

TOWARD GUIDELINES FOR PSYCHOLOGICAL PRACTICE WITH CONSENSUALLY
NON-MONOGAMOUS CLIENTS: RESULTS FROM A MIXED-METHOD ANALYSIS OF
THERAPY PRACTICES AND OUTCOMES

By

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Abstract

An estimated 4-5% of Americans endorse being in a consensually non-monogamous (CNM) relationship--numbers comparable to those identifying as lesbian, gay, or bisexual (LGB; Conley, Moors, Matsick, & Ziegler, 2012; Gates, 2011). Despite the pervasive stigma associated with CNM, it is considered healthy and viable romantic relationship option (Conley, Ziegler, Moors, Matsick, & Valentine, 2013; Rubel & Bogaert, 2014). Therapists, however, receive little to no training about CNM or the CNM community (Weitzman, 2006). Two hundred forty-nine individuals in CNM relationships responded to open and closed-ended survey questions about their experiences with past and current therapists. Of the therapists seen by CNM clients, nearly one-third (29%) were found to be lacking the basic knowledge of CNM needed to be an effective therapist, and only one in four (27%) were considered quite knowledgeable of CNM. Around one-quarter (26%) of the therapists seen were found to be either not at all helpful (15%) or destructive (11%) and approximately one in ten (11%) CNM clients prematurely terminated sessions because of a negative interaction with their therapist regarding their CNM identity/lifestyle. These results highlight the need for promoting awareness of CNM issues and creating empirically-based guidelines that could be included in mental health curricula and continuing education training. Resources developed for use with LGB clients may be helpful in developing CNM guidelines. In this study, swapping sexual orientation language for relationship orientation language (e.g., heterosexual for monogamous) on practice guidelines for LGB clients, led to the creation of a 13-item scale that accounted for half (50%) of the variance in therapist helpfulness scores for CNM clients. In light of the findings and available research, an initial set of empirically based guidelines for psychological practice with CNM clients are proposed.

Key words: consensual non-monogamy, psychotherapy, therapy outcomes,
psychotherapy treatment guidelines, sexual minorities

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Chapter 1: Introduction to the Study

Consensual non-monogamy (CNM) is a relationship type in which all partners mutually and ethically agree to allow romantic and/or sexual relationships with others outside the relationship (Conley, Moors, Matsick, & Ziegler, 2012). This is in contrast to monogamy, where relationship partners agree to romantic and sexual exclusivity, and is also in contrast to infidelity, where an individual has additional romantic partner(s) without their partner's consent. While some regions and countries (such as Scandinavia) hold more relaxed views towards consensually non-monogamous (CNM), most Western countries strongly disapprove of relationship agreements that permit any type of sexual or romantic contact outside of the primary relationship (Buunk & Dijkstra, 2000; Lawson & Samson, 1988; Thornton & Young-DeMarco, 2001). Individuals engaged in CNM relationships are seen as lower in relationship quality, less trusting, more jealous, and more sexually risky (Conley, Moors, et al., 2012; Moors, Matsick, Ziegler, Rubin, & Conley, 2013), despite a lack of evidence verifying these perceptions (Rubel & Bogart, 2014).

Research examining the experience of lesbian, gay, and bisexual individuals suggests that the psychological problems experienced by many sexual minorities are the result of experiencing a hostile and derogatory societal environment (Alexander, 1986; Herek, 2009a; Meyers, 2007). While research on consensual non-monogamy has been on the rise lately (Barker & Langdrige, 2009, 2010) little is known about the impact CNM stigma has on mental health outcomes and/or how it is impacting the quality of the treatment provided to CNM clients. Weitzman (2007), however, suggests that individuals in CNM relationships experience social disapproval similar to that experienced by members of the lesbian, gay, and bisexual community. To date, little

guidance is available on best practices for working with CNM clients (McCoy, Stinson, Ross, & Hjelmstad, 2015) and clinicians typically do not receive training on issues facing the CNM community (Weitzman, 2006), leaving clinicians susceptible to perpetuating stigma and demonstrating prejudiced mono-centric beliefs and practices towards their CNM clients. CNM clients seeking mental health services are tasked with finding culturally competent care within systems that, in many cases, may not be prepared to adequately address their concerns.

Problem Statement

In the past decade, literature to guide clinicians in their work with CNM persons has started to be published (e.g., Girard & Brownlee, 2015; Richards & Barker, 2013; Weitzman, 2006; Weitzman, Davidson, & Phillips, 2012; Zimmerman, 2012). Most of the and literature examining CNM has relied on qualitative interviews (Rubin, Moors, Matsick, Ziegler, & Conley, 2014) and it has been over three decades since the therapeutic treatment of CNM persons has been examined at a quantitative level (see Knapp, 1975; Hymer & Rubin, 1982). Given the stigma and size of this population (4-5% of the population; Moors, Conley, Edelstein, & Chopik, 2014), failure to consider research questions on this topic overlooks the welfare of individuals who may represent a sizable minority of those accessing mental health services.

The American Psychological Association (2012) recently created guidelines for psychological practice with lesbian, gay, and bisexual clients, and is in the process of creating guidelines for psychological practices for transgender and gender non-conforming (TGNC) clients (APA, 2015). The current project uses quantitative and qualitative methods to examine which practices are most and least helpful when working with CNM clients. This data is then used in conjunction with the available CNM data and gender and sexual minority data to create a set of empirically-based guidelines for psychological practice with CNM clients.

Chapter 2: Literature Review

Definition of Terms

A number of terms pertaining sexuality, relationships, and gender are used throughout the text.

For the sake of clarity, a few of the terms are reviewed in the following section.

Consensual non-monogamy.

Consensual non-monogamy (CNM) is a relationship agreement where those involved openly agree to allow more than one concurrent sexual, emotional, and/or romantic relationship (Conley, Ziegler, et al., 2013). CNM is distinct from monogamy (having one sexual/romantic partner) and infidelity (having separate sexual, emotional, or romantic relationship/s without consent). The current paper will specifically address four types of CNM relationships: polyamory, swinging, monogamish, and open relationships. CNM will be used to refer to all four relationship types. Special attention will be given to polyamory, however, as the majority of the sample self-identified as polyamorous.

Polyamory.

Polyamory is a relationship agreement allowing both sexual and romantic (love) involvement with multiple partners. There are also a number of possible multi-partner arrangements that are likely to vary in closeness, intensity, and commitment. To many who practice polyamory, emotionally intimate relationships that are not sexual are also considered polyamorous (Klesse, 2006; Deri, 2011). The emphasis of polyamory is not put on sexual promiscuity and it is not considered a sanctioned form of group sex as individuals may choose to have sexual encounters with all, some, or none of their partners (Easton & Hardy, 2009). While there is not one uniform way to practice polyamory (McCoy, Stinson, Ross, & Hjelmstad, 2015),

some of the more common polyamorous arrangements include having one or two “primary” partners (often the central or longest standing partner/s) and one or more “secondary” partner/s, triads (e.g., where three people are in a committed relationship with each other), and quads (e.g., two couples in a relationship with each other, Barker, 2005b). Over the past ten years, this relationship format has received considerable attention in the social sciences (e.g., Barker, 2005b; Klesse, 2006, 2014; Noël, 2006; Robinson, 2013; Sheff, 2005, 2006). There has been a growing interest in this relationship format recently, as demonstrated by the surge in articles appear in social science literature on the topic (e.g., Barker, 2005b; Klesse, 2006, 2014; Noël, 2006; Robinson, 2013; Sheff, 2005, 2006).

Swinging.

Comarital sex, more popularly known as swinging, refers to married couples exchanging partners solely for sexual purposes (Buunk & van Driel, 1989). Thus, this type of CNM relationship typically involves only sexual (i.e., not emotional) activities outside a primary relationship. Swingers often report that their primary reasons for becoming involved in swinging are for the variety of sexual experiences, pleasure, and excitement (see Jenks, 1998, for a review). This type of CNM relationship has been, by far, the most extensively empirically researched (e.g., Bergstrand & Sinski, 2010; Jenks, 1998; Visser & McDonald, 2007).

Open relationships.

Although open relationships are sometimes presented in the literature as the overarching term for non-monogamous relationships (e.g., Kurdek & Schmitt, 1986), the meaning of this type of relationship has changed. More recently, open relationships have been defined as a close corollary to swinging relationships, where couples desire to have only sexual (not romantic or emotional) relationships with someone other than their “primary” partner. However, unlike

swinging couples, those in open relationships typically pursue outside partners independently (i.e., not together at a “swing” type event). Despite the difference in definitions between the types of CNM, common themes among them are open communication, honesty, negotiation, and consensus about the terms of the relationships (Barker, 2005b; Jenks, 1998; O'Neill & O'Neill, 1972).

Monogamish.

Monogamish is a romantic relationship defined by some degree of openness to sexual/emotional relationship outside the couple (Berry & Barker, 2013). Coined by sex blogger Dan Savage, in this relationships type, a couple may identify as being mostly monogamous but have an agreement to allow occasional exceptions for certain types of sexual play (Savage, 2011). Notably, this term has begun to pick up in mainstream use (Luscombe 2014; Oppenheimer, 2011) and has been conceptualized as an open relationship format that is more accessible to the masses and an antidote to divorce (TED^x, 2015).

Sexual orientation.

Sexual orientation will be used to refer to the sex of those to whom one is sexually and/or romantically attracted. The categories used to describe sexual orientation sub-groups have historically been separated by attraction to members of one's own sex (lesbians or gay men), attraction to members of the other sex (heterosexuals), and attraction to members of both sexes (bisexuals). Despite the fact that these categories continue to be widely used, a growing body of research indicates that sexual orientation does not always emerge in clearly definable categories, and instead presents on a continuum (Klein, 1993; Klein, Sepekoff, & Wolff, 1985; Shively & De Cecco, 1977). In addition, some research indicates that sexual orientation is fluid for some

people, with women expressing this more often than men (Diamond, 2007; Golden, 1987; Peplau & Garnets, 2000).

Relationship orientation.

Relationship orientation will be used to refer to the type of relationship structure and/or number of preferred romantic or sexual partners. For the purposes of this paper, relationship orientation is considered similar to but distinct from sexual orientation. The categories used to describe relationship orientation sub-groups have historically been separated by attraction to one partner at a time (monogamous), and more than one partner at a time (polyamory, swinging, open relationships, monogamous).

Relationship structure.

Relationship structure will be used to refer to the actual agreements in a relationship. The common types of relationship structures (i.e., monogamy, polyamory, swinging, monogamish, and open relationships) are described above. Relationship orientation and relationship structure may be used interchangeably when a distinction is not considered necessary.

Compersion.

Compersion is often described as the opposite of jealousy (Durma, 2009), or feeling joy that one's partner is sharing closeness with another person (Polyamory Society, 2015). Ritchie and Barker (2006) describe how compersion is one of the terms to emerge because individuals in CNM relationships are restrained to by conventional mononormative language regarding partnerships, infidelities, and jealousy, and alternative language was needed in order to accurately capture polyamorous identities, relationships, and emotions.

Kink.

The term kink is used to describe unconventional sexual practices or concepts. It is often used to contrast conventional or ‘vanilla’ sexual expressions. Kinksters refers to people involved in non-normative sexual expressions and relationships that often involve bondage/discipline, dominance/submission and/or sadism/masochism (also referred to as sadomasochism; Sheff & Hammers, 2011).

Coming out.

Coming out refers to the process through which an individual acknowledges and accepts their own sexual, gender, or relationship preferences/orientation. It also includes the process one experiences when disclosing their preferences/orientation to others. The term *closeted* is used to refer to situations where an individual chooses to maintain secrecy or cautious privacy regarding one their sexual, gender, or relationship preferences/orientation.

Sex/biological sex.

Sex will be used to refer to a person’s biological status, which is typically categorized as male, female, or intersex (i.e., atypical combinations of features that typically differentiate female from male). There are many indicators of biological sex, including sex chromosomes, external genitalia, internal reproductive organs, and gonads.

Gender.

Gender will refer to the attitudes, feelings, and behaviors that a culture links with a person’s biological sex. Behavior that is aligns with cultural expectations will be referred to as gender normative, while behaviors that are viewed as discordant with these expectations is considered gender nonconformity.

Gender identity.

Gender identity will be used to refer to an individual's sense of self as male, female, or transgender. When an individual's gender identity and biological sex are not congruent, the individual may identify as transsexual or as another trans-gender category.

Gender expression.

Gender expression will be used to refer to the way someone behaves to communicate gender within their culture. This may be expressed through means such as actions, interests, or clothing. It is not assumed a person's gender expression will necessarily be congruent with their socially assigned gender role or gender identity. Gender expression will be used as a variable title instead of sex or gender, as one's gender expression is considered more salient and more observable. Since most studies acquiring gender-related demographic data do not distinguish between sex, gender, gender identity, and gender expression, it is assumed gender expression will adequately address the construct intended by the authors.

Gender and sexual minorities.

Gender and Sexual Minorities (GSM) will be used to broadly refer to individuals who identify as nonconforming in any number of gender and/or sexual domains. This includes but is not limited to sub-groups identifying as lesbian, gay, bisexuality, trans*, queer, intersex, asexual, consensual non-monogamous, dominant-submissive sex (i.e., "kink," BDSM [bondage, discipline, sadomasochism], "leathersex," and, "S&M."

Prevalence of CNM

Acquiring an accurate, statistically representative sample of the CNM population is a challenging task for a number of reasons. To access the CNM community, researchers typically have to rely on internet samples or word of mouth to recruit participants, which do not provide a

true random sample or access the actual range of people who identify or practice CNM. While the Internet is relatively accessible, online samples are still subject to being skewed toward white middle class individuals who have reliable access to Internet services and are able to access CNM sites and surveys in the privacy of their home, and are not restricted by filters on public library servers (Rubin, Moors, Matsick, Ziegler, & Conley, 2014). Further adding to the complexity is the fluid nature of an individual's relationships. Many authors have described how agreements are often influenced by contextual circumstances and how individual labels and identities may evolve over time (e.g., Easton & Hardy, 2009; Taramino, 2008). Someone who identifies as non-monogamous, for example, may currently be single. A couple that recently moved or had a child may also decide to temporarily adapt a monogamous agreement or simply be behaviorally monogamous due to a lack of desirable partners. While circumstances may not necessarily change how an individual identifies, in some circumstances, it might. There is also likely to be differences within and between CNM sub-groups. Polyamorists, for example, express differing perspectives about whether polyamory should be considered an identity or lifestyle (Tweedy, 2011). While no data could be found to clarify, there are likely differences in the percentage of individuals identifying as polyamorous, for example, who embrace CNM as an identity compared to individuals identifying as swingers.

Behavior is clearly not the only aspect that dictates an individual's relationship orientation and depending on how the question is asked (i.e., are you currently in a CNM relationship vs. do you identify as non-monogamous) makes a difference. A couple, for example, may allow periodic deviations from monogamy but still identify as monogamous (Moors, Conley, Edelstein, & Chopik, 2014). While openly non-monogamous relationships may be rarer, there is evidence to suggest that private CNM arrangements within relationships

are much more common. Cole and Spaniard (1974) found that seven percent of heterosexual couples engaged in CNM, but only 1.7% of couples embrace the open relationship label.

Blumstein and Schwartz (1983) conducted one of the first large scale studies addressing the prevalence of CNM when they asked over 6,000 couples whether or not they had an agreement that allowed sex outside of their relationship. The authors estimated that 15-28% of heterosexual married couples had an agreement that permitted extramarital sex under certain circumstances, but did not report how many embraced a CNM label.

In 2002, 18% of women and 23% of men were found to be participating in non-monogamy according to a representative sample conducted by the National Survey of Family Growth (NSFG; Aral & Leichter. 2010). While the NSFG survey suggest that an estimated 19 million Americans engage in non-monogamy, the numbers may not be reflective of those participating in CNM as their definition defined non-monogamy as having at least one sexual partner outside of their primary relationship within the past year. The authors did not mention whether these participants identified as being in a CNM relationship or if all partners were aware of and consenting to the relationship agreement, a necessary aspect of the current paper's definition of CNM.

In a recent, non-targeted poll of North Americans inquiring about participant relationship structure, Conley, Moors, Matsick, and Ziegler (2012) found that between 4-5% percent of participants were currently involved in a consensually non-monogamous relationship. Notably, these numbers may not capture participants who do not identify with CNM but allow deviations from monogamy (e.g., couples who periodically engage in a threesome). There is evidence to suggest that a sizeable number of individuals who have never engaged in CNM are interested and would be willing to try a non-monogamous relationship agreement (Moors, et al., 2014).

For example, YouGov/Huffington Post conducted a structured random sample of 1,000 US adults (interviewed from a pool created to mirror the actual population). They found that approximately 3% of participants were currently in an open relationship while an additional 10% said they were in one in the past (Moore, 2015). However, 14% of their participants said they would consider being in an open relationship and an additional 13% said they were not sure if they would consider an open relationship.

By way of comparison, non-targeted polls inquiring about sexual orientation typically hover around 3.5% of the North American population identifies as lesbian, gay, bisexual, or transgender (Black, Gates, Sanders, & Taylor, 2000; Gates & Newport, 2012). In a report published by Gates (2011), 1.8% of the population identified as bisexual, compared to 1.7% who identify as lesbian or gay, and 0.3% of adults identified as transgender. Similar to CNM, there are many individuals who engage in same-sex encounters but do not identify as lesbian, gay, or bisexual. Gates noted that 8.2% of Americans reported that they have engaged in same-sex sexual behavior and nearly 11% (nearly 25.6 million Americans) acknowledge at least some same-sex sexual attraction. The comparable size of the CNM and LGB communities suggests that the extent to which LGB individuals are extended rights because of the number of people identifying with or experiencing same-sex attractions, CNM individuals should not be afforded similar rights (Conley, Moors, Matsick, & Ziegler, 2012).

CNM Demographics

Despite CNM being described as a progressive relationship type that is fit for anyone (e.g., Haritaworn, Lin, & Klesse, 2006), most of the available research, mainstream media, and self-help books portray the CNM population as being rather homogeneous (e.g., Bennett, 2009; Noël, 2006; Sheff & Hammers, 2011). In their review of 36 CNM articles, Sheff and Hammer

(2011) found a mostly uniform samples of white, educated, middle- and upper-middle-class professionals with primary partners. In a sample of 81 polyamorists, Sheff (2005) found that approximately 89% identified as white, between ages 35 to 55, middle to upper class, and college educated. Swinger samples typically reveal similar demographics, with most (approximately 90%) identifying as white, between ages 28 to 45, with above average education and income levels (Jenks, 1985; Levitt, 1988). In a non-random sample of 126 individuals identifying with a number of CNM relationship types, Taramino's (2008) sample was mostly white (77%), mostly female (52%), bisexual (38%), kinky-identified (51%), polyamorous-identified (54%), having one primary partner (68%), and unmarried (54%).

The homogeneity of the CNM population has been called to question, however. According to Rubin, Moors, Matsick, Ziegler, and Conley (2014), the homogeneity may be a product of community-based recruitment strategies that create an inaccurate reflection of people who engage in CNM. This group compared the descriptive statistics of those in CNM relationships and those in monogamous relationships and found that people of color and White individuals were equally likely to take part in monogamous and CNM relationships. Their study was the first to indicate that White individuals were *not* disproportionately represented in CNM relationships. Furthermore, they contend that the biased sampling methods may be recreating the racially homogeneous stereotype associated with CNM.

CNM and sexual minorities.

There is evidence to suggest that CNM relationships may be more common and acceptable among gay, lesbian, and bisexual individuals. For example, Blumstein and Schwartz (1983) reported that 15–28% of heterosexual married couples had an understanding that allows non-monogamy under agreed upon circumstances, compared to 65% of gay men and 29% of the

lesbian women in their sample had this type of arrangement. CNM relationship agreements also appear to be more common amongst gay men and bisexual individuals than is typical for lesbians or heterosexuals (Herek, 1991; McWhirter & Mattison, 1984; Peplau, 1991). Consensual forms of non-monogamy appear to have been a part of gay male culture for at least the past five decades (Bettinger, 2005; Bonello & Cross, 2010; Klesse, 2007; Shernoff, 2006) with estimates of gay males' involvement in CNM ranging from 30% to 70%, leaving the actual prevalence rate to remain unclear (Bryant & Demian, 1994; Campbell, 2000; LaSala, 2005).

Bisexual individuals, however, may be more likely than lesbian or gay persons to be in a CNM relationship and to view polyamory specifically as an ideal relationship type (Rust, 1996; Weitzman, 2007). Moors, Rubin, Matsick, Ziegler, and Conley (2014), however, challenged this conclusion with their finding that female sexual minorities hold similar attitudes and desire to partake in CNM relationships just as much as male sexual minorities. Any gender differences observed may be due women being less likely than men to pursue CNM and/or report being involved in a CNM relationship because of the sexual double standard (i.e., women tend to be judged more punitively than men for engaging in the same sexual behaviors).

