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Abstract
This article presents partial results of a mixed methods study about consensual non-monogamists' perceptions of their parenting and sexual lifestyle, particularly those involving the transition to parenthood, intimacy and communication. Using The Expanding the Movement for Empowerment and Reproductive Justice Lens that was enhanced by Cowan and Cowan's Ecological Model of the Transition to Parenthood, six participants completed an online questionnaire and a semi-structured interview guide. Parenting consensual non-monogamists prioritise sexual intimacy over emotional intimacy, and communication is very important for them. The quantitative results support the qualitative ones: the participants had a higher level of parenting sense of competence, and the means for emotional and sexual intimacy were lower for primary partners than for secondary ones. Perinatal health care professionals including nurses need to know more about parenting consensual non-monogamists and their partner(s). More research is warranted with this particular group of parents, especially on their experiences of minority stress, resilience and taking a more intersectional research approach.

Keywords Consensual non-monogamy, Transition to parenthood, Emotional intimacy, Sexual intimacy, Communication

Parenting Consensual Non-Monogamists' Perceptions of Parenthood, Intimacy, and Communication

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Introduction

Although perinatal health care providers including nurses encounter parenting consensual non-monogamists (PCNMs), there is a dearth of studies on consensual non-monogamy (CNM) in the context of parenthood (1-3). CNM is defined as an individual choosing to engage in a romantic and/or sexual activity with more than one partner, with all partners being aware of their involvement (4,5). The three main types of CNM are polyamory, swinging, and open relationships. While polyamory involves having multiple romantic, loving and/or sexual long-term non-exclusive relationships (1), swinging involves non-exclusive sexual relationships, especially for heterosexual couples (6). Open relationships are romantic, and accompanied by additional sexual connections (1).

The transition to parenthood is "the period starting with the decision to have a child or becoming pregnant and terminating when the child is 2 years old" (7, p. 36). Many changes are associated with this transition such as physical and sexual (7). However, the two most affected dimensions are intimacy and sexuality (8-10). In the initial postpartum period, there is more emphasis on the parenting role due to the demands of the newborn and the new mother's recovery (9). Couples appear to cope better when they can more quickly strike a balance between the roles of lover, partner, and parent (9).

Stigma towards CNM can lead to health inequities for parents such as an increase in sexually transmitted infections (STI's) (11), and may also affect their children's lives (12). This stigma may result in parents who participate in CNM non-disclosure during health care interactions (12). Yet, Pallotta-Chiarolli (12) indicates that there are benefits in raising children in polyfamilies: less strain in the division of labour and the care

of the children; a greater sex-positive attitude; a stronger bond between parents and children; a better division of resources (financial, physical, emotional and others); polyparents having more time for themselves; and polychildren being exposed to more than one role model. This article presents partial findings from a larger study whose aim was to describe Manitoban consensual non-monogamists' perceptions of parenting and their sexual lifestyle. The partial findings featured in the article are in relation to the following research questions:

1) What are the perceptions of PCNMs in regard to their transition to parenthood, their emotional and sexual intimacy, and their communication? (QUAL)

2) What are the perceptions of PCNMs in regard to the Parenting Sense of Competence Scale and the emotional and sexual intimacy subscales of the Personal Assessment of Intimacy in Relationship Inventory? (quan)

3) What are the similarities and differences between the perceptions of PCNMs in regard to their transition to parenthood, their emotional and sexual intimacy, and their communication, and their perceptions in regard to the Parenting Sense of Competence Scale and the emotional and sexual intimacy subscales of the Personal Assessment of Intimacy in Relationship Inventory? (QUAL and quan)

Conceptual Framework

The study's conceptual framework relies on The Expanding the Movement for Empowerment and Reproductive Justice (EMERJ) (13) lens, which is a concrete way of integrating the Reproductive Justice Framework in research, or more practically, when working with communities, such as PCNMs. This lens assists in identifying the challenges that people face in regard to their gender, bodies and sexuality (13). The family dimension within the EMERJ lens was enhanced by Cowan and Cowan's Ecological Model of the Transition to Parenthood (8). This ecological model encompasses the five central aspects of family life: each person's inner world; the relationship between parents and children; the relationship between the parents; the one between grandparents, parents and grandchildren; and lastly, the one between family members and the institutions outside of the family unit.

