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Review

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

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A R T I C L E I N F O

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A B S T R A C T

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.

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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

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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 undeniably 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.

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