A number of authors have highlighted the number of bisexual women and men that are attracted to non-monogamy (e.g., Klesse, 2005, 2006; McLean, 2004; Rodríguez-Rust, 2000; Rust, 1996; Weitzman, 2006). One of the larger studies focusing on bisexuals includes Page's (2004) sample of 217 bisexual-identified participants, of whom, one in three (33%) were involved in a CNM relationship. In another sample of 576 bisexual identified participants, Brewster and Morardi (2010) found that 222 (39%) identified as polyamorous. These studies align with the most studies collecting data for both sexual and relationship orientation data, which routinely find between 30-40% of bisexual participants also identify as non-monogamous.

The higher prevalence of CNM may be due to CNM being more acceptable in the LGB community than it is in the heterosexual community, which may account for why non-heterosexuals are statistically more apt to pursue it.

The Intersection of CNM and the Gender and Sexual Minority Community

The movement that started with promoting the rights of individuals identifying as lesbian or gay led to other sexual subcultures becoming increasingly more organized, visible, and vocal about issues of equality. The larger GSM community has come to include additional subcultures, such as bisexuality, trans*, queer, intersex, asexual, consensual non-monogamy, and dominant-submissive sex (i.e., “kink,” BDSM [bondage, discipline, sadomasochism], “leathersex,” and, “S&M”; Nichols & Shernoff, 2007). There are clear and distinct differences that make each community unique, as well as some overlapping experiences that may be shared widely between GSM sub-cultures (i.e., experiencing societal stigma, coming out concerns, general minority stress, etc.). The concept of consensual non-monogamy has been found to resonate with critiques of compulsory monogamy in many non-conforming milieus, including feminist, leftist, lesbian, gay male, bisexual, transgender, BDSM and queer activism (Klesse, 2011). Yet, consensual non-monogamy’s fit in the GSM community is a topic of some debate.

According to Warner (1999), if there is a political divide in the GSM community, it is between those who emphasize inclusiveness and assimilation, and those who promote the importance of separatism and fostering differences. Arguments are currently being made over the biological, psychological, and social influences dictating whether CNM should be considered a sexual orientation (Tweedy, 2011; Klesse, 2014), relationship practice (Lano and Parry Lano, 1995), theory, (Emens, 2004), a philosophy, a relationship orientation (Anapol, 2010), or identity (Barker, 2005b).

Regardless of how CNM is conceptualized, it remains clear that many in the CNM community identify with the larger GSM community (Barker, 2005a, 2005b; Kassoff, 1989; Lasala, 2001; McLean, 2004; Ritchie & Barker, 2007, Sheff & Hammers, 2011) and many of the challenges faced are shared across communities. Weitzman (2007), for example, suggested that individuals engaged in consensual forms of non-monogamy experience social disapproval similar to that experienced by members of the lesbian, gay, and bisexual community. Other shared experiences include visibility management, potential for children may be bullied, marital/partnership rights, discrimination based on moral or religious grounds, extended family consequences/conflict, parental participation challenges at school, housing discrimination, within group issues, and difficulty finding community (Twist, Haym, Iantaffi, & Prouty, 2015).

Rather than ignoring broader GSM resources, they will be utilized and referenced, all while seeking to celebrate the unique aspects of each individual community. Grouping them together is not an effort to erase or ignore the significant differences, but to promote solidarity. Therefore, the current paper will pull from the larger body of GSM research where there are gaps in the CNM literature, while fully acknowledging that the research may not generalize directly or precisely to the CNM community.

A Note about CNM Relationship Types

While there are clearly distinguishable differences (per their definitions) in the CNM relationship structures highlighted (i.e., polyamory, swinging, monogamish, and open relationships), I will be focusing on the similarities and investigating non-monogamies as a whole. Frank and DeLameter (2010) addressed how conceptualizing polyamory as superior to more “pleasure focused” non-monogamies (i.e., swinging and open relationships) has created normative boundaries within sexual subcultures. For example, Klesse’s (2006) study of lesbian,

gay, and bisexual men and women in CNM relationships revealed rhetoric that differentiated between the “good polyamorist” and “promiscuous swinger” as a means of reinforcing the ideological differences between two CNM relationship types. Due to the difference in social perceptions and individual experiences, it cannot be assumed that all CNM clients will have similar experiences. The common presenting concerns may be substantially different, for example, between CNM subtypes.

While it important to articulate differences among the CNM sub-groups, privileging certain forms of non-monogamy serves to reinforce the moralization of traditional sexualities, which is perceived to be what fuels that stigmatization of forms of non-monogamy. In order to delineate any form of hierarchy amongst forms of ethical non-monogamy, Rubin, Moors, Matsick, Ziegler, and Conley (2014) suggested that relationships should be conceptualized on a monogamy spectrum, with some relationships falling strongly on the monogamous end of a continuum (e.g., even thoughts of being attracted to another person is not acceptable) and others falling on the consensually non-monogamous end (e.g., having explicit agreements with partners to engage in more than one sexual/romantic relationship). The current paper will adopt this perspective, where consensual departures from monogamy—regardless of whether they are sexual or romantic in nature—are considered having more similarities among one another than with they do with monogamy.

Perceptions of Consensual Non-Monogamy

In a number of subtle and overt ways, contemporary US culture privileges monogamous relationships and frequently fails to acknowledge or anticipate relationship structures that deviate from conventional forms (Moors & Schechinger, 2014; Mint, 2006). In their examination comparing public perceptions of monogamous versus CNM relationships, three studies

conducted by Conley, Moors, Matsick, and Ziegler (2012) revealed that most Americans overwhelmingly view monogamy as positive and stigmatize CNM. In their series of studies using different methods to compare CNM and monogamous relationships, CNM relationships (and the individuals involved) were consistently rated as less acceptable, lower in relationship quality, less sexually satisfied, sexually riskier, and lonelier than the monogamous relationship. Participants also rated the individuals in the monogamous relationship more positively on arbitrary qualities such as being more likely to floss their teeth daily. It was suggested that people might have rated the CNM participants lower because participants assumed they sought out CNM because they were unsatisfied in their relationship. The authors ran a follow up study to test this and explicitly stated that that the individuals CNM relationship were happy and found that the results did not differ (Moors, Matsick, Ziegler, Rubin, & Conley, 2013).

A common misconception is that individuals in CNM relationships are more inclined to contract sexually transmitted infections (STIs; Munson, 1999; West 1996; Weitzman, 2007). Weitzman (2007) found that 25% of her CNM participants (n = 1,944) had been diagnosed with an STI, which is comparable to the 17% of monogamous participants who indicated they had been diagnosed with an STI in a study by Michael, Gagnon, Laumann, and Kolata (1994). Notably, of the 25% in Weitzman's (2007) study who acknowledged having an STI at some point, two-thirds reported it was before they became non-monogamous. Weitzman concluded that her findings suggest that it is not the number of partners as much as the level of adherence to safer sex practices that dictates whether or not STIs are transmitted. Conley, Moors, Ziegler, and Karathnsis (2012) also found that sexually unfaithful individuals (in supposed monogamous relationships) engage in more risky sexual behaviors with extradyadic partners than people who have consensual agreements to engage in non-monogamy.

Lehmiller conducted a study directly comparing the STI rates of individuals in monogamous and CNM relationships and found that despite having about 40% more lifetime sex partners (average of 6.4 vs. 3.9 respectively), people in CNM relationships were not more likely to have an STI. While approximately three out of four of Lehmiller's CNM participants currently had multiple partners, nearly one in four of the (supposedly) monogamous participants did as well. This is likely what led to comparable rates of ever having an STI before (approximately 1 in 5 for each group), as the majority of the monogamous participants did not disclose their infidelity to their partner, and were less likely to use condoms with all their partners (primary and secondary) and were less likely to have ever been tested for STIs than the CNM participants. Regardless of the data, the stereotype that sex with multiple partners leads to STIs is still pervasive (Conley, Moors, Matsick, & Ziegler, 2012; Rust, 1996).

Stigma, as defined by VandenBos (2007), is a negative social attitude or social disapproval directed toward a characteristic of a person that can lead to prejudice and discrimination against the individual. The results of the Conley study revealed that participants viewed CNM relationships (and the individuals involved) as less committed, less trusting, less meaningful, less socially acceptable, less "in love," lower in trust, less sexually satisfied, more jealous, sexually riskier, and lonelier than the monogamous relationship. Participants also perceived the individuals in the CNM relationship more negatively on irrelevant qualities (e.g., floss teeth daily) than the individuals engaged in monogamy, indicating the robustness of the stigma.

Despite the stigma directed towards CNM relationships, a growing body of literature suggests that individuals engaged in these alternative romantic partnerings are in fact happy, well-adjusted, and satisfied (e.g., de Visser & McDonald, 2007; Jenks, 1998; Knapp, 1976;

Ritchie & Barker, 2006). Non-monogamous couples have also been found to have normal levels of marriage satisfaction and self-esteem (Buunk, 1980), and to have equivalent relationship longevity as monogamous couples (Rubin & Adams, 1986). Security (in terms of attachment) was also found to be more prevalent in CNM relationships than monogamous relationships (Moors et al., 2014). CNM relationships also appear to offer unique benefits that are not as common in monogamous relationships, including large social networks, sexual variety, feelings of compersion (an emotion described as the opposite of jealousy), and personal growth (Schechinger & Moors, in preparation).

Hosking (2013) interviewed 229 partnered gay men and concluded that adhering to the agreed upon conditions of a relationship is more important than the nature of the agreement (i.e., whether monogamous or non-monogamous). The men in their study who broke the relationship agreement tended to experience lower overall relationship quality regardless of relationship agreement. They also found that open relationships did experience less passion, but just as intimate and committed as monogamous and “threesome-only” relationships.

Researchers have also used psychological assessments to examine the mental health of CNM individuals. Watson (1981) as well as Kurdek and Schmitt (1986) administered the California Psychological Inventory and Symptom Checklist to CNM individuals and both concluded that there were no significant differences between the CNM and monogamous groups.

In their systematic review of the assumed benefits of monogamous relationships, Conley, Ziegler, Moors, Matsick, and Valentine (2013) concluded that that evidence does not indicate that monogamy affords individuals superior benefits relative to CNM, and that for those who choose it, consensual non-monogamy should be considered a viable alternative to monogamy. Rubel and Bogaert (2014) also conducted a meta-analysis of the associations between consensual

non-monogamy (swinging, open relationships, and polyamorous relationships), psychological well-being, and relationship quality. They concluded that the general trends in the available research indicate that the psychological well-being and relationship quality of consensual non-monogamists is not significantly different than that of monogamists. Overall, there is a growing body of evidence that suggests that relationship structure is a weak indicator of an individual's psychological well-being and relationship quality (amongst other psychological and relationship outcomes).

Since there is a lack of societal acceptance of CNM relationships, it would not be surprising if individuals in these relationship formats, as a whole, were less satisfied. Yet, as highlighted, current empirical evidence suggests that individuals in CNM relationships appear to be just as apt to enjoy positive relationship outcomes as individuals in monogamous relationships. That is not to say, however, that the stigma directed towards individuals in CNM relationships is harmless. The impact the societal stigma has on non-monogamous partnerings remains under-explored. Given the lack of research addressing this issue, the following review was extended to include the impact of stigma on gender and sexual minorities collectively.

Impact of Stigma on Gender and Sexual Minorities

It has been well documented that gender and sexual minorities experience stigma, prejudice, violence, and discrimination (e.g., Chonody, 2010; Herek, Chopp, & Strohl, 2007; Mays & Cochran, 2001; Nabors, Nettles, Balter, 2012; Poteat & Mereish, 2012; Powell, 2010). Furthermore, these experiences hold the potential to bring about psychological distress (Cochran & Mays 2006; Herek, 1991; Herek, 2009a; Herek, 2009b; Livingston & Boyd, 2010; Mak et al, 2007; Meyer, 2003; Meyer, 2007; Podchaski, 2009). In a landmark study, Ilan Meyer (2003) introduced the term *minority stress* to conceptualize and explain how stigma, prejudice, and

discrimination create a hostile and stressful social environment that *causes* mental health problems. These hostile and stressful environments can be experienced through reoccurring micro-aggressions (e.g., hearing racist comments or homophobic jokes) as well as more tangible events such as loss of housing, employment, marriage, child custody, as well as physical and sexual assault (DiPlacido, 1998).

Endorsed stigma, discrimination, and violence can facilitate a “felt stigma” on an ongoing subjective sense of personal threat to one’s safety and well-being (Herek, 2009a). While CNM relationships can potentially be concealed, concealable marginalized identities are also recognized as source of negative health outcomes (Quinn & Chaudoir, 2009). CNM stigmatization may vary based on geographic region, with non-urban regions generally expected to produce greater hostility (in terms of frequency and intensity) as there typically is not as much social support or exposure to non-normative identities (D’Augelli & Garnets, 1995).

Stigma has also been found to influence reactions toward groups in legal domains (Sherrod & Nardi, 1998; Ray, Dollar, & Thames, 2011). Currently, there are no forms of state or federal legislation that protect CNM individuals from discrimination, making it possible, for example, for employers to fire (or refuse to hire) someone based on her/his CNM identity. CNM parents are especially susceptible to discrimination and CNM individuals looking to adopt may have a more difficult time doing so because of the stigma directed toward CNM (Goldfeder & Sheff, 2013). Emens (2004) chronicled cases where the court system removed children from CNM households solely because of their parents CNM relationship structure, despite mental health professionals indicating the children were well-adjusted.

Stigma can also be experienced in less visible forms. Ritchie and Barker (2006), for example, address how mono-normativity is reproduced and perpetuated in everyday conversation

and overwhelms mainstream media depictions. The authors go on to argue how communities construct identities through language and how the potentials of amicable non-monogamous forms of relating are restricted and marginalized by conventional mono-normative language regarding partnerships, infidelities, and jealousy. They also address how non-monogamous individuals are reminded of their out-group status with each monogamous cultural reference (e.g., “*someday you’ll meet that special someone*”), and have to create new languages to adequately and accurately account for their non-dyadic relationships, identities, and emotions.

Green & Mitchell (2002) encourage mental health clinicians to consider the impact of societal prejudice and discrimination on CNM relationships. The authors suggest therapists draw attention to the potential impact of their client’s environment, as clients may not recognize how negative societal biases may be contributing to the relationship complications they are experiencing. Clinicians are also encouraged to have a baseline understanding of nontraditional relationship structures and resources when working with CNM clients (Weitzman, Davidson, & Phillips, 2012; Zimmerman, 2012).

Therapist Practices used with CNM Clients

Consensual forms of non-monogamy are generally considered an under-recognized and under-researched area of interest in the mental health field (McCoy, Stinson, Ross, & Hjelmstad, 2015). When choosing an intervention, it is important to understand individualized contextual factors that may be salient to the client, and how their client intends to evaluate the outcome of therapy (Fontes, 2008; Ivey & Ivey, 2013). Understandably, CNM clients are going to be more attune to the attitudes and practices a clinician uses that either affirm or disaffirm non-monogamies. Without high level of awareness about their own values, beliefs, needs, and limitations, clinicians are at risk of hampering the progress of a client in therapy (Corey,

Schneider-Corey, & Callanan, 1993). This has been found to be especially relevant when providing treatment and assessment services to sexual minority clients, as the mental health needs of sexual minorities may differ in some important ways from those with a traditional sexual expressions (Bieschke, McClanahan, Tozer, Grzegorek, & Park, 2000; Bridoux, 2000; Cabaj & Stein, 1996; Haldeman, 1994; Hughes, Haas, & Avery, 1997; Garnets et al., 1991; Morrow, 2000; Nichols & Shernoff, 2007; Weitzman, 2007; Weitzman, Davidson, & Phillips, 2012; Zimmerman, 2012).

While mental health professionals have historically played a critical role in providing support for marginalized populations, mental health professional attitudes are also influenced by the current cultural paradigms and are subject to bias and prejudice. In the early 1970s, an emergence of scholarship pertaining to consensual forms of non-monogamy began to appear the literature (i.e., Cole & Spaniard, 1974; Constantine & Constantine, 1971; Knapp, 1975; O'Neill & O'Neill, 1972; Rogers, 1973). Early writers, however, conceptualized sex outside of marriage as regressive (Stearns, 1976), immature, or antisocial (Greene et al., 1974). While limited, the studies from this era indicate that therapist attitudes towards CNM varied greatly, with a sizeable proportion holding negative attitudes.

Knapp's (1975) article was the first to extensively address therapist attitudes towards CNM clients. Of the 190 therapists participating, at least one out of three indicated that they were personally non-approving of sexually open marriage (33% non-approving), secret affairs (37%), and recreational swinging (58%) respectively. When asked if they were professionally non-supportive (i.e., did not necessarily hide their non-affirming beliefs with clients), between 16-38% indicated that they were professionally non-supportive of these practices (sexually open marriage- 16%, secret affairs- 25%, and recreational swinging- 38%). Nearly one in five (17%)

went as far as saying they would directly attempt to influence clients to abandon swinging, compared to 12% for secret affairs, and 9% for sexually open marriages. Knapp's results indicated that swingers were clearly the group that was most likely to experience negative bias from their therapist (when compared to individuals in secret affairs or sexually open marriages). Clinicians studied by Knapp in the mid-1970s were not only biased toward both types of consensual non-monogamy examined (open marriages and swinging), but were more likely to pathologize clients who consensually made agreements to be engage in casual sex with others (i.e., swinging), than their clients who were having secret extramarital affairs. Knapp's study also pointed to the negative bias of clinicians through approximately one-third of them indicating that they believed people in open relationships had some type of personality disorder or neurotic tendency, and nearly 20% of these therapists admitting they would try to influence their client to return to a monogamous lifestyle.

Hymer and Rubin's work (1982), although over three decades old, is the most recent investigation of therapist treatment of CNM clients. The authors surveyed 57 therapists and found that the overwhelming majority (89%) held negative evaluations of individuals who engage in extramarital sex. It should be noted that the extramarital sex they were referencing (secret affairs) is not considered a consensual form of non-monogamy. Of the therapists indicating negative evaluations of sexually open marriages, 24% perceived these individuals as fearing commitment or intimacy, 15% perceived them to be in marriages that were not adequately fulfilling, and 7% suggested they had identity problems.

It is anticipated that therapist attitudes towards CNM have become more affirming over the past three decades in part to the growing social and academic interest in alternative relationships initiated in the 1960s and 1970s. In the 1980s, the field of psychology started to

challenge the associations of consensual non-monogamies with promiscuity and dysfunctional relationships, and positive accounts of open-relationships and affirming suggestions for practice started emerging (i.e., Hymer & Rubin, 1982; Kassoff, 1988; Peabody, 1982). The expanding body of research on CNM has been emerging from feminist, queer, post-structuralist, and anarchist viewpoints (see Barker & Langdrige, 2010), and has been celebrated as a deviation from possessive and patriarchal forms of monogamy that presume monogamy as the hallmark of “healthy” and “natural” romantic relationships (Finn, Tunariu, & Lee, 2012).

In recent years, a number of suggestions for effective practice with CNM clients have emerged (e.g., Duggal, 2014; Fierman & Poulson, 2014; Moors & Schechinger, 2014; Richards & Barker, 2013; Weitzman, Davidson, & Phillips, 2012; Zimmerman, 2012). Girard and Brownlee (2015), for example, suggest that it is important to understand the core values and relationship structure of a relationship, as well as the relationship rules in place (if any) and how those involved define fidelity. The authors went on to offer considerations for clinicians regarding relevant topics in CNM relationships, including open communication, jealousy, boundaries, honesty, and safe sex practices. Anapol (2010) suggests that the most common issues that present in treatment include: jealousy, social discrimination, disapproval from social supports, issues with child rearing, emotional ties, rejection, time management, commitment, honesty, and boundaries. Little is known regarding how common presenting concerns may vary amongst CNM relationship types.

Authors have also started addressing the intersection of CNM and other contextual factors, such as sexual orientation, with recommendations being provided for practitioners working with gay men (Bettinger, 2005; Pawlicki & Larson, 2011; Shernoff, 2006), lesbians (Kassoff, 1988; Labriola, 1999), and bisexuals (Rust, 1996; Weitzman, 2006, 2007) in CNM

relationships. Research is lacking, however, that addresses contextual factors, such as race and ethnicity, immigrant status, gender identity/expression, religion, sexually transmitted infection status, geographical location (i.e., rural versus urban and/or country of origin), age and historical cohort, socioeconomic status (current and historic), and disability.

The prevalence of the societal stigma associated with CNM and lack of quantitative research examining CNM client experiences with therapists in the past three decades suggests the need for this study. Basic research examining the principles highlighted in the available guidelines in addition to lines of research addressing the intersectionality of CNM and other minority identities is lacking. In essence, the state of therapist treatment towards CNM clients, including the nature and prevalence of the best and worst practices, remains unexplored.