Methods

A brief overview of the methodology is presented here as it was previously published by Avanthay Strus and Polomeno in 2021 (14).

Research study type and design. The original mixed-methods research study type used the triangulation design-convergence model (19), including "a single phase, (and) both types of data are given equal emphasis" (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" (p. 84). This design was chosen for two reasons: 1) it is time efficient as both the quantitative and qualitative data are collected simultaneously, and 2) both data sets are considered of equal importance (19).

Population, sample and sample size. The research population focused on individuals who were parents and consensual non-monogamists. Eight participants met the following inclusion criteria: 1) be 18 years old and more; 2) having been in a consensually non-monogamous relationship in the last two years; 3) having 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 so since birth; and 6) speak, read and write in English. The exclusion criterion involved individuals in an exclusive same-sex relationship. Only six of the original eight participants completed the online questionnaire and the interview; two withdrew for personal reasons.

The sample consisted of four female and two male participants, their ages ranged from 31 to 45 years ($M = 37.67$ years, $SD = 6.37$), and five participants identified as bisexual or pansexual and the other one as heterosexual. At the beginning of the transition to parenthood, one participant identified as polyamorous, one was in an open relationship, and four participants were swingers. At the time of data collection, two participants identified as swingers, while four of them were polyamorous. Four participants were married, one was common-law, and the last one was separated. Three participants had secondary partners at the time of data collection and three had secondary partners during the transition to parenthood. The number of children for each participant ranged from 1 to 3, with an average age of 10.63 years at the time of the interviews. Their incomes ranged from $19 000 to over $60 000. All participants were Canadian born.

Data collection. The qualitative data were collected using a semi-structured interview guide (3) containing 32 questions divided into four different sections: 1) the participants' perceptions of the transition to parenthood; 2) their sexual lifestyle; 3) the conciliation of their parenting role and their sexual lifestyle; and 4) their perceptions of health care professionals. This guide was developed incorporating the EMERJ lens (13) as well as Cowan and Cowan's Ecological Model (8). Only the first two sections of the interview guide are considered for this present article (findings from the fourth section are now published (14)). The interviews took between 1.5 and 2 hours to complete.

The quantitative data were collected using an online questionnaire that contained 24 questions regarding sociodemographic, relational, and parenting characteristics and included three research instruments (see Avanthay Strus (3)): the Parenting Sense of Competence Scale (PSCS) (16); the Personal Assessment of Intimacy in Relationship Inventory (PAIR) (only the emotional and sexual intimacy subscales were retained) (17); and the Parenting Role-Sexual Role Conciliation Scale (PRSRCS) which was created for this study (3). Data from the PSCS and the two PAIR Inventory subscales are considered for this article. The online questionnaire took the participants between 15 and 20 minutes to complete.

The PSCS (16) is a 16-item self-administered questionnaire (with 2 subscales: efficacy and satisfaction) using a 6 point-Likert scale, from 1 = "Strongly Disagree" to 6 = "Strongly Agree". The seven questions pertaining to the 'Efficacy' subscale focus on the parents' competence, capability levels and problem solving abilities. The nine questions that are part of the 'Satisfaction' subscale measure parents' anxiety, motivation and frustration. A total score is obtained by adding the values for each item, with a higher score indicating a more positive parenting experience. The PSCS has an internal consistency using Cronbach's alpha ranging from 0.75-0.88 for the subscales and for the total scale.

The PAIR (17) Inventory is a 36-item self-administered questionnaire that measures the perceived and expected levels of intimacy in a relationship. It contains five subscales representing five dimensions of intimacy: emotional, social, sexual, intellectual, and recreational. Only the emotional and sexual intimacy subscales were retained for this study. Each item is rated on a 5-point Likert scale, from 1 = "Strongly Disagree" to 5 = "Strongly Agree". The scores are obtained by adding up the values for each item, with a higher score indicating a higher level of intimacy. 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; for example, less satisfaction with it. The Cronbach alpha reliability coefficients for the emotional and the sexual intimacy subscales are 0.75 and 0.77, respectively.

