her partner, but her partner is actually having unprotected sexual encounters with others on a regular basis. The patient provided no false information, but is losing the opportunity to be screened for potentially dangerous diseases. By contrast, the second patient might be in a CNM relationship with two men, neither of whom have additional sexual partners, and use condoms for every act of intercourse. Although this patient would likely be provided with STI testing, she actually has a far lower risk of acquiring STIs than the first patient who reported being “monogamous.”

In sum, ample evidence exists to support the possibility that patients who identify as CNM could sometimes be at lower risk for STIs than patients who identify as monogamous. Considering monogamy agreements with a critical eye could promote changes to basic screening procedures. Thus, it might be appropriate to screen all sexually active patients for STIs routinely, rather than presuming that questions about partner status can effectively determine which patients are at risk.

Broader implications and recommendations

Based on the current examination of monogamy, several recommendations can be made about the use of monogamy guidelines.

Recommendations for researchers.

Initial evidence suggests that maintaining truly monogamous relationships over a long period of time may lead to lapses from monogamy and, in turn, increased risk of STIs. Future research is needed to determine whether monogamy or CNM actually better prevents STIs over time. Specifically, researchers should consider STI outcomes for sexual partners longitudinally. By comparing the ubiquitous relational style of serial monogamy to CNM, researchers can help determine whether identifying oneself as a monogamous (albeit only serially) person is associated with lesser adherence to condom use and other safer sex recommendations than identifying oneself as engaging in CNM relationships.
Recommendations for practitioners and public health officials

Given the complex and idiosyncratic definitions of the seemingly straightforward term “monogamy,” either a simpler message needs to be developed (e.g., use condoms for every act of intercourse regardless of relationship status) or individuals need more guidance in how to effectively implement monogamy. Serially, monogamous individuals should appreciate that more partners means more risk, regardless of whether those partnerships are consecutive or concurrent. Similarly, medical advice that can only be undertaken by individuals—such as advice to “be mutually monogamous”—should not be dispensed to individuals.

To curb the rate of STIs, all sexually active individuals should receive STI testing, regardless of relationship status. This is crucial for several reasons. First, social desirability surrounding non-monogamy may lead patients to mischaracterize their background as monogamous despite having more than one partner—a patient may feel too ashamed to admit an extradyadic encounter for fear of judgment by the physician. Second, patients who have only one sexual partner may unwittingly be at risk for STIs from that (non-monogamous) partner. Similarly, serially monogamous individuals could label themselves as monogamous while having acquired scores of sexual partners. Routine testing would identify STIs more effectively than relying on questions about relationship status, monogamy, or subjective “need” for testing.

Given relatively high rates of reported infidelity and STI transmission, the idea that monogamy agreements are the most effective means of preventing STI transmission for all couples should be carefully examined. As compared to ostensibly monogamous individuals, CNM individuals engaged in more effective safer sex behaviors during their extradyadic encounters and in their primary relationships. Safer sex behaviors can help prevent the transmission of STIs to their primary partners. Encouraging honesty about their ability to be monogamous with their partner and to take appropriate safer sex precautions could possibly prevent STIs better than monogamy alone. Physicians should encourage patients to discuss how feasible monogamy seems and use this information to guide whether a monogamy agreement is appropriate, or whether a CNM agreement would be more suitable, given that CNM is likely more effective than failed monogamy at preventing STIs (Conley et al., 2012b; Conley et al., 2013b).

Notably, these recommendations likely would be viewed as departing from those of the United States Preventive Services Task Force (USPSTF). According to their website, “The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs).” (U.S. Preventive Services Task Force, 2014) The recommendation that providers somehow identify those “at risk for sexually transmitted infections” poses numerous problems. For example, it is not clear how to identify people whose ostensibly monogamous partners actually have other sexual relationships. Likewise, biases on the part of the provider likely mean that they will be inaccurate in their assessments of risk and patients are unlikely to be forthcoming with details about non-monogamous behaviors due to fear of stigma.

Similarly, CDC recommendations for STI screening reflect many of the biases elucidated here. According to their website, for example, the CDC recommends annual screening for STIs for all women (but, apparently, not men) who have “new or multiple sex partners” or a sex partner who has an STI (Centers for Disease Control and Prevention, 2014). It is not clear why having a “new” partner is more dangerous than having an established partner—“established” partners can and often do engage in infidelity, placing their primary established partner at risk for STIs. A “new” partner might be a virgin who poses very little risk. Likewise, the recommendation concerning “multiple partners” is perplexing—a person may be engaging faithfully in one-sided monogamy and have a far greater risk because of a straying partner. But a woman who has two sexual partners who are both engaging in one-sided monogamy (with her as their only sexual partner) is likely at a very low risk for STIs.

Given the USPSTF’s recommendations, practitioners and public health officials should support attempts to destigmatize many types of non-monogamy (including casual sex, infidelity, and CNM). Reducing stigma would likely promote more forthright responses from patients about sexual practices and also encourage patients to protect themselves, seek treatment, and alert partners about possible infections, thus preventing future transmissions. Moreover, although condom use has been actively encouraged for several decades, health care providers should support attempts to develop more pleasurable condoms (e.g., research by the Gates foundation) that would be more appealing to individuals, including those who have monogamy agreements with their partners (Pinkerton and Abramson, 1997; Doucelf, 2013). Lastly, it is important to promote findings indicating that sexual activity has positive physical and psychological health outcomes for adults (e.g., sexual intercourse provides benefits to the immune system, blood pressure reactivity, and the relief of migraines) (Charnetski and Brennan, 2004; Brody, 2006; Hambach et al., 2013). Therefore, partnered, consensual sexual activity itself is not inherently a risky or irresponsible behavior. Of course, we recognize that reducing stigma will be a long-term process. These are highly ingrained attitudes that will be difficult to change.

Conclusions

Questioning the utility of monogamy as a strategy for preventing STIs elucidates how monogamy, as medical advice, may fail to promote safer sex and positive sexual health outcomes. Given idiosyncratic interpretations of monogamy, compliance issues, and positive relationships between consensual non-monogamy and safer sex behaviors, monogamy directives may not be the best way to curb STIs. Researchers and practitioners should address the utility of promoting monogamy as a safer sex strategy relative to other STI-prevention methods, such as consistent condom use, STI testing, and partner communication.

Conflict of Interest Statement

The authors declare that there are no conflicts of interest.

References


Brody, S., 2006. Blood pressure reactivity to stress is better for people who recently had penile–vaginal intercourse than for people who had other or no sexual activity. Biol. Psychol. 71 (2), 214–222.


Markham, C.M., Conley, T.D., Ziegler, A., Moors, A.C., Rubin, J.D., 2014. Love and sex: polyamorous relationships are perceived more favorably than swinging and open relationships. Psychol. Sex. 5 (4), 339–348.