Therapist Helpfulness

Client ratings of therapist helpfulness have been used as a treatment outcome in a number of studies (e.g., Hill, et al., 1994; Elliott, 1985; Liddle, 1996), and have been found to hold strong concurrent validity with the therapist satisfaction (Conte, Buckley, Picard, & Karasu, 1994; Liddle, 1997). Liddle (1997) found suitable concurrent validity between Brooks' (1981) Therapist Helpfulness Scale and the Therapist Satisfaction Scale (Conte, Buckley, Picard, & Karasu, 1994), with a correlation of .84. Therapist satisfaction is strongly associated with therapy satisfaction (Oei & Green, 2008) and improved psychotherapy outcomes (Conte, Buckley, Picard, & Karasu, 1994).

A number of studies have also examined the concept of the therapeutic alliance, conceptualizing it as encompassing both therapist satisfaction and therapy satisfaction (e.g., Hartley & Strupp, 1983; Horvath & Greenberg, 1986; Tichenor & Hill, 1989). While the interrelatedness of therapist helpfulness, therapist satisfaction, therapy satisfaction, and the

therapeutic alliance appears to be strong, Oei and Green (2008) argue that satisfaction with therapy and satisfaction with therapist should be viewed as *constituents* of the therapeutic alliance, but not as completely synonymous with the alliance in and of itself. The authors also propose that therapy satisfaction and therapist satisfaction are also strongly related *yet distinct* concepts. They suggest satisfaction with therapy is the client's positive attitude toward therapy as a whole and encompasses an acceptance of rationale and expectancy of benefit, whereas satisfaction with the therapist is the appraisal of the therapist by the client. Oei and Green (2008) created the Satisfaction with Therapy and Therapist Scale (see Oei & Shuttlewood, 1999), a 12-item scale in which they separated satisfaction with therapy and satisfaction with therapist into two separate factors. Hence, it is presumed that the current examination of therapist helpfulness is strongly associated with therapist satisfaction, therapy satisfaction, and the therapeutic alliance, it cannot be presumed that results will directly generalize to these constructs.

Client ratings of therapist helpfulness have also been found to be associated with other variables, such as client ratings of perceived therapist empathy ratings ($r = .60$; Elliott, 1986). Hill, Helms, Spiegel, and Tichenor (1988) also reported that client's helpfulness ratings were related to client reactions, with positive reactions being associated with higher helpfulness ratings than negative reactions. In light of and in addition to its associations with the aforementioned constructs, therapist helpfulness is thought to be a valuable therapy outcome variable that has been found to hold influence on client perception of their global improvement (Hasler et al., 2004), decisions about where to seek future services (Sun et al., 2000), and whether the client will recommend utilized services to others (Boudreaux, Ary, Mandry, & McCabe, 2000).

Premature Termination

While some theoretical orientations (e.g., humanistic and solution-focused) do not necessarily conceptualize premature termination in therapy (also referred to as psychotherapy dropout and unilateral termination) problematic, clients dropping out of therapy early has been associated with poor outcomes (Heilbrun, 1982), especially for clients who dropout early (Pekarik, 1992). While the ‘optimal’ number of sessions is strongly tied to outcome criteria and diagnosis, a meta-analysis of over 2,400 clients conducted over three decades revealed that eight visits was when 50% of clients showed measurable improvement (Howard, Kopta, Krause, & Oriinsky, 1986). One problem with premature termination studies is the varying definitions of premature termination. Many studies defined dropouts (someone who prematurely terminates) and completers (someone who maintains sessions until the designated conclusion of sessions) are based off whether a specific number of sessions (Pekarik, 1985). Alternatively, premature termination can be determined based on the therapists’ judgment. In light of the varying definitions, psychotherapy dropout rates have been found to range between 30% and 60% (Garfield, 1986; National Institute of Mental Health [NIMH], 1981).

Wierzbicki & Pekarik (1993) conducted a meta-analysis of premature termination in therapy, but only identified three client demographic variables to be predictive of dropout: racial minority status, low education, and low socioeconomic status ($d = .23, .28, \text{ and } .37$, respectively). Due to the few predictive demographic variables and low effect sizes, the authors suggested focusing on client-therapist interaction variables. The therapeutic alliance between client and therapist is one of the most widely studied client-therapist interaction variables (Horvath, 2001). In their meta-analysis of therapeutic alliance and premature termination, Sharf and Primavera (2010) found a moderately strong relationship between psychotherapy dropout

and therapeutic alliance ($d = .55$), with weaker therapeutic alliances being more likely to lead to premature termination.

Reis and Brown (1991) suggest that many who prematurely terminate do so because their perspectives differ from those of their therapists. They go on to advocate that reducing premature termination will require clinicians to acknowledge the divergent perspectives that often estrange them from their clients. No literature could be found that addresses premature termination rates with CNM clients.

Research Questions

The current study was designed to explore the experiences of CNM clients who have utilized a therapy services. Methods were gleaned from prior gender and sexual minority research, including a study by Liddle (1996), created a set of 13 therapy practices based off the APA (1991) guidelines for practice with LGB clients. Liddle examined the extent to which the practices predicted therapist helpfulness with LGB clients. A modified version of Liddle's 13 therapeutic practices (three considered exemplary and ten considered inappropriate) were used in the current study to explore the degree to which the practices could predict therapist helpfulness and/or premature termination with CNM clients. These modified practices will be referred to as the 13 CNM practices. The three exemplary practices will be referred to as the exemplary practices or the exemplary practices subscale and the ten inappropriate practices will be referred to as the inappropriate practices or the inappropriate practices subscale. Open-format responses pertaining to practices that CNM clients found to be particularly helpful or harmful were also analyzed to determine there were any practices (either positive or negative) not represented in the 13 CNM practices. The applicability of the 13 CNM practices were also evaluated based on the results of the current study.

The questions addressed are as follows: What percentage of therapists are considered helpful/unhelpful by CNM clients (Q1.1)? Which of the 13 CNM practices do therapists treating CNM clients use the most/least (Q1.2)? How many of the 13 CNM practices does the average therapist use (Q1.3)? How often do CNM clients prematurely terminate therapy due to a negative CNM-related experience with their therapist (Q1.4)? How often are CNM clients screening therapists for CNM-affirming attitudes (Q1.5)? How well do the 13 CNM practices predict therapist helpfulness with CNM clients (Q2.1)? Which individual practices are the strongest predictors of therapist helpfulness (Q2.2)? How well do the 13 CNM practices predict whether a CNM client will prematurely terminate therapy (Q3.1)? Which individual practices are the strongest predictors of premature termination (Q3.2)? Are there helpful/unhelpful practices that are not represented in the 13 CNM practices (Q4)?

Hypotheses

The results are considered applicable to researchers and clinicians alike, and are intended to aid in the process of establishing empirically supported guidelines for psychological practice with CNM clients. In light of the identified questions, the following hypotheses were made:

Therapist helpfulness, screening, premature termination, and practice frequencies.

Most therapists will be rated as helpful by CNM clients (H1.1). The frequency that the 13 CNM practices are used will vary (H1.2). The number of the 13 CNM practices used by therapists will vary (H1.3). Some CNM clients will prematurely terminate or end sessions because of a negative experience based on their non-monogamous relationship(s) or identity (1.4). Some CNM clients will screen their therapist based on how supportive they perceive the therapist will be toward their relationship orientation/lifestyle (1.5).

The 13 CNM practices and therapist helpfulness.

The 13 CNM practices will emerge as a strong predictor of therapist helpfulness (H2.1).

A few of the 13 CNM practices will emerge as strong predictors of therapist helpfulness (H2.2).

The 13 CNM practices and premature termination.

The 13 CNM practices will emerge as a strong predictor of premature termination (H3.1).

A few of the 13 CNM practices will emerge as strong predictors of premature termination (H3.2).

Open-format helpful/harmful responses.

A few unique themes will emerge (H4).

Chapter 3: Methods

Participants

Data for the current study were collected as part of a larger study evaluating CNM relationship outcomes, perceived advantages and disadvantages of CNM, internalized stigma, and perceptions about men or women are more inclined toward either polyamory, swinging, or open relationships (Schechinger & Moors, in preparation). Participants were recruited by emailing announcements to listservs and organizations dedicated to CNM community groups across the United States. Announcements also requested that information about the study be forwarded to other CNM listservs or populations. The announcements clarified that study data would be collected anonymously and that the Institutional Review Board of the sponsoring university had approved the study. At times the announcements were shortened or altered to

facilitate posting in various online venues, but the basic information remained the same. No compensation was provided for participation.

Demographic information.

A total of 589 individuals in polyamorous, swinging, and open relationships participated in the survey. Seventy-two percent (424) of the 589 participants indicated that they had at least one therapy session. Of the 424 participants who engaged in therapy, 249 (59%) reported that their romantic relationship(s) were a topic of conversation in therapy with their current/most recent therapist, and were used in the current analysis. Participation was limited to this group to avoid therapy exchanges that relationship orientation/structure were not likely to come up/be relevant (brief medication management sessions with a psychiatrist, for example), and to limit memory recall bias and time period effects. There were a total of 249 participants who collectively saw 426 therapists when including non-current/most recent therapists (1.71 therapists per participant). Nearly two-thirds (61%) of the sample indicated that they have had more than 20 sessions of counseling or psychotherapy (9% had one to four sessions, 30% had five to 20 sessions).

The majority of the sample identified as polyamorous (polyamory 79%; open relationship 9%; monogamy 2%; swinging 1%; other 9%). Given the common themes between the types of CNM (open communication, honesty, negotiation, and consensus about the terms of the relationships; Barker, 2005b; Jenks, 1998; O'Neill & O'Neill, 1972), results are still considered to have relevance across CNM relationship structures. Participants ranged in age from 18 to 79 ($M = 36.62$), with the majority identifying as female (female 62%, male 25%, other 10%). The number of partners participants were romantically and/or sexually involved with ($M = 2.56$) ranged from one to eight partners: one (22%), two (35%), three (22%), four (9%), five (5%), six

(3%), seven (1%), and eight (1%). Notably, 57% of participants had two or fewer partners and 80% had three or fewer partners. Most participants were white (European American/White 83%; Multi-racial 6%, African American/Black 1%; Asian American 1%; Latino/a 1%; Native American 1%, other 6%), bisexual (bisexual 43%, straight 26%, pansexual/queer 20%, gay or lesbian 1%, other 7%) non-religious (Atheist 23%; Agnostic 19%; Spiritual but not religious 18%; Pagan/Wiccan 12%; Buddhist/Taoist 4%; Jewish 4%; Christian/Protestant 4%; Unitarian 2%; Christian/Catholic 1%; Other 11%), and middle-class (median income was \$40,000 - \$49,999). Most participants also designated that they resided in the United States (86%).

Procedures

Participants were provided with a link to an online secure survey (the survey can be found in Appendix A). The same strategy used by Liddle (1996) was incorporated in the present study, where participants were asked to describe their experiences with up to four different therapists: (a) current/most recent, (b) first, (c) most helpful, and (d) worst or most harmful. These categories were chosen in order to accommodate individuals who have had more than one therapist and to acquire a wide range of experiences. For most of the quantitative analyses, therapists were separated into three categories: most recent or current therapists (*Recent*; $n = 249$), past therapists (*Past*, $n = 177$) which consisted of the first, most helpful, and most harmful therapists, and all therapists (*All*; $n = 426$) which consisted of a combination of the recent and past therapists. Participants were asked about their most helpful and most harmful past therapists as a means of balancing any priming effects or memory bias. The number of therapists was capped at four to avoid testing fatigue and to limit a single participant's influence on the entire dataset. Participants also indicated if a romantic relationship concern was ever a topic of conversation in therapy for each therapist, and only cases in which a romantic relationship was a

topic of conversation were included to avoid therapy exchanges that relationship orientation/structure may not have come up (i.e., medication management sessions with psychiatrists).

Participants were asked to provide the initials (if known) and setting (i.e., college counseling center, private practice) to ensure therapists were represented only once in the survey. If, for example, a participant's most recent therapist was also the most helpful, participants were instructed to note this and only respond to the survey questions once per therapist. Participants also reported therapist gender (female, male, trans*, unknown), therapist sexual orientation (heterosexual, gay or lesbian, bisexual, or unknown), relationship orientation (monogamous, non-monogamous, unknown) and the approximate number of therapy sessions (if known).

Participants responded to the therapist helpfulness dependent measure used by Liddle (1996), including a therapist helpfulness scale created by Brooks (1981) and a modified version of Liddle's (1996) exemplary/inappropriate therapeutic practices, indicated if they prematurely terminated because of a negative CNM-related interaction with their therapist, and wrote out what their therapist did (regarding their relationship orientation/structure) that they found to be very helpful and/or very unhelpful. The results from the qualitative analysis (i.e., open responses regarding the very helpful and very unhelpful things their therapist did) were based on experiences with both recent and past therapists, regardless of whether a romantic relationship was addressed in therapy.

Measures

Therapist helpfulness.

Liddle (1996) replicated and extended a study conducted by Brooks (1981). To allow for comparison of findings, Liddle (1996) used the dependent measure created by Brooks (1981),

which was also replicated for the current study. Participants responded to the question, "How helpful was this therapist?" using one of the following four options: (1) *destructive*, (2) *not at all helpful*, (3) *fairly helpful*, or (4) *very helpful*. Brooks' (1981) scale has been found to have adequate concurrent validity with the Therapist Satisfaction Scale (Conte, Buckley, Picard, & Karasu, 1994), with a correlation of .84 (Liddle, 1997).

Premature termination.

For each therapist, participants were asked if had terminated therapy because of a bad experience that was based on their non-monogamous relationship(s) or identity. The rationale for this analysis is to see whether certain therapist behaviors are was associated with CNM clients dropping out of therapy before therapeutic benefits could be achieved. As one might expect, patients who drop out of therapy prematurely tend to have poorer outcomes than patients who continue in therapy until treatment goals are achieved (Archer, Forbes, Metcalfe, & Winter, 2000; Klein, Stone, Hicks & Pritchard, 2003; Moras, 1986; Wierzbicki, M., & Pekarik, G., 1993).

The 13 CNM practices scale.

The 13 therapy-related practices were derived from a list of suggestions for practices for working with LGB clients produced by a task for sponsored by the American Psychological Association (APA; see Garnets et al., 1991). The task force surveyed 2,544 psychologists regarding any incidents or practices that they perceived to be harmful or beneficial in psychotherapy with lesbian and gay clients. From these data, the committee developed a list of seventeen "biased, inadequate, or inappropriate practices," and fourteen "exemplary practices." Liddle (1996) created a scale by rewording the themes to eliminate professional jargon and to reflect therapist behavior that could be observed by a client. For example, the first theme

representing ineffective practice, "A therapist believes that homosexuality per se is a form of psychopathology, developmental arrest, or other psychological disorder" (Garnets et al., 1991, p. 966), was reflected in the following instrument item: "Your therapist indicated that he or she believed that a gay or lesbian identity is bad, sick, or inferior." Her team also condensed the Garnets et al. practices into two subscales: nine, *biased, inadequate, or inappropriate practices*, and four *exemplary practices* (see Liddle, 1996 for additional details).

Notably, most of the practices from the Garnets' study consisted of comparable concepts described in both the inappropriate and exemplary form. For example, "A therapist believes that homosexuality per se is a form of psychopathology, developmental arrest, or other psychological disorder" was listed as one of the Biased, Inadequate, or inappropriate practice, whereas "A therapist understands that homosexuality, in and of itself, is neither a form of psychopathology nor is necessary evidence of psychopathology or developmental arrest, and recognizes that gay men and lesbians can live fulfilling lives" was listed as an exemplary practice. Hence, in most cases, minor alterations could be made to an inappropriate practice to reflect the concept as exemplary and vice-versa. In light of this, the current study adjusted one of Liddle's exemplary practices was believed to read more effectively as an inappropriate practice (switching it avoided using a double negative in the item), so it was switched, resulting in two subscales, one consisting of ten inappropriate practices and the other with three exemplary practices.

After operationalizing themes from Garnets et al. (1991), Liddle had seven raters (all of whom were doctoral-level counseling or counseling psychology faculty or practitioners) examine the extent to which the items accurately reflected the content of themes from the Garnets et al. study. The raters anonymously rated each item on the extent to which it accurately represented the content of the corresponding theme or themes, using a 5-point Likert-type scale ranging from

1 (*very inaccurately*) to 5 (*very accurately*). The mean ratings for Liddle's 13 items ranged from 3.43 ($SD = 1.62$) to 5.00 ($SD = 0$), with a grand mean of 4.19 ($SD = 0.95$). Comments from a few raters indicated that when a low rating was given for a particular item, the concern was often that the item did not represent the full breadth of a theme that intended to encompass several different practices. Since Liddle's instrument was not intended to measure the full range of practices described by Garnets et al., and because mean ratings for all items fell above the scale midpoint, all 13 items were retained.

The 13 items derived by Liddle (see Appendix C) were then modified to apply to the CNM population (see Appendix D). Language referring to sexual orientation (i.e., heterosexual, homosexual) was switched to refer to relationship orientation/structure (i.e., monogamous, non-monogamous). For example, the item, "Your therapist gave some indication that he or she had automatically assumed you were heterosexual, before you indicated your sexual orientation," was altered to, "Your therapist gave some indication that he or she had automatically assumed you were monogamous, before you indicated your relationship orientation." The extent to which the items reflected those produced by Liddle were examined by three raters, two psychology doctoral candidates and a psychology faculty member. The modified items are referred to as the 13 CNM practices or the 13 CNM Practices Scale. The exemplary practices subscale consisted of 3 items ($\alpha = .67$) and the inappropriate practices subscale consisted of 10 items ($\alpha = .79$). For each therapist described, participants indicated (yes/no) whether their therapist engaged in any of the 13 practices. While the American Psychological Association has since come out with an updated version of guidelines for psychological practice with lesbian, gay, and bisexual clients (see APA, 2012 and Appendix E), the items Liddle's scale were selected as a means of exploring the potential relatedness of sexual and relationship orientation and because Liddle and her

colleagues already condensed and converted the recommendations for practice with LGB clients into practices that clients could observe.

Analysis

Therapist helpfulness, screening, premature termination, and practice frequencies.

Frequency tables including sums and percentages are presented regarding participant responses to Brooks' (1981) therapist helpfulness item (Q1.1), the frequently therapists engaged in the 13 CNM practices (Q1.2), the number of the 13 CNM practices therapists engaged in (Q1.3), how often CNM clients prematurely terminated or ended sessions because of a bad experience based on their non-monogamous relationship(s) or identity (Q1.4), and how often are CNM clients screened their therapist based on how supportive they will be toward their relationship orientation/lifestyle (Q1.5).

The 13 CNM practices and therapist helpfulness.

Three linear regression models were run to assess how well the 13 CNM practices predicted therapist helpfulness. The analyses of this model focused on participant's current/most recent therapist (*Recent*) in order to limit biased memory recall and time period effects (i.e., therapist attitudes are likely more accepting than they were 20 years ago). Scores on the therapist helpfulness item were first regressed on the three exemplary practices, and then again on the ten inappropriate practices to determine the most influential helpful and harmful practices, separately. Scores on the therapist helpfulness item were then regressed on all 13 CNM practice items to determine the most influential practices among both exemplary and harmful practices.

The 13 CNM practices and premature termination.

A logistical regression model was used to examine the extent to which the exemplary practices, the inappropriate practices, and the 13 CNM practices individually and collectively

predicted premature termination in therapy with CNM clients. Current/most recent therapists and most harmful therapists were selected for analysis based on the results from question 1.4 (*how often clients terminated or ended sessions with a therapist because of a bad experience that was based on their non-monogamous relationship(s) or identity*). Client yes/no responses to the premature termination (1 = *prematurely terminated*, 0 = *did not prematurely terminate*) question were regressed on the exemplary practices subscale (for current/most recent therapists and then separately with the most harmful therapists), followed by the inappropriate practices subscale, and then on all 13 CNM practices simultaneously. The premature termination responses for the exemplary and inappropriate practices were also both summed and regressed separately to see if the exemplary or inappropriate practices were collectively associated with premature termination.

Open-format helpful/harmful responses.

After completing the survey, participants were asked to describe in an open format, the things their therapist(s) did that were either “very helpful” or “very unhelpful.” Participants were asked after the survey to help prime their memory and to potentially identify practices (both helpful and unhelpful) outside the 13 already highlighted. Braun and Clarke’s (2006) epistemological approach to thematic analysis was used to identify the major and minor themes for each category because of its usefulness and theoretical flexibility to analyzing qualitative data. This approach was also selected for the purpose of identifying any practices that therapists may have been engaging in that were not captured in the 13 CNM practices. All responses were read through three times by the lead author, a psychology faculty member, and a trained Psychology Ph.D. student. Each of the investigators created a list of major and minor themes. The major and minor themes were then reviewed and combined by the lead author. The

combined draft of the major and minor themes was then reviewed by the other two contributors. Upon review and discussion, a final version of the major and minor themes was agreed upon. Each of the participants' responses were then reviewed and coded by the lead author as "1" if the theme if the theme was present, and "0" if the theme was not present. The endorsements were then added (including the sum and percentages) for each of the major and minor themes.