Data analysis. The qualitative data were analysed using the Schreier inductive method (18) to infer themes that came up during data analysis. This systematic approach to data analysis (18) used inductive and objective methods to infer these themes. This approach began by submersing in the data by repeatedly reading after the interviews were transcribed. General impressions and thoughts were noted following the general themes in the interview guide (Transition to Parenthood, Sexual Style/Sexuality, Conciliation of Roles, and Health Care Professionals). 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. Any inconsistencies that arose during the primary analysis were compared between co-researchers.

Descriptive statistics (15) were applied to all quantitative variables using Version 24 of SPSS Statistics (20). Following Creswell and Plano Clark's (19) triangulation design convergence model, both qualitative (primary data set) and quantitative (complimentary data set) data were collected at the same time and given equal emphasis (19). However, the qualitative data were first analysed, followed by the quantitative data. Once the data had been analysed, they were then converged during the interpretation phase. These comparisons could result in the data sets being congruent (similar) or divergent (dissimilar).

Ethical considerations. Ethics approval had been obtained from the first author's educational institution, where they were a master's student in nursing. Informed consent was obtained from each participant, while each was attributed a number (First Participant=P1, Second Participant=P2, etc.) to protect their identities. The participants chose the location and time for their interview.

Results

The qualitative data analysis from the original study resulted in five themes: perceptions of the 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. Results from the first two themes (perceptions of the transition to parenthood; emotional and sexual intimacy and communication) are featured in this article (see Table 1). Results from the corresponding quantitative data are also presented.

Perceptions of the transition to parenthood

The participants' perceptions regarding the transition to parenthood obtained from the interviews are divided into four phases: preconception, pregnancy, childbirth, and the first two years postpartum. The quantitative results from the PSCS are added here.

Qualitative results. During preconception, all of the participants in this study had conversations with their primary partners about having children. For four of them, this decision was a planned one. As P1 states: "It was the next logical step". Two others who did not prepare for pregnancy expressed concerns about the impact of schooling or a recent move.

Table 1: Results of Qualitative Data Analysis from the First Two Themes of the Original Study

Themes	Categories	Subcategories
Perceptions of Parenting Consensual Non-Monogamists Regarding their Transition to Parenthood	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
Intimacy and Communication During the Transition to Parenthood	Intimacy	Changes in emotional intimacy
		Changes in sexual intimacy
	Communication	Changes in communication with the arrival of children
		Impact of mental health on communication

Regarding the second phase of pregnancy, the participants described this period as being positive or negative. Those who had planned their pregnancies seemed to be more prepared to take on the parenting role, and those who had support were better able to deal with this phase. However, some of them had developed complications (n=3) such as pregnancy loss, multiple gestation or physical difficulties related to previous health conditions, resulting in negative perceptions of pregnancy. Three participants who had high needs children prior to pregnancy also had more negative perceptions. Participants with negative perceptions (pregnancy complications or high needs children) expressed how these circumstances adversely affected intimacy and communication in their relationships: for example, P4 indicates, "I felt jealous of her partners…felt like a third wheel".

Concerning the third phase of childbirth, the four female participants either experienced uncomplicated labour and birth (n=2) or a complicated one (multiple gestation, perineal tearing, postpartum hemorrhage, n=2). For the participants who described the childbirth experience as being positive, they expressed it in the following ways: "…hard, beautiful, interesting fascinating, scary" (P2), and, "…instant love…I would do it million times over" (P4). The participants with a more complicated childbirth were more affected in the initial postpartum period. Some participants expressed experiencing post-traumatic stress associated with traumatic childbirth experiences. P4 expressed how her male partner had experienced trauma from being present at the birth: "No guy wants to see that". It took longer for one female identified participant to resume sexual activity with her male primary partner due to the trauma that this primary partner had witnessed during childbirth. Her male primary partner was quicker to resume sexual activity with their female secondary partner. Certain participants (P2) took longer to take on the role of parent due to childbirth-associated trauma.

For the last phase of birth to two years of age (of the child/children), the participants indicated that they required time to adjust to having children. Also, this adjustment varied between the men and women in the study: the women identified with the parenting role earlier than their male counterparts. 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". Certain participants who expressed concerns about having difficulty meeting their own needs during this period had to deal with a high needs child.