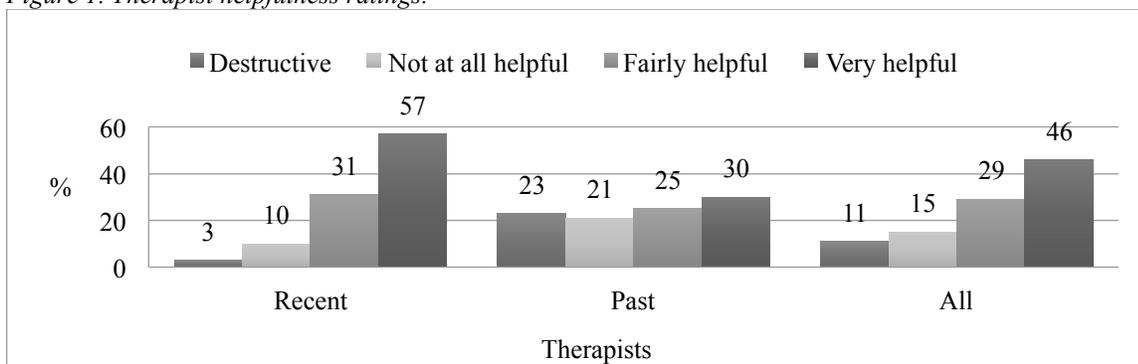
Chapter 4: Results

Therapist Helpfulness, Screening, Premature Termination, and Practice Frequencies

Perceived helpfulness of therapists with CNM clients.

Participants were asked to rate the helpfulness of each of their therapists (Figure 1). The majority (88%) of CNM clients surveyed rated their current/most recent therapist favorably- fairly helpful (31%) or very helpful (57%). Thirteen percent were rated unfavorably- not helpful at all (10%) or destructive (3%). When including past therapists, 75% of therapists were rated favorably- fairly helpful (29%) or very helpful (46%)-, while 25% were rated unfavorably not helpful at all (15%) or destructive (11%).

Figure 1. Therapist helpfulness ratings.



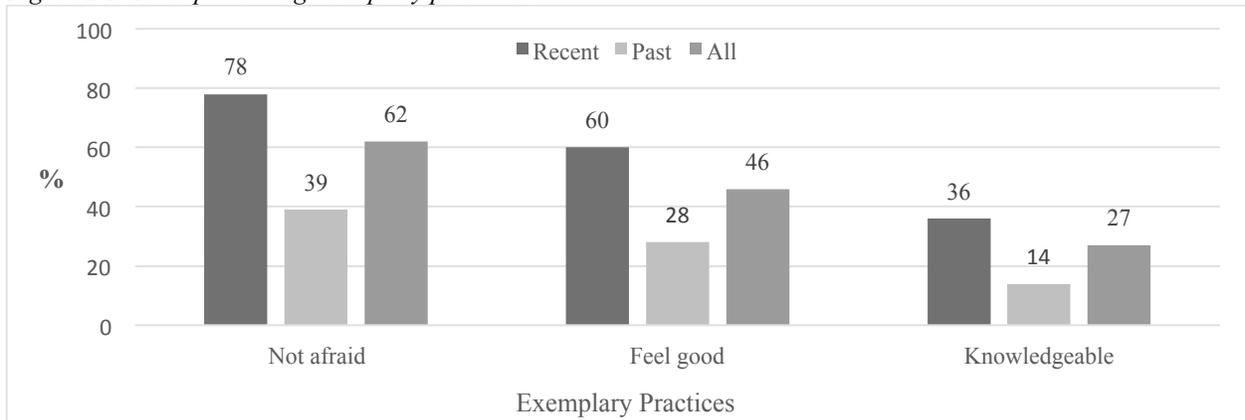
Response	Recent <i>n</i> = 249	Past <i>n</i> = 177	All <i>n</i> = 426
Destructive	6 (3%)	40 (23%)	46 (11%)
Not at all helpful	24 (10%)	38 (21%)	62 (15%)
Fairly helpful	77 (31%)	45 (25%)	122 (29%)
Very helpful	142 (57%)	54 (30%)	197 (46%)

Note. Recent = most recent therapist; Past = first, most helpful, & most harmful therapists; All = all therapists combined.

Most/lest used exemplary/inappropriate practices.

Seventy-eight percent of participant’s current/most recent therapists were not afraid to deal with their client’s relationship orientation when it was relevant, 60% helped their client feel good about being a consensually non-monogamous person, and 36% were knowledgeable of CNM communities and other resources (Figure 2.1). When including past therapists, these percentages drop to 62%, 46%, and 27% respectively. The most common inappropriate practices engaged in by participants’ current/most recent therapists include assuming a client was monogamous (35%), lacking basic knowledge of CNM issues (21%), and not recognizing the importance of and appropriately supporting CNM relationships (12%; see Figure 2.2). Past therapists (i.e., first, most helpful, and most harmful), in general, appeared to engage in more inappropriate practices and fewer exemplary practices than participants’ current/most recent therapists.

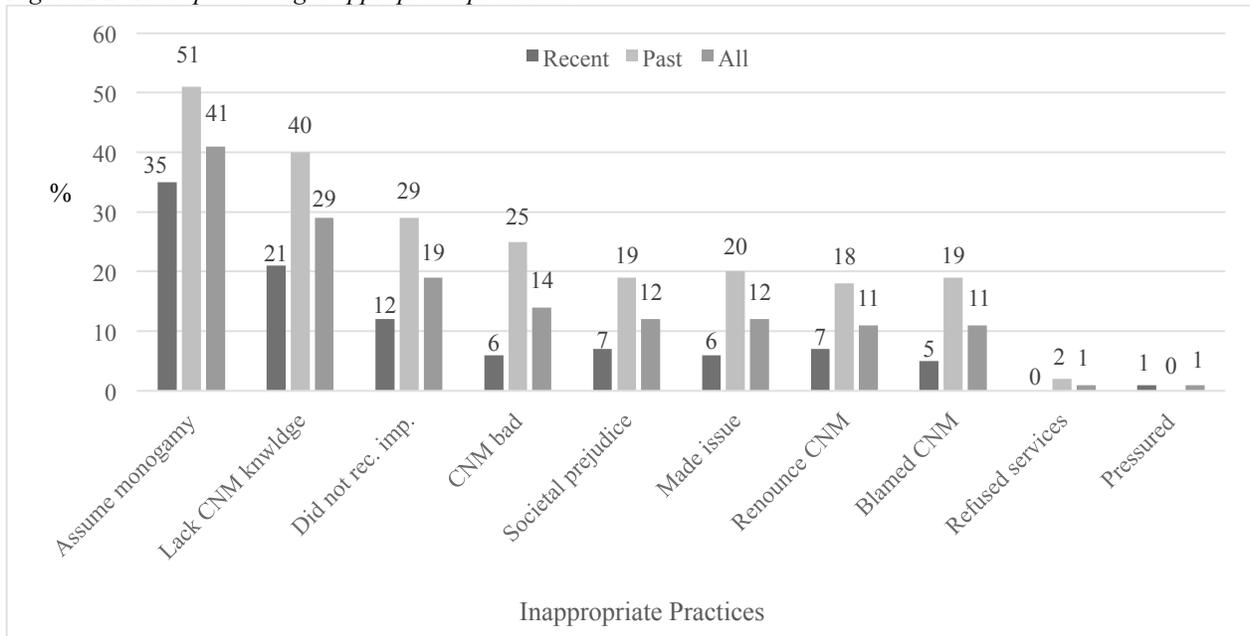
Figure 2.1. Therapists using exemplary practices.



#	Exemplary Practices	Recent <i>n</i> = 249	Past <i>n</i> = 177	All <i>n</i> = 426
1	<i>Not afraid.</i> Your therapist was not afraid to deal with your relationship orientation when it was relevant.	193 (78%)	69 (39%)	262 (62%)
2	<i>Feel good.</i> Your therapist helped you feel good about yourself as a consensually non-monogamous person.	149 (60%)	49 (28%)	198 (46%)
3	<i>Knowledgeable.</i> Your therapist was quite knowledgeable about consensual non-monogamy communities and other resources.	89 (36%)	25 (14%)	114 (27%)

Note. Recent = most recent therapist (*n* = 249); Past = first, most helpful, & most harmful therapists (*n* = 177); All = all therapists combined (*n* = 426).

Figure 2.2. Therapists using inappropriate practices.



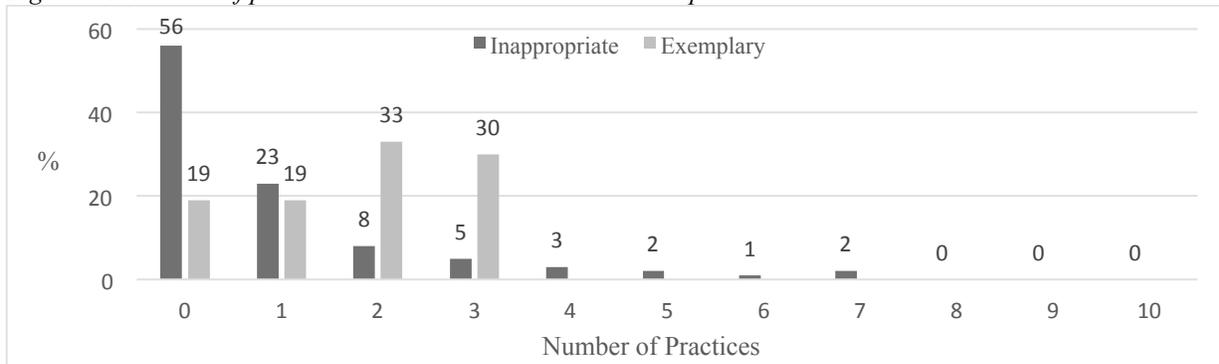
#	Inappropriate Practices	Recent <i>n</i> = 249	Past <i>n</i> = 177	All <i>n</i> = 426
1	<i>Assumed monogamy.</i> Your therapist gave some indication that he or she had automatically assumed you were monogamous, before you indicated your relationship orientation.	86 (35%)	90 (51%)	176 (41%)
2	<i>Lacked CNM knowledge.</i> Your therapist lacked the basic knowledge of consensual non-monogamy issues necessary to be an effective therapist for you and/or you had to be constantly educating him or her about these issues.	52 (21%)	71 (40%)	123 (29%)
3	<i>Did not recognize importance.</i> Your therapist did not recognize the importance of consensual non-monogamous relationships and/or did not appropriately support these relationships.	31 (12%)	51 (29%)	82 (19%)
4	<i>CNM bad.</i> Your therapist indicated that he or she believed that non-monogamy is bad, sick, or inferior.	14 (6%)	45 (25%)	59 (14%)
5	<i>Societal prejudice.</i> Your therapist apparently did not understand the problems of societal prejudice against consensually non-monogamous individuals.	17 (7%)	34 (19%)	51 (12%)
6	<i>Made issue.</i> Your therapist made an issue of your relationship orientation even when it was not relevant.	14 (6%)	35 (20%)	49 (12%)
7	<i>Renounce CNM.</i> Your therapist discounted, argued against, or pushed you to renounce your non-monogamous lifestyle/identity.	17 (7%)	31 (18%)	48 (11%)
8	<i>Blamed CNM.</i> Your therapist blamed your problems on your relationship orientation or insisted on focusing on relationship orientation without evidence that your relationship orientation was relevant to your problems.	12 (5%)	34 (19%)	46 (11%)
9	<i>Refused services.</i> Your therapist suddenly refused to see you any more after you disclosed your relationship orientation.	1 (<1%)	4 (2%)	5 (1%)
10	<i>Pressured.</i> Your therapist pressured or advised you to come out to someone in spite of the fact that you believed it was too risky.	3 (1%)	0 (0%)	3 (1%)

Note. Recent = most recent therapist (*n* = 249); Past = first, most helpful, & most harmful therapists (*n* = 177); All = all therapists combined (*n* = 426).

Average number of exemplary/inappropriate practices used.

The average number of practices used by current/most recent therapists was 0.99 inappropriate, and 1.73 exemplary, compared to 2.23 inappropriate and 0.81 exemplary for past therapists. Collectively, all the therapists sampled used 1.51 inappropriate and 1.35 exemplary practices on average. The majority (81%) of the current/recent therapists engaged in at least one exemplary practice while approximately one in five (19%) past therapists did not engage in any of the exemplary practices (Figures 3.1 – 3.3).

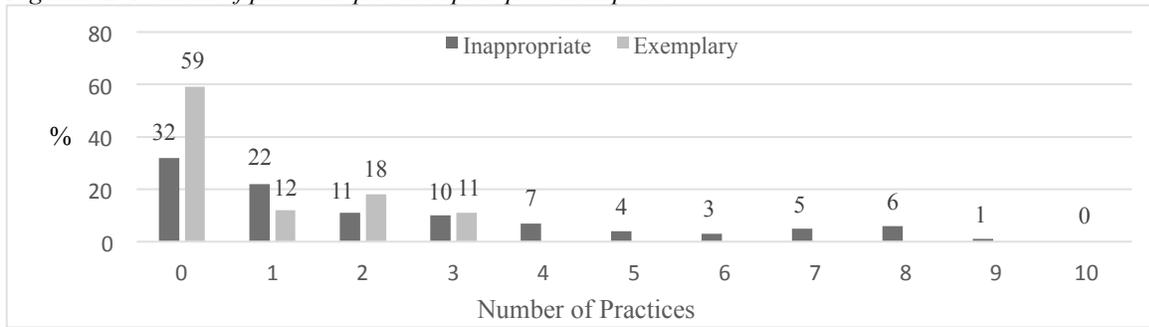
Figure 3.1. Number of practices used: current/most recent therapists.



Number of practices	0	1	2	3	4	5	6	7	8	9	10
Inappropriate (n = 10)	140 (56%)	57 (23%)	19 (8%)	12 (5%)	7 (3%)	5 (2%)	3 (1%)	4 (2%)	1 (<1%)	1 (<1%)	0 (0%)
Exemplary (n = 3)	47 (19%)	47 (19%)	81 (33%)	74 (30%)							

Note. Inappropriate = inappropriate practices; Exemplary = exemplary practices

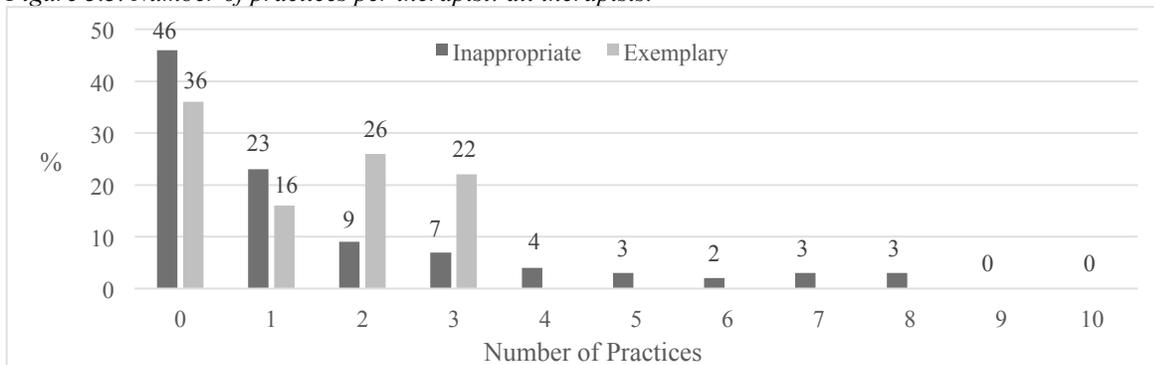
Figure 3.2. Number of practices per therapist: past therapists.



Number of practices	0	1	2	3	4	5	6	7	8	9	10
Inappropriate (n = 10)	57 (32%)	39 (22%)	19 (11%)	18 (10%)	12 (7%)	7 (4%)	6 (3%)	8 (5%)	10 (6%)	1 (1%)	0 (0%)
Exemplary (n = 3)	105 (59%)	21 (12%)	31 (18%)	20 (11%)							

Note. past therapists = first, most helpful, and most harmful therapists; Inappropriate = inappropriate practices; Exemplary = exemplary practices

Figure 3.3. Number of practices per therapist: all therapists.



Number of practices	0	1	2	3	4	5	6	7	8	9	10
Inappropriate (n = 10)	197 (46%)	96 (23%)	38 (9%)	30 (7%)	19 (4%)	12 (3%)	9 (2%)	12 (3%)	11 (3%)	2 (<1%)	0 (0%)
Exemplary (n = 3)	152 (36%)	68 (16%)	112 (26%)	94 (22%)							

Note. all therapists = current/most recent therapists and past therapists; Inappropriate = inappropriate practices; Exemplary = exemplary practices

Premature termination.

CNM clients terminated or ended sessions because of a negative experience based on their non-monogamous relationship(s)/identity with 4% of their current/most recent therapist, and with 19% of their past therapists (Table 1). Sessions with 11% of the all therapists in the

current study were prematurely terminated because of a negative interaction with their therapist regarding to CNM.

Table 1: Premature termination.

Question	Recent <i>n</i> = 249	Past <i>n</i> = 177	All <i>n</i> = 426
Did you terminate or end sessions with a therapist because of a negative experience that was based on your non-monogamous relationship(s)/identity?	11 (4%)	34 (19%)	45 (11%)

Note. Recent = current/most recent therapists; Past = first, most helpful, and most harmful therapists; All = all therapists combined

Screening for CNM-affirming attitudes.

Forty-six percent of CNM clients screened their recent or current therapist based on how supportive they thought the therapist would be toward their relationship orientation/lifestyle, compared to 27% of past therapists. Thirty-eight percent of all the therapists in the sample were screened based on their perceived attitudes toward CNM (Table 1).

Table 2: Screening for CNM-affirming attitudes.

Question	Recent <i>n</i> = 249	Past <i>n</i> = 177	All <i>n</i> = 426
When you sought out this counselor, did you screen based on how supportive he or she would be of your relationship orientation/lifestyle?	114 (46%)	48 (27%)	162 (38%)

Note. Recent = current/most recent therapists; Past = first, most helpful, and most harmful therapists; All = all therapists combined

The 13 CNM Practices and Therapist Helpfulness

The exemplary practices and therapist helpfulness.

Therapist helpfulness was regressed separately on the three exemplary practices and on the ten inappropriate practices. The exemplary practices model was statistically significant ($R^2 = .34$, $F [3, 245] = 42.16$, $p < .001$) the two practices (*feel good* and *not afraid*) uniquely predicting therapist helpfulness (Tables 3.1 – 3.3).

Table 3.1. Linear regression model summary: exemplary practices, current/most recent therapists.

Model Summary							
R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change	Change Statistics F Change	df1	df2
.58	.34	.33	.62	.34	42.16	3	245

Table 3.2. ANOVA table: exemplary practices, current/most recent therapists

ANOVA					
	Sum of Squares	df	Mean Square	F	Sig.
Regression	49.33	3	16.44	42.16	.00
Residual	95.55	245	.39		
Total	144.88	248			

Table 3.3. Coefficients table: exemplary practices, current/most recent therapists.

Coefficients					
#	Practices	B	β	Sig.	
	(Constant)	2.64		.00	
1	<i>Not afraid.</i> Your therapist was not afraid to deal with your relationship orientation when it was relevant.	.60	.33	.00	
2	<i>Feel good.</i> Your therapist helped you feel good about yourself as a consensually non-monogamous person.	.47	.30	.00	
3	<i>Knowledgeable.</i> Your therapist was quite knowledgeable about consensual non-monogamy communities and other resources.	.13	.08	.15	

The inappropriate practices and therapist helpfulness.

The inappropriate practices model was statistically significant ($R^2 = .40$, $F [10, 238] = 16.16$, $p < .001$), with three practices (*made issue, did not recognize importance, assumed monogamy*) uniquely predicting therapist helpfulness (Tables 4.1 – 4.3).

Table 4.1. Linear regression model summary: inappropriate practices, current/recent therapist.

Model Summary							
R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change	Change Statistics F Change	df1	df2
.64	.40	.38	.60	.40	16.16	10	238

Table 4.2. ANOVA table: inappropriate practices, current/most recent therapists.

ANOVA					
	Sum of Squares	df	Mean Square	F	Sig.
Regression	58.59	10	5.86	16.16	.00
Residual	86.29	238	.36		
Total	144.88	248			

Table 4.3. Coefficients table: inappropriate practices, current/most recent therapists.

Coefficients				
#	Practices	B	β	Sig.
	(Constant)	3.67		.000
1	<i>Made issue.</i> Your therapist made an issue of your relationship orientation even when it was not relevant.	-.90	-.27	.00
2	<i>Did not recognize importance.</i> Your therapist did not recognize the importance of consensual non-monogamous relationships and/or did not appropriately support these relationships.	-.61	-.26	.00
3	<i>Assumed monogamy.</i> Your therapist gave some indication that he or she had automatically assumed you were monogamous, before you indicated your relationship orientation.	-.18	-.11	.04
4	<i>Lacked CNM knowledge.</i> Your therapist lacked the basic knowledge of consensual non-monogamy issues necessary to be an effective therapist for you and/or you had to be constantly educating him or her about these issues.	-.18	-.09	.14
5	<i>Renounce CNM.</i> Your therapist discounted, argued against, or pushed you to renounce your non-monogamous lifestyle/identity.	-.27	-.09	.31
6	<i>Refused services.</i> Your therapist suddenly refused to see you any more after you disclosed your relationship orientation.	-.50	-.04	.45
7	<i>Pressured.</i> Your therapist pressured or advised you to come out to someone in spite of the fact that you believed it was too risky.	.04	.01	.91
8	<i>CNM bad.</i> Your therapist indicated that he or she believed that a non-monogamy is bad, sick, or inferior.	-.03	-.01	.92
9	<i>Blamed CNM.</i> Your therapist blamed your problems on your relationship orientation or insisted on focusing on relationship orientation without evidence that your relationship orientation was relevant to your problems.	-.02	-.01	.95
10	<i>Societal prejudice.</i> Your therapist apparently did not understand the problems of societal prejudice against consensually non-monogamous individuals.	.00	.00	.99

The 13 CNM practices and therapist helpfulness.

Therapist helpfulness scores were regressed on the 13 CNM practices. The overall multiple regression was statistically significant ($R^2 = .50$, $F [13, 235] = 17.78$, $p < .001$; see Table 5.1 – 5.2). According to this model, two exemplary practices (*feel good* and *not afraid*) and two inappropriate practices (*made issue* and *did not recognize importance*) uniquely predicted therapist helpfulness ratings. Specifically, *feel good* and *not afraid* were uniquely associated with increased ratings of therapist helpfulness, whereas *made issue* and *did not recognize importance* were uniquely associated with decreased ratings of therapist helpfulness. It is important to note that the zero-order correlations for all the practices were associated with therapist helpfulness scores in the appropriate direction (i.e., negatively correlated with the inappropriate practices, positively correlated with the exemplary practices; see Table 5.3). Thus,

this analysis should not be interpreted as suggesting that the non-significant exemplary practices are not helpful, or that the non-significant inappropriate practices are not harmful. Rather, this analysis reveals that *feel good, not afraid, made issue, and did not recognize the importance* are uniquely influential practices for evaluations of therapist helpfulness. While *assumed monogamy* uniquely predicted therapist helpfulness with the Inappropriate Practices Subscale, it did not reach significance when regressed amongst all 13 practices.

Table 5.1. Linear regression model summary: the 13 CNM practices, current/recent therapist

Model Summary							
R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change	Change Statistics F Change	df1	df2
.704	.496	.468	.558	.496	17.778	13	235

Table 5.2. ANOVA table: the 13 CNM practices, current/most recent therapists

ANOVA					
	Sum of Squares	df	Mean Square	F	Sig.
Regression	71.833	13	5.526	17.778	.000
Residual	73.042	235	.311		
Total	144.876	248			

Table 5.3. Coefficients table: the 13 CNM practices, current/most recent therapists

Coefficients					
#	Practices	B	β	Sig.	Zero-order
	(Constant)	3.075		.000	
Exemplary					
1	<i>Feel good.</i> Your therapist helped you feel good about yourself as a consensually non-monogamous person.	.389	.250	.000	.500
2	<i>Not afraid.</i> Your therapist was not afraid to deal with your relationship orientation when it was relevant.	.309	.169	.007	.502
3	<i>Knowledgeable.</i> Your therapist was quite knowledgeable about consensual non-monogamy communities and other resources.	.035	.022	.684	.309
Inappropriate					
1	<i>Made issue.</i> Your therapist made an issue of your relationship orientation even when it was not relevant.	-.714	-.215	.002	-.502
2	<i>Did not recognize importance.</i> Your therapist did not recognize the importance of consensual non-monogamous relationships and/or did not appropriately support these relationships.	-.406	-.176	.012	-.529
3	<i>Renounce CNM.</i> Your therapist discounted, argued against, or pushed you to renounce your non-monogamous lifestyle/identity.	-.330	-.109	.174	-.422
4	<i>Lacked CNM knowledge.</i> Your therapist lacked the basic knowledge of consensual non-monogamy issues necessary to be an effective therapist for you and/or you had to be constantly educating him or her about these issues.	-.142	-.076	.217	-.416
5	<i>Refused services.</i> Your therapist suddenly refused to see you any more after you disclosed your relationship orientation.	-.595	-.049	.330	-.202
6	<i>Societal prejudice.</i> Your therapist apparently did not understand the problems of societal prejudice against consensually non-monogamous individuals.	.113	.037	.507	-.214
7	<i>Blamed CNM.</i> Your therapist blamed your problems on your relationship orientation or insisted on focusing on relationship orientation without evidence that your relationship orientation was relevant to your problems.	-.084	-.024	.778	-.445
8	<i>Pressured.</i> Your therapist pressured or advised you to come out to someone in spite of the fact that you believed it was too risky.	.090	.013	.789	-.013
9	<i>CNM bad.</i> Your therapist indicated that he or she believed that non-monogamy is bad, sick, or inferior.	.076	.023	.800	-.456
10	<i>Assumed monogamy.</i> Your therapist gave some indication that he or she had automatically assumed you were monogamous, before you indicated your relationship orientation.	.007	.004	.940	-.339

The 13 Practices and Premature Termination

The 13 CNM practices and premature termination.

Analyses attempting to identify associations of individual practices with premature termination were unsuccessful due to issues with sparse data (for current/most recent therapists and for most harmful therapists); for many individual practices, there was complete separation of termination (v. not terminating) (i.e., there were no observations of premature termination, or conversely, not terminating, for an individual practice). Analysis of termination therefore relied

on predicting termination from the sum of exemplary and sum of inappropriate practices. The results from this model indicate that as the number of inappropriate practices increase, CNM clients are more likely to prematurely terminate (for both current/most recent therapists and most harmful therapists). With current/most recent therapists, for every increase in inappropriate practice experienced, the odds of a client prematurely terminating increased 3.6 times (Table 6.1). For participants' most harmful therapists, each additional inappropriate practice experienced increased the odds of premature termination 1.5 times (Table 6.2). A statistically significant relationship was not found between exemplary practices and premature termination for either therapist group.

Table 6.1. Logistical regression model: current/most recent therapists.

	Variables in the Equation					
	B	S.E.	Wald	df	Sig.	Exp(B)
Inappropriate practices	1.272	.304	17.536	1	.000	3.570
Exemplary practices	.720	.610	1.393	1	.238	2.055
Constant	-7.561	1.805	17.552	1	.000	.001

Table 6.2. Logistical regression model: most harmful therapists.

	Variables in the Equation					
	B	S.E.	Wald	df	Sig.	Exp(B)
Inappropriate practices	.381	.121	9.949	1	.002	1.463
Exemplary practices	.241	.469	.265	1	.607	1.273
Constant	-1.744	.590	8.747	1	.003	.175

Open-Format Helpful/Harmful Responses

Identifying novel themes.

Results are presented in Tables 7.1 – 7.2. One hundred fifty (60%) of the original 249 participants chose to articulate what their therapist did that was very helpful, while 94 (38%) expressed something their therapist did that was very unhelpful. Percentages of those who wrote out responses were calculated. Percentages do not equal 100 as some respondents indicated that their therapist did more than one helpful/unhelpful thing (i.e., “accepted my lifestyle and offered

practical advice”). Those participating identified, on average, 1.44 "very helpful things" that their therapist did, and 1.28 "very unhelpful things" respectively.

The "very helpful" practices.

The Helpful theme mentioned most was that their therapist was affirming of the client regarding non-monogamy (*affirming*) with over one-third of participants (39%) responses being categorized under this theme. Of the *affirming* responses, almost one in five (18%) mentioned that their therapist was supportive of their CNM identity and decisions, while 9% acknowledged CNM as a valid option, and 8% validated/trusted their client's decisions.

The second most common "very helpful" major theme, also endorsed by just over one-third of the sample (36%), was that their therapist did not judge them based on their relationship orientation/status (*nonjudgmental*). Approximately 11% of participants whose response fell under the *nonjudgmental* major theme indicated their therapist was generally nonjudgmental about CNM, while 11% mentioned that their therapist normalized their non-monogamy/didn't over-react, and 8% of the sample indicated that their therapist was accepting toward CNM.

With 35% of the sample responses being coded under helpful (*helpful*), it was the third most common major theme. The minor themes for this category include prioritizing the client's needs/goals/values (10%), providing helpful advice (7%), or helping to improve/navigate the client's relationship(s) (7%).

The next major theme was a therapist demonstrating ample level of interest in CNM (*interest*; 25%). The minor themes for *interest* are asking good questions about the clients experience with CNM (10%), listening effectively (7%), or being open to learn (5%).

Knowledge of CNM (*knowledgeable*) was endorsed by 9% of the sample. The minor themes for this category were having a basic information about CNM (7%) and providing CNM resources (2%).

Table 7.1. Major/minor themes for qualitative data- percentage of participants mentioning theme: helpful things.

Major Themes	% of participants	Example responses	Minor themes	% of participants
Affirming	39	“Supportive of polyamory.” “Helped me understand that the poly lifestyle is good and valid.”	Supportive of CNM identity/decisions	18
			Acknowledged CNM as valid option	9
			Validated/trusted clients decisions	8
			Queer affirming (e.g., kink, bisexuality)	3
			Acknowledged societal stigma	1
Nonjudgmental	36	“No judgments” “Not making a big deal out of non-monogamy.” “Therapist accepted the relationship structure without hesitation.” “Apologized for making assumptions.”	Was nonjudgmental	11
			Normalized/didn't over-react	11
			Was accepting	8
			Acknowledged bias	3
			Didn't pathologize/blame CNM for problems	2
			Remained neutral	1
			Didn't avoid or hyper-focus on CNM	1
Helpful	35	“Focused on my needs and wants without focusing on who provided them.” “Offered practical advice.” “Treated each relationship separately/respectfully.”	Prioritized client's needs/goals/values	10
			Provided helpful advice	7
			Helped to improve/navigate relationships	7
			Valued relationships individually	6
			Helped explore/manage emotions	5
Interest	25	“Asked questions about relevant details.” “Researched non-monogamy on her own.”	Asked good questions	10
			Listened effectively	7
			Open to learn	5
			Sought outside information	3
Knowledgeable	9	“Being familiar with non-monogamous issues.”	Had basic knowledge of CNM	7
			Provided CNM resources	2

Note: % of participants = % of those who wrote responses that endorsed the theme.

The "very unhelpful" practices.

A therapist being judgmental towards the client for being CNM (*judgmental*) was mentioned by nearly half (45%) of participants and was found to be the most common "unhelpful" major theme. Those falling under the judgment major theme indicated that their therapist was generally judgmental towards them or CNM (11%), indicated that they believed CNM was wrong or not ideal (10%), emphasized religion or traditional values (7%), or

experienced nonverbal judgment or discomfort from their therapist (7%).

Thirty-eight percent of the sample mentioned that they felt like their therapist pathologized CNM (*pathologize*). Responses coded in this category include therapists indicating that CNM was the cause or the symptom of another problem (28%), harms relationships (6%), or is not good for women (4%).

The next highest major theme category was therapists' lack of knowledge pertaining to CNM (*knowledge*; 15%). Answers falling under this category include a therapist either lacking/refusing to gather CNM information (12%) or expecting their client to educate them during therapy sessions (3%).

The three remaining major themes include therapists being dismissive towards CNM (*dismissive*, 13%), aggressive toward the client about CNM (*aggressive*, 13%), or focusing on CNM in therapy too much or too little (*focus*, 5%).

Table 7.2. Major/minor themes for qualitative data- percentage of participants mentioning theme: unhelpful things.

Major Themes	% of participants	Example responses	Minor themes	% of participants
Judgmental	45	“Judging and moralizing.” Judging with facial expressions.” “Had obvious issues with bisexuals and CNM.”	Generally judgmental	11
			CNM is wrong or not ideal	10
			Emphasized religion/traditional values	7
			Nonverbal judgment/discomfort	7
			Felt unsafe discussing CNM	4
Queer critical (e.g., kink, bisexuality)	3			
Pathologize	38	“Equating CNM to a commitment problem.” “Trying to ‘cure’ me.” “Insisting a ‘real’ woman would want monogamy.”	CNM is the cause/symptom of another problem	27
			CNM harms relationships	6
			CNM is not good for women	4
Knowledge	15	“Didn’t really understand non-monogamy.” “Failing to research CNM.”	Lacked/refused to gather CNM information	12
			Expected client to educate therapist	3
Dismissive	13	“Tried to disprove CNM.” “Not listening to what I expressed regarding my relationship status.”	Dismissed CNM	4
			Not listening/grasping CNM concerns	4
			Assumed monogamy	2
			Refused service	2
Aggressive	13	“Suggested I leave my b/f because he’s poly.” “Called me a whore.”	Pressured to end a relationship or come out	10
			Criticized/shamed for being CNM	3
Focus	5	“Far too interested in sexual details of poly.”	Focused on CNM too much	3
			Avoided CNM	2

Note: % of participants = % of those who wrote responses that endorsed the theme.

Chapter 5: Discussion

Summary of Results

An estimated 4-5% of Americans endorse being in a consensually non-monogamous (CNM) relationship--numbers comparable to those identifying as lesbian, gay, or bisexual (LGB; Conley, Moors, Matsick, & Ziegler, 2012; Gates, 2011). Despite the pervasive stigma associated with CNM, it is considered healthy and viable romantic relationship option (Conley, Ziegler,

Moors, Matsick, & Valentine, 2013; Rubel & Bogaert, 2014). Therapists, however, receive little to no training about CNM or the CNM community (Weitzman, 2006). Two hundred forty-nine individuals in CNM relationships responded to open and closed-ended survey questions about their experiences with past and current therapists. Of the therapists seen by CNM clients, nearly one-third (29%) were found to be lacking the basic knowledge of CNM needed to be an effective therapist, and only 27% were considered quite knowledgeable of CNM. Twenty-six percent therapists seen were found to be either not at all helpful (15%) or destructive (11%).

Approximately one out of every ten (11%) CNM clients prematurely terminated sessions because of a negative interaction with their therapist regarding their CNM identity/lifestyle. These results highlight the need for empirically-based guidelines that could be included in mental health curricula and continuing education training. Resources developed for use with LGB clients may be helpful in developing CNM guidelines. In this study, swapping sexual orientation language for relationship orientation language (e.g., heterosexual for monogamous) on practice guidelines for LGB clients, led to the creation of a 13-item scale that accounted for half (50%) of the variance in therapist helpfulness scores for CNM clients. In light of the findings and available research, an initial set of empirically based guidelines for psychological practice with CNM clients are also proposed.

Therapist Helpfulness Ratings and Practice Frequencies

Perceived helpfulness of therapists with CNM clients.

As hypothesized, most therapists were found to be helpful, as three out of four (75%) of all the therapists accounted for in the study ($n = 426$) were rated as either *fairly helpful* or *very helpful*. This rate is lower than a national survey that found approximately 89% of respondents indicated that therapy either *helped somewhat* or *helped a lot* (Consumer Reports, 1995, as

reported in Liddle, 2000). The 25% of the therapists sampled in this study rated unfavorably (i.e., the *not at all helpful* or *destructive* answer options) is above the typical range (between 5% and 20%) of psychotherapy clients that are dissatisfied with their treatment found by Urquhart, Bulow, Sweeney, Shear, and Frances, 1986. These results may be due to societal stigma and a lack of education. Given how helpful LGB training programs have been found to be at improve the knowledge and skills (Rutter, Estrada, Ferguson, & Diggs, 2008) and expose non-affirming LGB attitudes (Boysen & Vogel, 2008), including CNM issues in professional and continuing education programs may be an effective means of challenging potential therapist biases and increasing favorable therapist ratings by CNM clients.

The results of the present study also highlight a potential disparity in the ratings of CNM client's current/most recent therapists and their past therapist(s). While 13% of the current/most recent therapists were rated as being *not at all helpful* (10%) or *destructive* (3%), nearly half (44%) of past therapists were found to be *not at all helpful* (21%) or *destructive* (23%). Supplementary research is needed to clarify the reason for the substantial differences between recent and past therapists. It may be that clients were more apt to screen after having a negative experience and/or are doing a better job of screening. Attitudes toward CNM may also be becoming more affirming with time. Rubin (2001), for example, argues that the increasing acceptance of homosexual started a shift towards increasing acceptance of other alternative sexualities and lifestyles, including CNM.

Most/least used exemplary/inappropriate practices.

It was anticipated that the 13 CNM practices would vary substantially in terms of how often the individual practices were experienced by CNM clients and the results confirm this hypothesis. The results also point to substantial room for improvement as a small majority of all

therapists in the study were not afraid to deal with CNM when it was relevant (62%), while a minority of therapists made clients feel good about themselves as CNM individuals (46%) or were found to be quite knowledgeable of CNM communities and other resources (27%). The exemplary practices were endorsed more frequently among current/most recent therapists (78% *not afraid*, 60% *feel good*, 36% *knowledgeable*), but there is still much room for improvement, especially in affirming clients about their CNM identity/relationship(s) and being knowledgeable about CNM communities and resources.

Current/most recent therapists were also found to engage in fewer inappropriate practices than past therapists on nine of the ten inappropriate practices. The most common inappropriate practice was a therapist automatically assuming their client was monogamous (recent, 35%; past, 51%; all, 41%). This problem can easily be remedied by simply asking clients to self-select the relationship structure (e.g. monogamy, monogamish, polyamory, swinger, open relationship) that they identify with on intake paperwork. Moors and Schechinger (2014) suggest that failing to assess relationship orientation at intake perpetuates mono-normativity and forces CNM clients to choose whether to bring up non-monogamy with their clinician without knowing whether their therapist will be affirming. Including a relationship orientation question on intake paperwork holds the potential to normalize and legitimize CNM relationships to clinicians and monogamous clients alike, while informing clients that the clinicians at the practice at least have enough knowledge of CNM to include it on their intake form.

Coming out and being refused services.

Based on the frequency in which the 13 "LGB-inspired" practices were endorsed, a case could be made that all of the exemplary practices and eight of the ten inappropriate practices are also applicable to the CNM community. Eleven of the 13 practices were endorsed as being used

by at least 11% of all therapists in the data. Two responses, however, were used by one percent or less of therapists- pressuring clients to come out to someone in spite of the fact that the client believed coming out would be too risky, and refusing to see the client upon learning that he or she identifies as CNM¹. While these two practices were not experienced by many participants in the current survey, existing CNM literature indicates that they are areas of concern to CNM clients.

The fact that so few therapists in the current study pressured their CNM clients to come out in spite of the perceived risks is encouraging. It is not known, however, if the issue did not come up in therapy very often with the current sample, or if it did come up often and therapists simply were not pressuring clients about coming out. It may be the case that coming out concerns are not as salient to CNM individuals as they may be to LGB individuals (i.e., the items were created from LGB guidelines for psychological practice). Coming out concerns, however, are often listed as a common presenting problem for many CNM therapy clients (Richards & Barker, 2013; Weitzman, Davidson, & Phillips, 2012). CNM is not a protected minority status (Emens (2004) and there are many potential ramifications for coming out. Decisions about if, when, how, and to whom a client comes out to should be left to the client, with therapists playing a supportive role in the client's effort to carefully think through the issue. A few therapy resources (e.g., Weitzman, Davidson, & Phillips, 2012) and journal articles (e.g., Rambukkana, 2004) address the challenges associated with coming out as non-monogamous, and provide guidance for how to effectively navigate the process.

Similarly, while it may not happen that often, some clients were refused services upon disclosing their CNM identity. In the open response section, one participant in the current study

¹ This item also included the text “Do not include cases where the therapist made a sensitive and appropriate referral to a therapist who was especially skilled in your expressed areas of concern.”

who did not endorse this item noted, *“We screened therapists very thoroughly before selecting this one (our only therapist). Several of those we interviewed did not return calls, refused to refer us to someone, or sounded discouraged that they were not equipped to help us. It was unhelpful because we were going through some very intense emotions and hearing from so many people who were flat-out unwilling to help us was discouraging.”* Another participant who did not endorse this item wrote, *“In screening for the current therapist, my partner called about a dozen therapists--when given the basic details (i.e., a relationship in trouble, with other relationships that aren't very related), several insisted that the problem would be helped by ending other relationships.”*

In light of this, despite the low endorsement rate, both pressuring about coming out and refusing services based on CNM are considered relevant issues to CNM clients. Clinicians should strive to eliminate the effect of biases on their work and consider the risks and benefits of coming out and referrals on a case-by-case basis. Therapists are encouraged to align with their client regarding when weighing the pros and cons of when, how, or if the client would prefer come out, and evaluate their own competencies and the limitations of their expertise when offering services to CNM clients.