Five out of the six participants had high needs children for their first or third child. One participant expressed how the first three months were traumatic due to extreme sleep deprivation.

> "I would so that the first 3 months were extremely traumatic...She had severe colic and needed to be held constantly so the stress of the sleep deprivation for my wife and I was…um…almost unmanageable. We had support, but there wasn't a lot of support that could be given…" (P2).

Also, the father participants had to contend with sleep deprivation and providing for their families. At the same time, their female partners took time off due to parental leave to look after the children.

Quantitative PSCS results. The total score of the PSCS can range from 17 to 102, with a higher score indicating a parent's higher sense of competence. All of the participants' total scores for the PSCS were on the higher side, ranging from 74 to 90 (M = 84.00; SD = 6.85) (see Table 2). Female identified participants had a higher mean score (M = 85) than male identified participants (M = 77.5),

For the efficacy subscale, the only item that produced the lowest score 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 parenthood has challenges and that these problems are not easily solved. However, Item #17 ('Being a good parent is a reward in itself') had the highest number of participants (four out six) who scored 6 out of 6 ('Strongly agree').

For the satisfaction subscale, 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 quantitative results from the PSCS can be compared with the previously mentioned qualitative ones. 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 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.

Emotional and sexual intimacy

The qualitative results for emotional and sexual intimacy obtained from the interview guide will first be presented, followed by the quantitative results derived from the PAIR Inventory.

Qualitative results. *Emotional intimacy.* Some participants reported an increase or a decrease in emotional intimacy, while there was no change for others. P6 shared how emotional intimacy continued to increase after the children's birth. This was attributed to the couple's need to present themselves as a 'united front' in the face of obstacles regarding their parenting challenges. Even if emotional intimacy had increased gradually over time, they did regain the prepregnancy level to when the child was a year of age. P6 shared the following:

> "…in terms of being able to see my spouse to become a parent and be ready for that role and just caregiver in general…and having him feel the baby move… particularly the second time around…just seeing that uh blossom in my spouse was was (a) special time for me" (P6).

For two others (P1 and P2), there was a decrease in emotional intimacy after the birth of their child, but it did increase again, with a return to a prepregnancy level when the child was slightly younger, at about 10 months of age.

> "There was definitely more intimacy before my daughter, and it's at this point though…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" (P2).

Table 2: Results from the Parenting Sense of Competence Scale (n=6)

	Mean	Standard Deviation	Range
Efficacy	41.33	2.77	8-48
Satisfaction	41.00	6.36	9-54

P3 and P4 did not notice a change in their emotional intimacy during the initial postpartum period.

Sexual intimacy. Concerning sexual intimacy, differences were noted between female and male participants and from one pregnancy to the next. Male participants indicated a change in their levels of sexual interest throughout the transition to parenthood. All participants waited for the new mother's physical healing before resuming sexual activity, especially with perineal tearing. One participant explained:

> "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" (P1).

The female participants who breastfed (n=4) reported a decreased libido, while two participants also noted 'touch fatigue' related to breastfeeding. During sexual play, most participants did not include the breasts, while two did. The participants who had a breastfeeding partner made modifications to sexual positions to accommodate for this: 'female on top' and 'doggy style' were the preferred positions while limiting the 'missionary' position. For those identifying as female, changes in their appearance affected their desire for sexual intimacy. P3 stated, "I did not feel like myself afterwards or sexy, an object of desire".

The participants who were in open relationships or identified as swingers did not participate in CNM in the initial postpartum period, being limited by the physical changes due to childbirth. However, those in polyamorous relationships were more cognizant of their emotional and sexual intimacy. All participants mentioned that sexual activity during the first postnatal year was more 'vanilla' with less incorporation of BDSM practices. P2 shared the following: "short and quick right…not as tantric".

Quantitative PAIR Inventory results. All the participants completed the perceived emotional and sexual intimacy PAIR Inventory subscales for their primary partner, three of them for a secondary partner, however, none responded for a third partner.

Emotional intimacy. The perceived levels of emotional intimacy scores for the participants' primary partners (n=6) ranged from 24 to 92 (M = 69.00; SD = 30.61), while for the secondary partners (n=3), the score range was between 80 and 96 (M = 85.33; SD = 9.23) (see Table 3). Looking more closely at each of the items individually, only two items had a 67% agreement or disagreement (four out of six participants): strongly agreed for, 'My partner listens to me when I need someone to talk to' (Item #1), and strongly disagreed with, 'I often feel distant with my partner' (Item #13).

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). Yet, most of the participants did score in the expected range of between 48 and 58 (17). The lower scores for the perceived level of emotional intimacy for two participants were corroborated with the qualitative results: these two participants had a decrease in emotional intimacy after the birth of their first child. All participants with secondary partners reported either a similar or higher perceived level of emotional intimacy for their secondary partners than for their primary partners during the transition to parenthood.

Sexual intimacy. The scores for the perceived level of sexual intimacy for the participants' primary partners (n=6) ranged

Table 3: Results for Perceived Level of Emotional and Sexual Intimacy (PAIR Inventory) (n=6)

	Mean	Standard Deviation	Range
Emotional Intimacy (Primary Partner)	69	30.61	0-96
Emotional Intimacy (Secondary Partner)	85.33	9.33	0-96
Sexual Intimacy (Primary Partner)	88.67	9.35	0-96
Sexual Intimacy (Secondary Partner)	88	4.00	0-96

from 68 to 92 (M = 86.67; SD = 9.35), while the scores ranged from 84 to 92 (M = 88.00; SD = 4.00) for the secondary partners (n=3) (see Table 3). Nevertheless, there was a greater range in the scores for the primary partners than for the secondary ones. When analysis was carried out for each item individually, there were two items that all participants were in disagreement with (100%): 'I hold back my sexual interest because my partner makes me feel uncomfortable' (Item #21), and 'My sexual partner seems disinterested in sex' (Item #33). Indeed, participants in this study scored above the reported average for the perceived level in sexual intimacy, for both their primary and secondary partners: in a non-clinical sample of 385 respondents (17), the average perceived level of sexual intimacy ranged between 48 and 58.

Communication during the transition to parenthood

Only qualitative results are available for communication during the transition to parenthood. 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 improved communication, which was out of necessity: they were more open and honest with each other after having children. Their ability to come together allowed them to overcome obstacles they faced during parenthood.

> "…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 and, how you are going to meet those needs together as a team" (P6).

Two other participants (P1 and P2) noticed decreased communication and desire to express their wants and needs. They reported drifting apart and experiencing decreased intimacy stemming from perinatal losses while trying to conceive and having different opinions about childrearing practices. The added stress of postpartum depression and having a high-needs child are two other factors that contributed to their breakdown in communication. Emotional intimacy and communication ability gradually increased over time, returning to the prepregnancy level once their child was one year of age.

One participant (P3) noted increased intimacy and emotional connection due to better communication after the second child's birth. Still, communication decreased after the third child's birth due to having a high-needs child and mental health concerns.

Communication was likewise affected when the participants faced a mental health concern, which resulted in partners becoming closer or leading to a breakdown in communication. Five participants dealt with postpartum depression (PPD) in themselves or their partners. These concerns were compounded by having a 'high needs' child. Two participants were able to surmount this hurdle by working on rebuilding their communication, leading to an improvement in this part of their relationship. For the other three participants, mental health concerns (PPD or PPD with psychosis) led to a breakdown in communication. For P3, her mental health concerns ultimately led to a relationship breakdown with her partner. The breakdown occurred postnatally after the third child's birth, during which time her primary partner had an extra-conjugal affair. In hindsight, she understood why her partner left, "it wasn't his job to fix me, their dad leaving me made me take responsibility for my own mental health".

Participants emphasized how their ability to communicate their needs was due to their participation in CNM. P6 expressed the following:

> "…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" (P6).

Once participants began to reengage in CNM after the birth of their children, the transition to parenthood combined with their experience with CNM allowed them to better read their partners' emotional needs during lifestyle events, and to gauge whether or not they were comfortable in various situations. They also made it a regular practice to do planned check-ins with each other to ensure that their partner's body language matched how they were feeling and to tell each other what they desired and needed.