Average number of exemplary/inappropriate practices used.

It was anticipated that the number of the 13 CNM practices would vary and this was found to be true. The entire sample of therapists used 1.51 inappropriate and 1.35 exemplary practices, but these numbers are obviously influenced by the number of exemplary (n = 3) and inappropriate (n = 10) practices participants had to choose from. The fact that current/most recent therapists are engaging in fewer inappropriate practices than past therapists on average (0.99 compared to 2.23 practices, respectively) is encouraging., The fact that current/most recent

clinicians are typically using one of the inappropriate practices suggests there is still a need for therapists to be educated on CNM issues.

Premature termination.

It was expected that some CNM clients would prematurely terminate or end sessions because of a bad experience based on their non-monogamous relationship(s)/identity and this hypothesis was confirmed. Four percent of participants prematurely terminated over a CNM related issue with their current/most recent therapists compared to nineteen percent of past therapist/client relationships (11% of the entire sample of therapists). Once again, the numbers point to more favorable outcomes with current/most recent therapists as well as the need for improved training on working with CNM clients.

Screening for CNM-affirming attitudes.

My hypothesis that some CNM clients would screen their therapist based on how supportive they perceived the therapist would be toward their relationship orientation/lifestyle was confirmed. Thirty-eight percent of all therapists in the study were screened compared to 63% of therapists being screened by LGB clients in a 1997 study (Liddle, 1997), suggesting that CNM clients may be screening less for CNM-affirming attitudes than LGB clients are screening for affirming LGB attitudes. The fact that nearly half (46%) of current/most recent therapists were vetted based on their attitudes towards CNM suggests the importance of CNM in the lives of non-monogamous clients. The higher rate of screening between current/most recent and past therapists (19%) combined with what appears to be higher therapist helpfulness ratings amongst current/most recent therapists, suggests that CNM clients screening therapists on their attitudes towards CNM may be associated with therapist helpfulness. This result would align with

research indicating screening for affirming attitudes improves outcomes for sexual minorities (Liddle, 1997).

The 13 CNM Practices and Therapist Helpfulness

The exemplary/inappropriate practices and therapist helpfulness.

The prediction that a few individual practices would emerge as strong predictors of therapist helpfulness was confirmed. It seems particularly important for a therapist to help a CNM client feel good about her or his CNM identity/lifestyle (*feel good*) and not be afraid to address CNM when it is relevant (*not afraid*). It appears uniquely unhelpful when therapists working with CNM clients make an issue of CNM when it is not relevant (*made issue*), do not recognize the importance of and amply support CNM relationships (*did not recognize importance*), and automatically assume their client is monogamous (*assumed monogamy*).

These findings provide additional clarity regarding shared and unique needs of LGB and CNM therapy clients. Based on the rate of endorsement in the previous model and available literature, all the tested practices pulled from guidelines designed for the LGB population appear to be “applicable” (to varying degrees) to the CNM population. While the model cannot determine if the practices *cause* an increase or decrease in therapist helpfulness scores, this model helps illuminate which practices may be most important for therapists to avoid or use when treating CNM clients. The exemplary and inappropriate subscales in isolation both emerged as effective predictors of how helpful CNM clients will perceive their therapist and could be expanded and refined via factor analysis.

The 13 CNM practices and therapist helpfulness.

It was predicted that the 13 CNM practices would emerge as a strong predictor of perceived therapist helpfulness with CNM clients and the results confirmed this hypothesis.

Notably, all the practices were significantly correlated in the anticipated direction (exemplary positively and inappropriate negatively) with therapist helpfulness (see zero-order correlations). In light of this, guidelines for treating CNM clients should consider addressing each of the exemplary and inappropriate practices in this study, taking particular note of the four practices that were unique predictors of therapist helpfulness. Upon regressing all 13 of the practices simultaneously on therapist helpfulness, four of the five unique predictors from the exemplary/inappropriate subscale regression model maintained their unique effect. *Feel good*, and *not afraid* (exemplary) as well as *made issue* and *did not recognize importance* (inappropriate) remained unique predictors of therapist helpfulness while *assumed monogamy* was no longer found to be a unique predictor when all the practices were regressed simultaneously. In other words, the negative effects of assuming a client is monogamous may be absolved if a therapist also is utilizing exemplary practices. It could be argued that the four practices emerging as unique predictors when all 13 practices were regressed are the most important practices for therapists to use or avoid.

While the majority of current/most recent therapists used and/or avoided these four practices, a sizeable minority did not. Twenty-two percent of therapists *were* reported as being afraid (or perhaps hesitant) to deal with their client's relationship orientation when it was relevant, forty percent did *not* help their CNM client feel good about being a CNM individual, six percent made an issue of their client's relationship orientation when it was not relevant, and twelve percent did not recognize the importance of and/or appropriate support a client's CNM relationships. The data also suggest that the state of treatment was far worse with past therapists. Collectively, the evidence points to the importance of creating empirically based guidelines for treatment and including CNM in the multicultural training that clinicians receive. The two

practices pertaining to CNM knowledge (either being quite knowledgeable of CNM communities/resources (exemplary) or lacking knowledge of basic CNM issues (inappropriate), were both found to individually correlate with therapist helpfulness in the expected direction. The rate at which these two practices were endorsed suggests there is a significant need to educate clinicians on how to effectively work with CNM clients.

Collectively the 13 CNM practices were strong predictors for determining how helpful CNM clients perceive their therapist to be. This is promising as LBG research is more advanced than CNM research, and the LGB resources may prove to be helpful in improving outcomes for CNM clients as well. Rather than “re-inventing the wheel,” it may be helpful for CNM researchers to build off the foundation of LGB research already available. Further research is needed, however, to tease out the overlap and unique aspects of these two populations. These findings, however, do appear to confirm a theoretical linking between LBG and CNM experiences. At a very basic level, the principles underlying effective treatment for lesbian, gay, and bisexual clients do appear to have some merit when working with CNM clients.

The 13 CNM Practices and Premature Termination

The 13 CNM practices and premature termination.

My hypothesis that a few individual practices emerging as strong predictors was not affirmed because the analyses attempting to identify associations of individual practices with termination were unsuccessful due to issues with sparse data (for current/most recent therapists and for most harmful therapists). For many of the individual practices, there was complete separation of termination (v. not terminating) (i.e., there were no observations of premature termination for an individual practice, or conversely no observations of not terminating for an individual practice).

Analysis of termination therefore relied on predicting termination from the sum of exemplary and sum of inappropriate practices. The aggregate-level hypothesis was partially confirmed with the inappropriate practices being positively correlated with premature termination (every additional inappropriate practice increased premature termination 3.6 times for current/most recent therapists and 1.5 times with most harmful therapists), but no significant relationship was found between the exemplary practices and premature termination. It appears that the presence of inappropriate practices does increase the likelihood of premature termination but it is not clear if using the exemplary practices decreases the likelihood of premature termination.

Open-Format Helpful/Harmful Responses

Identifying novel themes.

Asking participants to respond in an open format what their therapist(s) did that was particularly helpful or unhelpful was designed to help identify potential similarities as well as practices that were not captured in the 13 CNM practices. It was hypothesized that a few unique themes will emerge, and this was in fact found to be the case. The majority of the helpful and unhelpful things that participants wrote about seemed to be captured in the 13 CNM practices. The practices that *may* be more centrally relevant to the CNM population included being affirming of the alternative sexualities often associated with the CNM community (e.g., kink/BDSM), valuing each relationship individually, and CNM not being good for women specifically. It was determined that all the other major and minor themes were represented in the 13 CNM practices.

While alternative sexualities (e.g., kink/BDSM) are not something considered exclusive to the CNM population, it is a topic that consistently comes up in the CNM literature (see Sheff

& Hammers, 2011). The intersection of these two practices is something that therapists should be educated about, especially considering the stigma associated with each. While early psychologists pathologized alternative sexualities (Freud, 1938), more recent scholarship has challenged these negative evaluations (Kleinplatz & Moser, 2005; Moser, 2002, with some feminist scholars praising alternative sexualities as sexually empowering to women (Califia, 1981; Rubin, 1984).

While there are a number of LBG individuals who also identify as CNM, since having multiple partners is a core concept of CNM, it is not surprising that valuing each relationship individually was identified as a theme that was not captured in the 13 CNM practices. Therapists who hold judgmental attitudes toward CNM may be apt to ignore or dismiss non-primary partners as not important or “illegitimate” while therapists who are not educated about CNM issues may undervalue the importance of a satellite partner.

Given the restrictions placed on female sexuality and the associations with CNM and promiscuity, it was not a surprise that CNM not being good for women was an identified as a theme not represented in the 13 CNM practices. Clinicians should recognize how the assertion that CNM is not good for women does not appear to be supported by the extant literature. To the contrary, a number of feminist scholars praise CNM for promoting equity and empowering women (Jackson & Scott, 2004; Moors, Rubin, Matsick, Ziegler, & Conley, 2014).

The helpful practices.

The helpful practices that therapists used were more equally distributed than the unhelpful practices. Therapists being generally affirming, nonjudgmental, helpful, and expressing appropriate interest in their client’s non-monogamy were endorsed by 39%, 37%, 35%, and 25% of respondents, respectively. The responses indicating their therapist did

something that was helpful (i.e., was affirming, helpful, expressed interest, and had knowledge of CNM) is not necessarily surprising. We expect that therapists would provide a service when we seek them. Yet, the significance of the societal stigma and resulting expectations of CNM clients was made rather apparent when such a sizable proportion of respondents (36%) indicating that their therapist simply abstaining from doing something (i.e., being judgmental) was one of the most helpful things their therapist did. CNM clients are clearly aware of and impacted by the societal stigma, and it speaks volumes that that simply not judging clients on the basis of the relationship structure is one of the most frequently endorsed things a therapist can do. It does not seem like much to ask therapists to be generally affirming, nonjudgmental, helpful, interested, and somewhat knowledgeable of CNM.

The unhelpful practices.

The two *Unhelpful* major themes that stood out were therapists being judgmental (*Judgmental*) and pathologizing CNM (*Pathologize*), as they were collectively endorsed by 83% of those responding to this question. In other words, therapists should be mindful that the most common mistakes made include are being judgmental toward CNM and/or unjustly blaming a client's problems on CNM. The other four major themes (*Knowledge*, *Dismissive*, *Aggressive*, and *Focus*) were collectively endorsed by 46% of participants. Over one-fourth (28%) of respondents indicated that it was very unhelpful for their therapist to indicate that CNM was either the cause of their problem (e.g., CNM is causing you to feel depressed or causing the issues in your relationship) or a symptom of another problem (e.g., you're CNM because you were abused as a child or grew up in a divorced household).

Limitations

The present study is limited in how broadly the results can be generalized. The study consists of mostly polyamorous identified individuals (79% of the sample) who were recruited via online convenience sampling. While the CNM subgroups examined appear to share core commonalities (e.g., societal stigma, non-exclusive agreements), common presenting concerns and needs may differ significantly between CNM subgroups. The current article emphasized the similarities between CNM individuals but the need for research identifying the unique needs of CNM subgroups is clearly needed as well. Participation was also limited to individuals who indicated a romantic relationship was a topic of conversation with their current/most recent therapist, and cannot be generalized to *all* CNM individuals who seek therapy. Limiting participation to those that discussed a relationship may have increased the rate at which the 13 CNM practices were endorsed. However, given the higher rate of inappropriate practices used by past therapists, excluding those who did discuss a romantic relationship with a past therapist but not their current/most recent therapist may have painted a more positive picture of treatment practices with CNM clients.

The qualitative analysis was helpful in both reinforcing the fit of the 13 CNM practices and identifying potential areas in which common experiences between the two populations may differ. The responses may have impacted by the fact that this open-response question was asked after responding to questions about whether or not their therapist(s) engaged in any of the 13 CNM practices. Many of the responses did align with the 13 CNM practices and new practices were identified, but they may have aligned to a lesser degree and more unique practices may have emerged if asked before asking about the 13 CNM practices.

There were also a limited number of exemplary practices. The greater number of biased, inadequate, or inappropriate practices reflects what appears to be greater diversity of unhelpful attitudes and practices found by Liddle (1996) and her team. While the current study altered one of the exemplary practices from Liddle's (1996) study to be an inappropriate practice ("*Your therapist never made an issue of your sexual orientation when it was not relevant*" was changed to "*Your therapist made an issue of your relationship orientation even when it was not relevant*"), the altered item ended up being the strongest predictor of therapist helpfulness of all 13 items. The logistic regression analysis was also rather limited due to an unforeseen lack of observations of clients prematurely terminating for each individual practice. Ideally the individual practices most strongly associated with premature termination would have been identified.

Implications for Future Research

As this paper serves as one of the few forays into the empirical study of therapist treatment of CNM clients and the first following a substantial hiatus in the literature, there are many exciting avenues for future research. Expanding on the breadth of possible directions is beyond the scope of this paper, and attention will be given on what type of research is considered priority for being able to establish empirically supported guidelines for psychological practice with CNM clients.

Applicability of LGB resources with CNM clients.

Simply exchanging sexual orientation language for relationship orientation language (i.e., your therapist assumed you were heterosexual versus your therapist assumed you were monogamous) led to the creation of a 13-item measure that proved to be very effective in predicting the perceived helpfulness of a therapist working with a CNM client. The 13 CNM

practices were endorsed at a high rate by CNM clients (average of 1.51 inappropriate and 1.35 exemplary practices experienced per therapist) and were strong predictors of perceived therapist helpfulness. Each of the practices were also statistically significant in the anticipated direction; the inappropriate practices were negatively correlated with therapist helpfulness scores at the individual and aggregate level and positively correlated with premature termination at the aggregate level, while the exemplary practices were positively correlated with therapist helpfulness scores at the individual and aggregate levels (no significant relationship was found between the exemplary practices and premature termination). The majority of the open responses were also accounted for in the 13 CNM practices. The results suggest that the 13 CNM practices appear to be effective indicators of therapist helpfulness, and the collective evidence implies that some counseling resources designed for use with LGB clients may be able to be slightly modified to help meet the needs of the CNM population.

This is of course not to say that all the unique aspects related to CNM and have been captured. While efforts were made to try and capture (through open responses) any concepts that may not have been represented in the 13 CNM practices, the information gathered is only considered an initial step in highlighting the intersections of sexual and relational orientation. It does not address why or how the constructs are related, but simply suggests that they are in some respects. While a simple conclusion, the implications are potentially profound regarding future work with CNM individuals. The results indicate that it may be worthwhile to examine the available in the body of LGB research for potentially helpful resources for improving outcomes with CNM clients. Existing LGB resources could be modified and expanded *in addition* to generating novel research and clinical guides for CNM clients. The results may have also identified some of the practices that tend to be rather helpful/unhelpful for not just CNM clients

specifically, but perhaps for sexual minorities in general. Further analysis of these practices is warranted.

Sexual orientation and relationship orientation: distinct yet related constructs.

While the present study points to the interrelatedness of sexual and relational orientation, the constructs of are theoretically and clinically distinct, demonstrating separate but concurrent linked development across the lifespan. The prevailing assumption around monogamy being the ideal seems to have prohibited inquiry into the topic of relationship orientation. In order to determine the ways in which LGB resources may be applicable to CNM clients, it seems necessary to explore how these identities are related and distinct.

On the surface, it seems logical that some individuals will be more biologically inclined toward non-monogamy, perhaps similar to how some individuals are more inclined toward same sex attraction. Assuming this to be true, it raises the issue of whether the restricting or trying to change an individual's relationship orientation has similar negative consequences as trying to change someone's sexual orientation. In essence, should we be thinking of and treating someone who is non-monogamous similar to how we think about and treat someone who is lesbian, gay, or bisexual? While this review focused more on sexual orientation, the same questions could be raised regarding gender. Along with that, should similar approaches be taken to promote awareness of non-monogamy issues? Rather than a 'one-size-fits all' approach to relationships, it is likely in the best interest of our clients to create a safe space for them to discover their natural preference based on their internal inclinations, similar to how we support clients exploring their sexual orientation.

Attitudes and delivery as potential mediators of helpful/unhelpful practices.

Upon examining the major themes of the present study, it appears most could be conceptualized as being facilitated by non-affirming attitudes towards CNM. A therapist who is *affirming* and *nonjudgmental* toward CNM, for example, is likely to have affirming attitudes towards CNM, while those that are *judgmental* and *pathologize* CNM are not. A therapist's knowledge of CNM is also expected to be moderated by attitudes to a lesser extent as a therapist could hold affirming attitudes toward CNM and simply lack exposure to CNM information. Identifying if the presence or absence of particular exemplary or inappropriate practices are moderated by therapist attitudes toward CNM would potentially simplify how to improve outcomes and inform what the most effective way to educate therapists would be. That is, perhaps instead of focusing on what practices a therapist is using, the most important thing might be to test what their attitudes are toward CNM. A few questions that could be asked therapists to determine their attitudes might also help in making decisions about when to refer.

Along with that, therapeutic practices (i.e., the content) are clearly important, but do not address how the content was delivered. For example, some clients in the current study enjoyed when therapist asked about CNM while others expressed frustration with having to educate their therapist in session. Attitudes and delivery are both likely to be significant mediating variables in explaining therapist outcomes. That is, a client may more inclined to think favorably of a therapist asking for information who has non-judgmental attitudes towards CNM than a therapist they sense is being judgmental. This seems to be in line with a study conducted by Brooks and Inman (2013), who surveyed 101 clinicians and found that *only* significant predictor of perceived and actual bisexual counseling competency is a therapist's attitudes toward bisexuality.

Screening, education, and prioritizing the establishment of empirically based guidelines for treatment.

Vetting therapists for CNM-affirming attitudes was positively associated with therapist helpfulness, and the therapists in the current study were undereducated about CNM issues and resources, which was negatively associated with therapist helpfulness. Screening therapist for CNM-affirming attitudes and educating therapists about CNM issues seem viable options for further exploration. A number of training manuals addressing clinical practice with CNM clients recommend screening therapist to ensure they hold affirming attitudes towards CNM relationships (Weitzman, Davidson, & Phillips, 2012; Zimmerman, 2012; Finn, Tunariu, & Lee, 2012), and this practice does appear to be supported by the current findings. While I would recommend that CNM clients screen therapists for affirming attitudes (especially if a romantic relationship is relevant to their presenting concern), it is not considered ideal that the responsibility is with the clients. The need to screen would likely be substantially reduced if therapists were receiving adequate education. It seems less than ideal to place responsibility on an already marginalized population to have to take extra steps to ensure that the person they are seeking for mental health services is going to be affirming toward an aspect of their sexual/relational identity.

According to Weitzman (2006), most graduate mental health training programs do not address CNM in their textbooks, curricula, or internships. Further research is needed, however, to verify the impact of not educating therapists on CNM issues, and the avenues for best educating therapists. Furthermore, enough foundational research must be conducted on CNM client experiences for ample educational resources to be established. An initial set of guidelines is provided (based heavily on the guidelines established for psychological practices with lesbian,

gay, bisexual, transgender, and gender non-conforming clients) as a means for guiding both researchers and clinicians in their work with CNM clients. In order to improve outcomes with CNM clients, it is suggested that research addressing CNM mental health outcomes should be prioritized in terms of what is needed to establish enough foundational research to create guidelines with robust empirical support.

Implications for Practice

There are also clear implications for practice that can be derived from the results of this study. Initial guidelines for practice are presented based on the current results and the available research. Given the scarcity of the research addressing the intersection of mental health practices and CNM individuals, the guidelines are made with the hope and expectation that they will be modified and expanded as additional information and perspectives are accounted for.

Guidelines for psychological practice with consensually non-monogamous clients.

Sixteen years after APA's 1975 resolution that same-sex attraction implies no impairment in judgment, reliability, or general social and vocational abilities, the APA put together a task force to investigate the range of bias that may occur in psychotherapy with lesbians and gay men (see Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991). The group solicited responses from 2,544 psychologists and their responses to four open-ended questions about any incidents or practices that they perceived to be harmful or beneficial in psychotherapy with lesbian and gay clients. From these responses, the task force developed a list of seventeen "biased, inadequate, or inappropriate practices," and fourteen "exemplary practices."