Discussion

The partial findings from this mixed methods study contribute to a newly emerging body of research that aims to understand the four phases of the transition to parenthood concerning CNM, as previous researchers (1,22) have focused only on childbirth or parenting. The discussion that ensues focuses on the participants' profile, their perceptions of the transition to parenthood, emotional and sexual intimacy, and communication within this context.

Participants' profile. The participants' profile is more varied than previously published studies (5,22,23) but aligns with more recent ones (22,37), having more diverse samples. Particular attention was paid to how the participants were recruited to try to overcome the "artifact effect of community-based strategies that have created an inaccurate reflection of people who engage in CNM" (25, p. 1). As the study's sample was located in Winnipeg, Manitoba, their characteristics may differ than those from other parts of Canada and even the United States (11,23,24,26). Overall, there appears to be a greater acceptance of sexual diversity in Canada and elsewhere, including the swinging culture (25).

Transition to parenthood. Regarding the transition to parenthood, the participants in the current study are similar to other parents who undergo this transition; however, the findings reveal that differences are present, particularly concerning their sexuality.

The decision to become a parent was a significant finding during the preconception phase, as all participants (100%) had had this talk. This finding was present in the study published by Arseneau and colleagues (1), referring to it as 'Deliberately Planning Families'. Given the nature of this study, it would be interesting to explore further the deliberate planning of families that most PCNMs appear to make. We wonder why consensual non-monogamists seem to put more effort into this decision. Indeed, the Society of Obstetrics and Gynecology of Canada reveals that only 50% of all pregnancies in Canada are planned (27).

During the second phase of pregnancy, the participants had positive and negative reactions to it. The participants expressed the importance of support during low- and high-risk pregnancy, which increased their positive response to pregnancy. Indeed, from a conjugal perspective, the findings from the present study reveal how such complications can bring partners closer to each other. On the other hand, opportunities for sexual intimacy were limited, so these participants were more aware of their feelings toward the primary partner and the importance of communication. Balzarini and collaborators (28) explain how polyamorous parents are more adept at communicating, thus support is more available. This warrants further consideration in the context of pregnancy for pregnant consensual non-monogamists.

The participants experienced positive and negative reactions during the third phase involving childbirth. Those with no complications had positive reactions to childbirth, while those with complications had negative ones. Childbirth complications impacted the women, their relationships, their attachment to their babies, and their postnatal sexuality. The female participants who had these complications had postnatal sexual difficulties. This warrants additional investigation as women who are consensual non-monogamists and experience childbirth complications may have more concerns about their postnatal sexuality, particularly the resumption of sexual activity. Notably, women with perineal tears and episiotomies found that their postnatal sexuality had been negatively affected, leading to a delay in the resumption of sexual activity (9). Another study finding was that participants who experienced birth trauma experienced post-traumatic stress disorder. Birth trauma's consequences are detrimental to conjugal relationships, sexual dysfunction, fear of childbirth, and difficulties with mother-infant relationships (9). These findings highlight the need for perinatal health nurses to assess the birthing parent and the relational partner(s), both research-wise and clinically.

In the last phase of parenting, two findings were unexpected: there was a higher prevalence (five out of six participants) of postpartum depression (PPD) and having special needs children (five out of six participants). As most participants had special needs children, this increased their likelihood of having PPD. The prevalence for these two conditions is higher than in the perinatal and parenting populations (29). Despite these challenges, all participants found ways of dealing with their situations and using strategies to reach a new level of adjustment. Jenks (23) posits that polyamorists and swingers are pushed to communicate and find new coping methods as no social norms exist. The polyamorous participants appear to have fared better, which could partially be explained by a greater distribution of resources between the parents. This is similar to the findings reported in the Pallota-Chiarolli study (12), wherein polyamorous parents were better able to reconcile their various roles (lover, partner, parent), had more time for themselves, and had less stress relating to household tasks and childrearing.

In regard to the PSCS, two aspects are noteworthy: first, the participants' scores for the PSCS were higher compared to previously published studies (16,30); and second, the female participants had higher scores than the men. For the first aspect, it appears that the participants' higher PSCS scores may be attributed to the support that they received, either with secondary partners or from others in their social network. This aspect warrants further investigation as to how this support occurs in the context of parenting consensual non-monogamy. For the second aspect, the female participants identified with the parenting role during their pregnancies, whereas the men did so when their children were about 12 months of age.