The Garnets et al. study was essential for the progress of treating sexual minorities because it led other researchers to address the needs of LGB clients. The Garnets et al. report, in addition to studies by numerous other authors (e.g., Fox, 1996; Greene, 1994; Liddle, 1996;

Pilkington & Cantor, 1996) suggested that there was significant need for enhanced education and training in working with lesbian, gay, and bisexual clients. As a result, in 2000, the APA put together another committee to create “Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients” (see Division 44/Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force on Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients, 2000). These guidelines were then updated in 2012 (see American Psychological Association, 2012) by the APA’s Division 44/Committee on Lesbian, Gay, Bisexual, and Transgender Concerns.

Since the publication of the Garnets et al. (1991) study and the original APA guidelines (Division 2000), a number of publications have also detailed specific ways that therapists can be more effective when working with their LGB clients (e.g., Campos & Goldfried, 2001; Eubanks-Carter et al., 2005; Liddle, 1996; Martell, Safren, & Prince, 2003; Pachankis & Goldfried, 2004; Perez, DeBord, & Bieschke, 2000; Ritter & Terndrup, 2002). Further, a number of articles have also been produced that highlight specific ways training and supervision can more successfully address diversity issues, including sexual identity (e.g., Ancis & Ladany, 2001). While LGB clients have historically experienced harmful therapy experiences, LGB clients appear to be increasingly more satisfied with their therapy experiences (Jones & Gabriel, 1999; Liddle, 1999).

It is my hope that the current project would address the need for continued CNM-related research and contribute to the unfolding of a process to establish a similar set of guidelines for practice with CNM clients. The current research provides insight regarding which practices are particularly helpful and which are especially harmful when working with CNM clients. In light of the results and the existent data (albeit limited), an initial draft of guidelines for psychological practice with CNM clients has been produced. By no means are the proposed guidelines considered exhaustive or complete. They are intended to be a useful starting place for ongoing

research while providing guidance for clinicians based on the resources currently available. The guidelines are generate more questions than provide answers and highlight the vast need for additional research into the psychological treatment of CNM clients, and establish possible directions for future research. The format intentionally resembles that used in the American Psychological Association's guidelines for practice with lesbian, gay, and bisexual clients (APA, 2012), as well as the guidelines for practice with transgender and gender nonconforming clients (Appendix F; APA, 2015).

Education and training.

Guideline 1: Include CNM in professional education and training.

Clinicians strive to include CNM issues in professional education and training, and increase their knowledge and understanding of CNM through continuing education, training, supervision, and consultation.

The results of the present study point strongly to the need for providing basic training of CNM issues in professional education and training. Over one fourth (29%) of the therapists accounted for in the study were found to be lacking the basic knowledge of CNM issues necessary to be an effective therapist and/or had to be constantly educated about CNM issues by their client. Not surprising, the CNM clients who experienced this tended to rate their therapist lower than clients who did not. Furthermore, while being quite knowledgeable about CNM communities and other resources was positively associated with therapist helpfulness, only 27 percent of therapists were rated as being quite knowledgeable of CNM communities and other resources.

Currently, graduate mental health training programs are not addressing CNM in their textbooks, curricula, or internships (Weitzman, 2006). When the issue of monogamy is

addressed, trainings often conflate all forms of non-monogamy with “infidelity” or “adultery,” with an emphasis placed on stopping the affair rather than accommodating non-monogamous inclinations (Berry & Barker, 2013). Supervisors, consultants, and faculty are encouraged to incorporate contemporary, research-based information about consensual non-monogamy issues throughout graduate-level training. Moors and Schechinger (2014), for example, suggest that therapists can reduce mononormativity by addressing breaches of trust in cases of infidelity without privileging monogamy (e.g., requiring the cheating partner to break off the relationship) or pathologizing a non-monogamous orientation (e.g., implying that it is inherently wrong to desire multiple partners or keep both relationships).

Zehner (2015) found that therapist education about CNM was positively associated with perceived competency in working with CNM clients and negatively associated with clinician perception that CNM relationships are “afraid of commitment.” Training has also been shown to increase knowledge and skill levels and expose biases with lesbian, gay, and bisexual clients (Boysen & Vogel, 2008; T. Israel & Hackett, 2004; Rutter, Estrada, Ferguson, & Diggs, 2008). There are a few resources available that could be utilized in either program curricula and/or in training and supervision (e.g., Easton, 2010; Fierman & Poulsen, 2014; Finn, Tunariu, & Lee, 2012; LaSala, 2001; Richards & Barker, 2013; Weitzman, 2006; Weitzman, Davidson, & Phillips, 2012; Zimmerman, 2012). Both instructors and students alike are encouraged to explore their own attitudes and biases. In light of the existing attitudes directed toward CNM, it may be helpful to visit articles that empirically address whether the existing stigma is justified (e.g., Conley, Ziegler, Moors, Matsick, & Valentine, 2012; Rubel & Bogaert, 2014).

In addition to including CNM issues in professional education and training, clinicians are encouraged to pursue additional education, training, experience, consultation, and/or supervision.

A few topics that could be addressed include (a) human sexuality; (b) mental health issues impacting CNM people; (c) CNM identity development in a mononormative society, including ethnic and cultural factors affecting identity development; (d) the impact of microaggressions and stigmatizing CNM individuals, relationships, and families; (e) the intersections of multiple identities (e.g., relationship orientation, sexual orientation, gender identity, race, etc.); (f) career and workplace issues faced by CNM persons; (g) issues pertaining to religion and spirituality; (h) health and wellness issues; (i) coming out concerns; (j) infidelity issues from a CNM-affirming perspective; (k) effectively and ethically opening and closing relationships; and (l) CNM issues across the lifespan.

Attitudes toward consensual non-monogamy.

Guideline 2: Impact of knowledge and beliefs on CNM clients.

Clinicians are encouraged to be aware of how their knowledge and beliefs about CNM may influence treatment.

Results of the present study point to the potential negative impact of having biased attitudes can impact therapeutic outcomes when working with CNM clients. The quantitative and qualitative responses suggest that when CNM is seen as evidence of mental illness or psychopathology, the client's relationship orientation as a source of the client's difficulties, and doing so is negatively correlated to therapist helpfulness. Therapists are called to evaluate the competencies and limitations of their knowledge and expertise and especially when offering assessment and treatment services to people who share characteristics that are different than their own. The fact that only twenty-seven percent of the therapists accounted for in this study were found to be quite knowledgeable of CNM issues is concerning. Given how saturated our culture is with monosexist attitudes, language, theories, and psychotherapeutic interventions, a therapist

failing to consciously make efforts to identify and counteract these forms of monosexism leaves CNM exposed to appearing abnormal, deviant, and/or undesirable.

The current study also suggests how avoiding the topic of relationship orientation, or adapting a sense of intentional “blindness” to a client’s relationship orientation is an ineffective therapy practice. Denying or ignoring this aspect of a client’s identity or lifestyle creates and invalidates and denies the culturally unique experiences that are often critical to the therapy process. Similar to how adopting a “sexual orientation blind” perspective seems to perpetuate heterosexism in a way that is unhelpful to LGB clients (Garnets et al, 1991), the same appears to be true for CNM clients. Clinicians are encouraged to be intentional about reducing the stigma related challenges that affect CNM individuals and to promote positive social change. Drawing on the recommended key areas clinicians are encouraged to be familiar with when working with LBG clients (from APA, 2012), clinicians working with CNM clients are encouraged to be familiar with (a) human sexuality across the life span; (b) the impact of social stigma on relationship orientation and identity development; (c) the coming-out process and how such variables as age, gender, ethnicity, race, disability, religion, and socioeconomic status may influence this process; (d) multiple-partner relationship dynamics; (e) family-of-origin relationships; (f) the struggles with spirituality and religious group membership; (g) career issues and workplace discrimination; and (h) the coping strategies for successful functioning.

Guideline 3: Understand the impact of stigma.

Clinicians are encourage to be mindful of how societal stigma may be impacting the lives of CNM individuals.

CNM relationships are perceived to be less acceptable, less committed, less trusting, less meaningful, more jealous, lower in relationship quality, less sexually satisfied, sexually riskier,

and more lonely than the monogamous relationships (Conley, Moors, Matsick, and Ziegler, 2012; Munson, 1999; West 1996; Rust, 1996) despite evidence to validate these perceptions (Moors, Matsick, Ziegler, Rubin, & Conley, 2013; Lehmler, 2015; Rubel & Bogaert, 2014). CNM individuals are likely to be influenced by stigma as other minority populations, and the current study also suggests that many CNM individuals are experiencing discrimination from the therapists they are seeking for support. The extent and nuanced impact of societal stigma on CNM individual's lives remains under-researched and psychologists are encouraged to examine this topic. The current study points to a number of shared experiences with LGB individuals and researchers may wish to consider generating ideas from studies exploring stigma with other minority populations.

Over one in ten of the therapists in the current survey were found to lack understanding the problems of societal prejudice against consensually non-monogamous individuals, suggesting the need for greater efforts to include CNM in education and training curricula. Clinicians are encouraged to be mindful of the possible forms of discrimination their CNM clients may be experiencing. Social stigma directed towards CNM may be impacting the lives of clients in a number of ways, including (but not limited to) distress about visibility management (e.g., when, if, and/or how to come out), children being bullied, marital/partnership rights disputes (e.g., cases of divorce or child custody), discrimination based on moral or religious grounds, extended family consequences/conflict, parental participation challenges at school, housing discrimination, within group issues, access to CNM-affirming healthcare, and difficulty finding community (Twist, Haym, Iantaffi, & Prouty, 2015; Weitzman, Davidson, & Phillips, 2012). CNM individuals holding other marginalized identities, such as race and ethnicity, gender identity, immigrant and socioeconomic status, religion, age, historical cohort, disability, geographic

location, and sexually transmitted infection status, may be at a greater risk for experiencing discrimination. Therapists and researchers alike are encouraged to examine and be mindful of the unique forms of oppression that may be extended toward CNM individuals with other minority identities.

The degree to which CNM individuals experience internalized negative attitudes towards consensual non-monogamy (internalized monosexism) is also a topic that merits exploration. Forms of mononormativity appear to be pervasive and integrated into our culture in ways that may not be evident to a CNM client, and clinicians are encouraged to be mindful of how CNM stigma may be present in the lives of their clients even if it is not mentioned as a presenting concern.

Results of the current study suggest that a lack of knowledge or judgmental attitude toward CNM relationships may decrease a therapist's helpfulness and increase the probability of premature termination. Thus, for optimal therapeutic outcomes, mental health professions are encouraged to be aware of their biases and the potential impact of subtle and overt forms of discrimination. Failure to do so could result in perpetuating stereotypes and subsequent poor client outcomes.

Guideline 4: Create a CNM-affirming environment.

Clinicians strive to create a CNM-affirming environment and assist clients in accessing and navigating systems.

Barker and Langridge (2010) described mononormativity as being analogous to the assumptions surrounding heterosexuality and inherent in the term heteronormativity. As a result of a disproportionate and overemphasis on relationships being monogamous, individuals and communities engaging in CNM relationships are often forced to negotiate monocentric systems

that pathologize them. These prescriptions are contained in broader contexts of a sexual negative society, which organize sexuality into systems of power, rewarding practices that are heterosexual and monogamous, and punishing practices that are not (Rubin, 1984). Clients in the current study expressed concern about mentioning their relationship orientation when entering therapy and overwhelmingly indicated the importance of their therapist creating an affirming, non-judgmental space. In light of the pervasive societal stigma, therapists are encouraged to be proactive about creating spaces for non-monogamous individuals and partners to explore their respective identities. By failing to be proactive, clinicians inadvertently maintain the status quo and reinforce the erasure of multi-partner relationships.

Those who do not conform to monogamous heterosexual relationships are often marginalized. Barker and Langridge (2010) discussed how saturated with monocentric messages our cultural narratives are and how we do not often think of the impact of phrases such as “finding the one,” “staying together,” and “living happily ever after.” These societal narratives put relationships under undue pressure to both remain static as well as change and adapt over the lifetime when that may not be every individual’s relational objective. This can be particularly problematic for CNM couples entering therapy where the therapist is not aware of their own biases about relationship formations. Similar to how some LGB clients experience internalized heterosexism (internalization of negative messages about homosexuality by LGB individuals; Szymanski, Kashubeck-West, & Meyer, 2008), some CNM clients may experience internalized monosexism (internalization of negative messages about non-monogamy by CNM individuals), and therapists may have to help clients recognize the impact of mononormativity on their own attitudes toward non-monogamous inclinations. In light of the number of clients in the current study who experienced prejudice and discrimination with their therapist(s), clinicians may have

to have specific conversations with CNM clients about their experiences with mental health systems in order to promote a safe space. By taking a non-judgmental approach and adequately affirming their client's non-monogamous identity/lifestyle, the therapeutic relationship is likely to benefit, and clients appear to find their therapists to be much more helpful.

Guideline 5: CNM is not a mental illness.

Clinicians recognize that non-monogamy is not a mental illness.

The extant evidence does not support the claim that CNM individuals are predisposed to maladjustment or psychopathology. Studies examining monogamous and CNM individuals have demonstrated no differences between the groups on a number of psychological constructs (Conley, Ziegler, Moors, Matsick, & Valentine, 2013; Kurdek & Schmitt, 1986; Rubel & Bogaert, 2014; Watson, 1981). Should differences be found between the two groups, the effects of stress from relationship orientation related stigmatization would need to be accounted for. Despite the documented unjustified societal stigma and evidence suggesting CNM is a healthy and viable relationship structure, the major mental health organizations have yet to issue any statements affirming that CNM is not a mental illness. Consider the benefits of CNM and that there are no indications that CNM itself is harmful to clients.

Guideline 6: CNM is an equally viable alternative to monogamy.

Clinicians recognize CNM as an equally viable alternative to monogamy.

As we continue to explore the diverse nature romantic relationship preferences and biological dispositions, it remains unclear what the impact of seeking to change or modify an individual's relationship orientation might be. It is unknown how confronting the societal stigma and expanding the "legitimate" relationship agreements to include non-monogamous options might impact relationship satisfaction levels or infidelity and divorce rates. There are many

circumstances that individuals experiencing unwanted feelings for someone outside their monogamous partnership satisfactorily chooses to suppress those feelings. It is likely that there is much diversity regarding the number of factors determining one's relationship orientation, and it is unknown how easy or difficult it is to change someone's preference in this regard, let alone what the consequences are for attempting to do so. Negative attitudes about homosexuality and bisexuality were found to be primary factors for influencing individuals to change their sexual orientation (Hayes, 2004). Religious values or beliefs are also anticipated to be a primary factor restricting someone from considering non-monogamy. It may be the case that a number of individuals would be more satisfied with a non-monogamous agreement but either do not consider it or avoid pursuing it due to the societal stigma or fear of oppression. Having the autonomy to choose one's relational expression without marginalization is proposed as a stronger predictor of satisfaction in relationship outcomes than the particular relationship structure chosen. The present study highlights how efforts to discourage or discredit CNM are negatively associated with therapist helpfulness. Additional research is needed, however, to determine the impact of attempting to change an individual's relationship orientation.

Guideline 7: Different types of CNM relationships.

Clinicians understand that CNM relationship agreements take many different forms and may fluctuate over time.

Four different "types" of non-monogamous relationships were featured in this article (i.e., polyamory, open relationship, swinging, and monogamish), they are not considered an exhaustive list of relationship agreements. There are a number of categories relationships may fall under, but it cannot be assumed that the clinician's definition of these terms will match the clients. During the initial sessions, therapists are encouraged to gain a clear understanding of the

relationship agreements, labels, and preferred language around issues such as fidelity, communication, and jealousy (Humphrey, 1987). It also cannot be assumed that agreements will remain static, as they are likely to evolve as circumstances within and/or surrounding the relationship change, with re-negotiations most commonly occurring during major life transitions (e.g., moving to another state or having children; Anapol, 2010; Easton & Hardy, 2013).

The common presenting concerns between relationship types (e.g., swinging and polyamory) are thought to share more similarities than differences, but further research is needed to clarify this assumption. Some of the common presenting concerns may include helping decide which form of non-monogamy is the best fit, negotiating agreements and boundaries, coming out/visibility management concerns, dealing with societal stigma, developing a relationship exit strategy, communication issues, connecting with and navigating non-monogamous communities and resources, schedule related stressors, and/or challenges associated with jealousy (Easton, 2010; Richards & Barker, 2013; Weitzman, Davidson, & Phillips, 2012). Therapists would ideally be prepared to support their CNM clients with any of these concerns. A few resources readily available for therapists and clients are provided in Appendix G.

Guideline 8: Relational, sexual, and gender identities are distinct yet related.

Clinicians recognize that relationship orientation, sexual orientation, and gender identity are distinct yet related constructs.

The current study points to the interrelatedness of sexual and relationship orientation and the possibility that many of the LGB resources may be broadly applicable to CNM clients. It is considered important to recognize both the similar and unique aspects of each of these constructs. Sexual orientation is often referred to as someone's sexual or emotional attraction to another person (Klein, 1993), while relationship orientation refers to one's preferred number and

type of sexual and/or romantic partnerships. That is not to say that these conceptualizations are universally accepted. Tweedy (2011), for example, suggests that the definition of sexual orientation should be expanded to include relationship orientation, arguing that CNM is a sufficiently embedded identity to be considered a sexual orientation.

One promising avenue of research includes exploring the developmental pathways of sexual and relational orientation. While there is research to suggest the sexual orientation developmental pathway appears to be distinct from the gender identity development pathway (Devor, 2004), little is known about the developmental pathway of relationship orientation. While gender identity development typically occurs in young toddlerhood (American Academy of Child and Adolescent Psychiatry [AACAP], 2012; Kohlberg, 1966), awareness of same sex attraction tends to occur around age 10 (AACAP, 2012; D'Augelli, 1993; Herdt & Boxer, 1993; Savin-Williams & Diamond, 2000). It is expected that the developmental pathway of relationship orientation would share some similarities to both gender identity and sexual orientation (e.g., having multiple stages of awareness such as awareness, exploration, integration, etc.), and perhaps more in common with sexual orientation, but this has yet to be empirically verified.

Another topic pointing to the interrelatedness of sexual and relational orientation is the disproportionate number of lesbian, gay, and bisexual individuals who also identify as CNM. While a disproportionate number of gay and lesbian identified persons identify as CNM, CNM is more prevalent amongst gay men than lesbian women (Bettinger, 2005; Herek, 1991; Klesse, 2005; Pawlicki & Larson, 2011; Peplau, 1991; Shernoff, 2006). The greatest discrepancy, however, is among bisexual individuals. Approximately two percent of individuals in national randomized samples embrace the label bisexual (Gates, 2011), compared between 30-40% who

embrace the term in CNM samples (Brewster & Marardi, 2010; Klesse, 2005, 2006; Page, 2004). Forty-three percent of the current sample self-identified as bisexual. Clinicians should be aware that bisexual individuals have been found to be impacted by negative individual and societal attitudes toward bisexuality, which are expressed by both heterosexual and gay/lesbian individuals (Bradford, 2004; Eliason, 2001; Evans, 2003; Herek, 2002; Mulick & Wright, 2002). In addition to the stigma about the validity of their relationship structure, bisexual persons also have to deal with challenges regarding the validity of their sexual orientation (Dworkin, 2001).

Psychological researchers and clinicians have a unique responsibility of noting that, similar to sexual orientation and gender identity, an individual's relationship orientation cannot be determined by simply examining behaviors or external appearance. The process of discovering one's relationship orientation may be difficult given the prevalence of CNM stigma. Relationship orientation should not be considered collectively better or worse than monogamy, as there appear to be a number of advantages and disadvantages to each. The stereotypes and societal stigma associated with CNM, however, may restrict many individuals from considering it as an option. Attempts must be made to respect the self-identification of CNM clients and not strive to box in or categorize one's relationship orientation, for doing so may neglect the potential fluidity in relational attraction that some CNM people experience. Furthermore, given the societal stigma, therapists may have to address biases that may be restricting clients from considering all their viable relationship options.

Relationships and families.

Guideline 9: Importance of CNM relationships.

Clinicians strive to be knowledgeable about and respect the importance of consensually non-monogamous relationships.

Failing to recognize the importance of and adequately supporting CNM relationships was one of the two inappropriate practices most negatively correlated with therapist helpfulness, and was the third-most utilized inappropriate practiced (19% of all the therapist accounted for in the survey). It is critical for therapists to recognize the importance of each relationship in the lives of CNM clients. If a relationship is not that important to a client, let the client be the one to determine that. CNM clients also often endure criticism for the sake of embracing non-monogamy and having multiple partners a central tenant of CNM (for many), so it is not that hard to imagine why it would be offensive to feel as if one's therapist was not acknowledging and supporting all of their relationships individually.

CNM relationships should be understood as being both similar and different than monogamous relationships. It should be expected that CNM relationships are formed for similar reasons, experience similar levels of satisfaction, and follow similar developmental patterns. Yet, it is important to recognize the potential differences as well. CNM relationships may differ in terms of sexual behavior (e.g., multiple partners, kink, etc.), gender role expectations (i.e., in light of the disproportionate number of lesbian, gay, and bisexuals that identify as CNM; Herek, 1991; Peplau, 1991), and the amount of stigma experienced in the relationship. Individuals in CNM relationships often have to hide or stay closeted about their relationships for fear of vocational or social repercussions (Weitzman, Davidson, & Phillips, 2012) and adapt to environments that devalue to their relationships.