These findings are similar to those reported by Condon and colleagues (31), in which fathers integrated their parenting role later than the mothers. Also, fathers incorporate the parenting role more when they feel like better partners.

When comparing the qualitative results with the quantitative PSCS ones, the participants' parenting satisfaction was lower when they had PPD and/or a high-needs child. Ross and collaborators (32) found that plurisexual parents with greater levels of PPD attributed it to minority stress, decreased parenting self-efficacy, and lack of social support. Plurisexual individuals appear to be at significant risk of being excluded both by their heterosexual counterparts and sexual minority communities, which in turn, affects their mental health during the transition to parenthood (33).

Emotional intimacy. The study participants reported a decline in their emotional intimacy in the initial postpartum period, with a gradual return to it (9). Similarly, they were trying to find a way to integrate their parenting role with their other roles of lover and partner. This sample had additional stressors, as they had to deal not only with multiple gestation and multiple pregnancy losses, but also with PPD and/or having a high-needs child. Since the participants are PCNMs (3), they seem to be better able to recognize this emotional decline and reach out to their partners to rebuild their relationship. Although there was a dip in the participants' emotional intimacy after the birth of their children, as demonstrated by the qualitative results, the quantitative results indicate that the participants had a higher level of conjugal satisfaction.

The participants demonstrated a higher level of resilience, which could partially explain these findings. Additional resilience was established when there was the presence of a secondary partner. Resilience theories gather around two critical components: a significant threat or stressor and positive adaptation to the situation despite the threat or stressor (34). The transition to parenthood is considered stressful in itself, so any changes that the participants may have experienced in emotional intimacy with a return to a positive level, may be partially attributed to their resilience (3,35).

Sexual intimacy. The participants experienced physical discomfort during pregnancy and early postpartum (9). Even though some of them did experience birth trauma, which affected their capacity for intimacy, they did bounce back, demonstrating resilience (34). When looking more closely at the participants' scores in relation to perceived levels of sexual intimacy, their scores showed higher levels of sexual intimacy than previously published studies (17). As expected for most partners during the postnatal period, the potential decline would either appear not to have happened or could have happened but remained higher than the average.

When considering the qualitative and quantitative results together, PCNMs appear to be better prepared for the transition to parenthood, seem more aware of the sexual changes associated with this transition, and do not appear to experience the same period of non-sexuality (9). In the initial postpartum phase, it appears that PCNMs do not partake in the lifestyle because of the physical changes associated with childbirth and the decreased libido related to breastfeeding. Sexual activity during the first postnatal year was more vanilla, and participants decided to practice CNM and BDSM away from their home. Consensual non-monogamists have a higher level of sexual satisfaction, even during the transition to parenthood (22).

PCNMs in this study seem to place greater emphasis on sexual intimacy during the transition to parenthood. They have a greater ability to communicate their sexual desires and needs to their partner(s).

Communication. The participants used communication as a way to regain emotional and sexual intimacy and to strike a balance between the roles of lover, partner and parent. Changes and challenges with communication can be expected during the transition to parenthood as parents' roles change (8). Three dimensions are salient to the conciliation of roles during the transition to parenthood: role expectations, role enactment, and role negotiation (36). Communication is needed for all three dimensions. During this transition, most parents initially focus on their new role of parent to the detriment of their other roles of lover and partner (37). Because new parents usually prioritise the role of parent over those of lover and partner postnatally, there is often a decrease in emotional and sexual intimacy and communication (3,8). However, the findings from this present study suggest that PCNMs chronologically concentrate on the role of parent, followed by the role of lover and then, that of partner.

Although the study participants reported stress and disorganization after the first child's birth (8), their communication was still distinct in three ways. First, the participants recognized the importance of communication as they were more aware of their communication skills. Putting their advanced communication skills into practice empowered these parents to overcome the challenges faced with PPD and/or having a high-needs child. Second, these advanced communication skills could have stemmed directly from their 'lifestyle'. Individuals who uphold CNM need good communication in order to consult with each other before,

during and after a CNM encounter, with a potential spillover effect for their parenting (3). Third, as part of the 'lifestyle', the participants had to do regular check-ins. Through this transparency, it appears that their desires and needs were easily identified, enabling them to not only share them with each other but also to support them. Consequently, these combined skills helped to better equip the participants in their roles of lover, partner, and parent, increase their satisfaction with their relationship and help them navigate more than one person as a partner and more than one relationship.

Strengths and Limitations

This study contributes to the growing body of perinatal health nursing research that examines CNM associated with the four phases of the transition to parenthood: preconception, pregnancy, birthing and parenting. The breadth and depth of the data analyses were demonstrated through the comprehensive results obtained for this study. However, the goal of this study was not to generalise, but to gain a greater understanding and contextualization of the transition to parenthood for PCNMs. This greater understanding and contextualization were particularly meaningful, as they were supported by the application of the conceptual framework that relied on the EMERJ lens (13) and enhanced by Cowan and Cowan's Ecological Model (8).

Implications for Nursing Education, Practice and Research

Although this study was exploratory and descriptive and did not seek to generalize, several recommendations and/or implications emerged from the findings for nursing education, practice, and research.

Nursing education. It is recommended that parenting CNM should be part of the undergraduate curriculum in perinatal health nursing for the theory and clinical practicum courses. The clinical practicum usually includes a learning laboratory, simulations, and placement in a healthcare facility. Students can become more aware of this particular group of parents, better understand their needs, and learn how to intervene clinically. Concretely speaking, content can be added to the theory and clinical practicum courses, including post-clinical conferences, that focuses on the four phases of the transition to parenthood, and on this particular group of parents' intimacy (emotional and sexuality) and communication. Training in human sexuality that includes parenting CNM can also be extended for continuing perinatal health nursing education through conferences, webinars, workshops, and podcasts (14).

Nursing practice. PCNMs may disclose their sexual lifestyle to perinatal health care providers including nurses who demonstrate support, empathy, and cultural safety. Cultural safety requires these providers to reflect on the structures in place that assumes heteromononormativity. It is recommended that frontline nurses and other HCPs integrate a cultural safety approach with this group of parents: these providers through educational sessions would learn to recognize their own assumptions about their clients based on sex, sexual orientation and sexual practices, age, gender, race, relationship status, ability, socioeconomic status, and other aspects (37).

The findings also suggest that PCNMs require a different clinical approach: the participants in this particular study were well-versed in the health risks involved with their lifestyle, and were more likely than their monogamous counterparts to deliberately plan their families, and to ask questions on how their lifestyle could influence the first phase of the transition to parenthood (decision to be a parent). Perinatal nurses would be better prepared and equipped to have more open communication and discussion with these clients and their partner(s), in order to talk about these health risks for themselves and their children (unborn and born), thereby increasing their knowledge, and consequently, their resilience. Acknowledging additional relational partners promotes a more family-centred approach to care for all concerned parties. It is therefore recommended that continuing education should be offered to perinatal health nurses, in order to raise their awareness of the growing diversity of families, including sexuality diversity families. With these changes, PCNMs will feel more encouraged to access perinatal health care services throughout the transition to parenthood, thus resulting in better perinatal health outcomes.

Nursing research. Further research is warranted with this particular group of parents by using bigger samples, replicating the study in other parts of Canada and in other languages such as French. The use of other conceptual frameworks such as intersectional theory is suggested for future studies as well as more participatory approaches, bringing the voices of PCNMs to the forefront (39).

Conclusion

From the study findings, perinatal health nurses can better understand PCNMs, who are unique yet are just like other parents. Despite the challenges the participants faced regarding the four phases of the transition to parenthood and the adjustments in intimacy and communication, they managed to keep the connection in their relationships. It appears that this sexuality diversity group has an underlying resilience that helps them cope with parenthood and modify

their sexual lifestyle. All perinatal health care professionals, including nurses, need to know that 'family comes first' for these parents.

Ethical Permissions

Ethics approval was obtained from the University of Ottawa Research and Ethics Board in Ottawa, Canada (Ethics File Number H05-17-05). All study participants provided informed consent, and their anonymity was preserved.

Conflict of Interest

The two authors do not have any conflict of interest to report.

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