Guideline 10: Experiences and challenges faced by CNM parents.

Clinicians strive to understand the experiences and challenges faced by consensually non-monogamous parents.

Despite concerns about the potential harm ascribed to children in CNM families (such as a negative impact on development caused by discord, violence, exploitation, and competition between spouses and children for attention), there is no evidence to suggest children of polyamorous parents are faring any better or worse than children with monogamous parents (Goldfeder & Sheff, 2013; Sheff, 2010). It appears that there are both positive aspects (such as additional resources, role models, and attention from a variety of adults) and negative aspects (such as the stigma of having CNM parents and developing attachments to adults who may then disappear from their lives when the parents break up), but that the negative aspects encountered (outside the stigma associated with CNM) were not found to be unique to CNM relationships as they are experienced in monogamous relationships as well (Sheff, 2010). CNM relationships were also found to be associated with “a sense of honesty that permeates the familial relationship and encourages closeness and open acceptance; a group of well-adjusted, thoughtful children of different age groups; and a plethora of economic and emotional child support, both comforting for children in their times of need and helpful in the most humdrum and pragmatic ways” (Goldfeder & Sheff, 2013, p. 237).

CNM parents also have to deal with the concerns about the lack of legal protection and deciding if, when, and how to disclose to their children as well as (Weitzman, Davidson, & Phillips, 2012). Pallotta-Chiarolli, Haydon, & Hunter (2013) found that issues of being “out” to their children, relations with extended families and friendship networks, and navigating broader societal systems and structures were the greatest concerns for polyamorous parents. In their

survey about polyamorous parenting, Watson and Watson (1982) discovered that the majority of their participants (75%) wanted to disclose to their children, but only 21% of them actually had informed their children of the full extent of their involvements with other partners. Some parents expressed concern about it being too upsetting, something they would not understand, or had concerns about being outted by their children in a setting that might prompt prejudice toward them and/or their children. A more recent survey found that 45% were not “out” to their own children (Weber, 2002). Taramino (2008) found that just over half (52%) of her participants with children were out to all their children, while a sizable minority (31%) chose not to come out to any of their children.

Many CNM individuals choose not to come out to anyone (outside their partners) about their multiple relationships due to concern about non-acceptance from wider society (Peabody, 1982). This understandable concern about prejudice and discrimination prompts many CNM parents to have to forego disclosing to close family members and friends as well (Ziskin & Ziskin, 1975, Weber, 2002). Researchers are encouraged to continue to explore the concerns raised with multi-partner parenting and clinicians are encouraged to be aware of their own biases and create a safe space to discuss and concerns CNM parents may be experiencing.

Guideline 11: CNM may impact family of origin relationships.

Clinicians strive to understand how being non-monogamous may impact family of origin relationships.

For families that are unprepared or accept their family members CNM identity/lifestyle because of ethnic, cultural, or familial norms; negative stereotypes; or religious beliefs, a number of issues could arise. In light of their concern, a number of CNM individuals choose not to come out to their families. A non-random sample of 126 CNM-identified individuals found that most

(74%) were out to all their friends, but less than half (42%) were out to all their family members (Taramino, 2008). While there is no knowing research addressing family reactions to a loved one coming out as non-monogamous, reactions are expected to be similar to the reactions experienced by other sexual minorities (e.g., distancing, restricting attendance to family events, being denounced as a family member, judgment/criticism for ‘lifestyle decisions,’ conflicts with parents and siblings; Dickens & McKellen, 2003; Griffin, Wirth, & Wirth, 1996; Savin-Williams, 2003). Therapists are encouraged to consider the unique circumstances and assist CNM client’s efforts to navigate whether the advantages of coming out are worth the associated risks.

For many CNM individuals, concerns about disclosure and/or discrimination toward their relationship orientation/lifestyle may prompt an emotional distancing from their family members. Some family members may tolerate CNM, but for many, tolerance this falls short of the support and understanding that may be needed. In light of this, many who identify with CNM may feel inclined to develop alternate or “chosen” family made up of a network of close friends who may (or may not) be related to them. These “families of choice” may end up being a more central source of social support for CNM individuals than biological family members. Therapists are encouraged to be mindful of this possibility and supportive of these chosen families given the importance of social support in promoting relationship satisfaction, stigma management, and psychological well-being (Beals, Peplau, & Gable, 2009). Chosen families have also been found to mitigate the effects of discrimination with other sexual minorities (Weston, 1992).

While many families will also be supportive, it should not be assumed by therapists that this is be the case. Therapists are encouraged to be mindful of the possibility that CNM clients

may not be out to their family. Further, it should not be assumed that being out to all or any family members is necessary or ideal. A number of individuals may find the associated risks of coming out to given family members is not worth the benefit of doing so. Others may feel inclined to come out to their family (or select family members). The decision should be left to the client. Therapists are encouraged to be prepared to assist their client(s) seeking to navigate these their circumstances and strive to understand the culturally specific risks associated with CNM individuals coming out to their family of origin.

Issues of diversity.

Guideline 12: Unique challenges of CNM racial and ethnic minorities.

Clinicians strive to recognize the unique challenges faced by consensually non-monogamous racial and ethnic minority groups.

Consistent with much of the data indicating the demographic homogeneity amongst individuals who participate in CNM relationships (Sheff & Hammers, 2010; Sheff, 2005), the large majority of the participants (83%) in the current study were European American/White. While Rubin, Moors, Matsick, Ziegler, and Conley (2014) question the homogeneity of the CNM population, suggesting it may be due to community-based recruitment strategies that create an inaccurate reflection of people who engage in CNM, they do contend that several barriers exist that dissuade people of color from participating in mainstream CNM communities, such as having to navigate the social norms, values, and beliefs in both mainstream and their minority cultures. The authors go on to suggest the importance of elucidate the racial/ethnic diversity of CNM individuals through research recruitment strategies in order to combat the racially homogeneous stereotype associated with CNM and to create a more accurate depiction of the social perceptions of CNM relationships.

CNM individual with diverse racial background have been found to feel vulnerable at mostly-White events due to their race (Sheff, 2005) and a content analysis of consensual non-monogamous texts (i.e., ‘self-help’ books and narratives) revealed that the dialogue often assumes a White audience, subsequently ignoring the experiences of people of color (Nöel, 2006). Willey (2006, 2010) also discussed how ignoring the experiences of diverse racial, cultural, and ethnic background perpetuates essentialist perceptions of race and sexuality. Individuals with diverse racial, ethnic, or cultural backgrounds in other sexual minority groups have been found to experience a “conflict of allegiance” (Gock, 2001) where expectations of their sexual and racial/ethnic/cultural groups clash, potentially leaving the individual feeling like they don’t belong to either group completely (Green, 2007). People of color are also put in a position of having to navigate the historical positioning of non-White sexualities as deviant and excessive (Collins, 2005; Hooks, 1981). Consequently, reproducing White privilege in both literature and mainstream community spaces may deter individuals of color from participating in popular CNM social networks (Rubin et al., 2014). Clinicians and researchers are encouraged to examine the ways in which having additional minority statuses may complicate and exacerbate the challenges being faced.

Guideline 13: Influence of religion and spirituality.

Clinicians are encouraged to be aware of the influences of religion and spirituality in the lives of consensually non-monogamous persons.

The experiences of CNM individuals with religion and spirituality are diverse and varied. For some, religion has been a source of judgment and oppression, while others may experience great solace and even perceive their CNM relationships as a spiritual expression, while others still may feel rather ambivalent about religion and spirituality. A number of participants in the

current study mentioned how unhelpful it was to feel judged or have their therapist emphasize a religion or traditional values system. The perceived immorality of CNM was also listed as a perceived disadvantage of CNM by a random sample of (mostly monogamous) participants (Conley, Moors, Matsick, Zeigler, 2012).

There have been a wide range of historical reactions to CNM among religious/spiritual practices. While the majority of religions appear are critical of CNM, a few are affirming. Ferrer (2007), writing from a Buddhist perspective suggested that, “It may be perfectly plausible to hold simultaneously more than one loving or sexual bond in a context of mindfulness, ethical integrity, and spiritual growth, for example, while working toward the transformation of jealousy into sympathetic joy and the integration of sensuous and spiritual love.” He went on to state, “I should add right away that, ultimately, I believe that the greatest expression of spiritual freedom in intimate relationships does not lie in strictly sticking to any particular relationship style—whether monogamous or polyamorous—but rather in a radical openness to the dynamic unfolding of life that eludes any fixed or predetermined structure of relationships.” Unitarian Universalists are also CNM affirming and active in promoting understanding of polyamory and other responsible non-monogamous relationship expressions (Avirham, 2008). While a sizeable minority of the current participants identified as atheistic (23%) or agnostic (19%), the majority embraced some form of spiritual or religious identity, including ‘spiritual but not religious’ (18%), Pagan/Wiccan (12%), or a form that was not captured in the provided options (11%).

In light of the diverging perspectives and experiences religion and spirituality, clinicians are encouraged to be aware of and respectful toward the historic and current role and impact religion may (or may not) play in the lives of their CNM clients. Given the number of CNM individuals who also identify as religious/spiritual minorities (i.e., non-Christian), clinicians

should be aware of the additional stressors that may be associated with holding dual marginalized identities. Furthermore, the APA's "Resolution on Religious, Religion-Based and/or Religion-Derived Prejudice" (Anton, 2008) called clinicians to examine their own religious beliefs and prevent these beliefs from taking precedence over professional practice and standards in their clinical work with lesbian, gay, and bisexual clients. Therapists are encouraged embrace a similar stance when working with CNM clients.

Guideline 14: Gender and CNM.

Clinicians are encouraged to be mindful of the unique challenges associated with gender and consensual non-monogamy.

The open responses of the current study indicated a distinct view amongst a minority of therapists that CNM is distinctly bad, unnatural, or unhealthy for women. The perception that a particular form of sexual expression is unsuitable for women is not considered an issue unique to CNM. It is not surprising, however, that it comes up in a CNM context given the associations with promiscuity often CNM is often labeled with. In addition to challenging stereotypes about CNM being all about sex, clinicians should be made aware of how unhelpful it is to presume CNM is not good for woman and the overwhelming number of feminist scholars that consider CNM to be founded in feminism and a pro-female way of managing relationships (e.g., Askham, 1984; Jackson & Scott, 2004; Moors, Rubin, Matsick, Ziegler, & Conley, 2014; Munsen & Stelboum, 1999; Rich, 1980; Ritchie & Barker, 2005; Ritchie & Barker, 2007; Robinson, 1997; Rosa, 1994; Sheff, 2005). Jackson and Scott (2004), for example, argue that women in CNM relationships are less likely to become dependent, isolated, and detached from their communities. Sheff (2005) also expressed how polyamorous women were able to expand their family, cultural, gender, and sexual roles and felt empowered by their greater freedom to make their own sexual

choices, create new roles for themselves, and express themselves sexually. Ziegler, Matsick, Moors, Rubin, and Conley (2014) argue that monogamy is an institution that often upholds a system of gender oppression while polyamory often promotes greater gender equality, allows women to fulfill their communal and relational roles, and may provide benefits geared towards women's sexual satisfaction, agency, and gender role flexibility.

Unfortunately, there is remarkably little literature addressing the intersection of CNM and the transgender/gender non-conforming (TGNC) community. Similar to other minority statuses, clinicians are encouraged to be mindful of how one's gender identity and/or gender expression may intersect with their relationship orientation. TGNC people have been found to be more open to exploring their sexual orientation and/or may redefine sexual orientation as they move through transition (Daskalos, 1998; Devor, 1993; Schleifer, 2006), but it is not known how the transition process may interact with relationship orientation. When relevant, therapists are encouraged to help clients understand the differences between gender identity, gender-related behavior, sexual orientation, and relationship orientation when these issues are in conflict. Furthermore, gender non-conformity in CNM clients may serve to exacerbate stigmatization. Therapists may need to provide support to partners of TGNC individuals who may experience difficulty with their partner's evolving gender identity or transition (APA, 2015). Support groups and establishing relationships with other TGNC people, other partners of TGNC people, and couples who have successfully navigated transition may also help TGNC clients and their partners have also been found to be protective factors (Brown, 2007). In order to address these issues effectively, therapists are encouraged to be aware of their own values and biases regarding sex, gender, sexual orientation, and relationship orientation (APA, 2008; Gainor, 2000).

Guideline 15: CNM and physical, sensory, and cognitive-emotional disabilities.

Clinicians are encouraged to recognize the unique challenges that CNM individuals with physical, sensory, and cognitive–emotional disabilities may experience.

There may be a number of additional challenges that individuals with disabilities face. People with disabilities are often seen as being asexual (Tepper, 2000). Iantaffi (2009) pointed out how little research addressing the sexuality of people with disabilities exists and described the challenges of the intersectionality of being disabled and non-monogamous as a complex process of negotiating challenging linear identity politics from multiple standpoints. Health practitioners rarely talk about sexuality with patients with disabilities because they are generally not educated on this issue during their training (Haboubi & Lincoln, 2003). Similar to how the current study found that therapists were prone to blame client problems on CNM, people with disabilities whose gender or sexuality did not fall within traditional boundaries (i.e., those who are trans*, non-heterosexual, into kink, or CNM) were often seen as deviating from normative sexuality because of their disabilities (Iantaffi, 2009). Clinicians working with CNM individuals with disabilities are encouraged to be mindful of the intersection of the client’s disability and sexual identities, ensuring that they do not trivialize their desire for multiple partners or pathologize either of their identities.

Guideline 16: CNM may not be a salient identity.

Clinicians recognize that CNM intersects with other cultural identities and may not be the most salient aspect of a CNM individual’s life, experiences, or current concerns.

The current study points to the frustration experienced by CNM clients when their therapist either focuses too much or too little on relationship orientation. For some clients, their relationship orientation may be relevant; for others, it may not be. It is also anticipated that an

individual's relationship orientation may have significant intersections with other aspects of their identity (i.e., sexual orientation, age, gender, religious/spiritual affiliation, disability status, immigration status, education, race/ethnicity, occupation). Certain aspects of their identity may grant them privileges, while others may facilitate disadvantages. Therapists are encouraged to be mindful of and not afraid to address the intersecting identities that may impact a CNM client's experience, presentation in therapy, and/or access to resources. After all, CNM individuals who experience additional oppressed identities may experience more stressors and/or greater restricted access to resources. However, they may have also developed a greater sense of resilience for coping with the disadvantages that they have experienced, and their presenting problem may have nothing to do with their CNM status or any other minority status. Clinicians are encouraged to treat each client as an individual, being mindful of their intersecting identities, while not making assumptions about the salience of a client's identities or experiences.

Workplace issues.

Guideline 17: Workplace issues.

Clinicians strive to understand the unique workplace issues that exist for consensually non-monogamous individuals.

Since US culture was founded in a system of institutionalized compulsory monogamy (Emens, 2004), most people, by default, expect monogamy. To embrace CNM, one has to go through a process of rejecting the standard relationship model that is introduced and reinforced since birth. We typically do not ask, "when did you discover monogamy?" When the members of a stigmatized population are not easily identifiable, they are also inevitably put in a position of having to face questions about disclosure (Goffman, 1963). Challenges associated with coming out as non-monogamous may be one of the most common topics address by therapists working

with CNM clients (Richards & Barker, 2013; Weitzman, 2006). In addition to questions about whether to come out to family, friends, or their children, CNM individuals have to address whether they will come out at work. Many in CNM relationships opt to not disclose and lead a double life out of necessity (Weitzman, Davidson, & Phillips, 2012). While there are additional stressors associated with closeting one's sexual identity (Browning, Reynolds, & Dworkin, 1991), and there sexual identity disclosure has been linked to positive mental health outcomes (Herek & Garnets, 2007) CNM individuals may feel forced into adopting impression management strategies to avoid real or anticipated workplace discrimination. When asked about their process of coming out, participants in one study emphasized exercising discretion when coming out, coming out quietly, and not coming out to critics (Peace, 2012). Utilizing concealment strategies regarding sexual orientation have also been found to present a number of distressing challenges, including having to separate personal and work lives, constant vigilance about sharing information, having to cope with feelings of dishonesty and invisibility, burnout from the stress of hiding identity, and isolation from social and professional collegial networks and support (see Croteau et al., 2008; Fassinger, 2008).

When ones status is not kept secret, CNM individuals are often put in a position of having to prove the viability of their lifestyle to those who found out (Falco, 1995). CNM is not a protected identity or social class and those in non-monogamous relationships are subject to being fired entirely on the basis of the relationship orientation (Tweedy, 2011). While a work environment may be LGB-affirming, this does not necessarily guarantee that it is safe to disclose about CNM status. CNM clients also have to choose how out to be. Issues may arise about which partner to invite to work parties, for example. While some individuals choose to be out, others may choose to maintain secrecy. Clinicians are encouraged to assist their clients in

understanding their partner(s)' needs; negotiate their boundaries regarding when, if, and how to disclose; and cope with any rejection that they may receive (Weitzman, 2006).

Research.

Guideline 18': CNM Research.

In the use and dissemination of research on CNM and related issues, researchers strive to represent results fully and accurately and strive to be mindful of the potential misuse or misrepresentation of research findings.

There have been improvements regarding the inclusion of non-heterosexual populations in psychological research. For example, the American Psychological Association (APA) created a task force on non-heterosexist research and made it an initiative that LGB persons be included in mainstream psychological research (Herek, Kimmel, Amaro, & Melton, 1991). It is of great importance that this task force was created, and researchers are encouraged to consider ways in which sexual minority research could be expanded to include other alternative sexualities. Moors and Schechinger (2014) argue that too often, research on LBG individuals is only included insofar as it replicates heterosexual findings and/or focuses on monogamous relationships, and that the pervasive dyadic assumptions underlying psychological theories and scales of measurement need to be re-examined in order to deconstruct the moral hierarchies related to sexuality. They also suggest that researchers should continue to explore the assumption revolving around monogamy being the hallmark of healthy romantic relationships.

A growing body of evidence is emerging that challenges the assumption that monogamy is the ideal relationship structure for our species (Conley, Ziegler, et al., 2013), and researchers are encouraged to explore the role of culture in creating relational structure norms. Asking participants about actual and/or preferred relationship structure is another practical step that

could be taken. Failing to gather relationship orientation/structure information or account for the significance of culture in shaping relationship norms perpetuates the idea that sexual exclusivity is the only relationship structure that is biologically congruent for our species (Ryan & Jetha, 2010; Rubin, 1984). Doing and would challenge the assumption that everyone is or should be monogamous.

Conclusions

The data point to a number of trends regarding the overall state of psychological treatment with CNM clients. While therapists outcomes may be improving with time (44% of former therapists compared to 13% of current/most recent therapists were found to be not at all helpful or destructive), it is concerning that over one-fourth (26%) of the therapists seen by the CNM participants in this study were found to be not at all helpful (15%) or destructive (11%). Furthermore, over half (54%) the therapists used at least one inappropriate practices while and over one third (36%) failed to use any of the exemplary practices, and over one in ten (11%) of CNM clients prematurely terminated sessions because of a negative interaction with their therapist regarding their CNM identity/lifestyle. The results highlight how, in addition to experiencing societal stigma, many CNM individuals are seeking psychological services from clinicians who are not equipped to adequately support them.

Four specific practices emerged as (arguably) the most important practices for clinicians to consider when working with CNM clients. Namely, clinicians working with CNM clients are encouraged to: (1) be affirming toward their client's CNM identity/lifestyle; (2) not fear or avoid addressing CNM when it's relevant; (3) avoid making an issue of CNM when it is not relevant; and (4) recognize the importance of and adequately support a client's CNM relationships. The open responses also aligned with the quantitative results, as in general, the most helpful things a

clinician can when working with CNM clients do is to simply be affirming toward the CNM aspects of their clients life, and avoid being judgmental.

Screening therapists based on their attitudes toward CNM was found to be an effective strategy, and is especially encouraged in scenarios that romantic relationships are likely to be a topic of conversation in therapy. It is suggested, however, that the onus of responsibility should not be on CNM clients. It is time for clinicians and researchers alike to acknowledge the effects of mononormativity and start addressing the needs of this growing population.

Burckell and Goldfriend (2006) found that when LGB individuals seek treatment, therapists who had LBG-specific knowledge and general therapeutic skills tended to be the most highly valued, while therapists who held heterocentric views were avoided. Assuming that there is overlap in the experience of sexual minorities, it is concerning that only one out of every four (73%) of the participant's therapists in the current study were endorsed as being quite knowledgeable about CNM communities and other resources, and almost one-third (29%) were found to be lacking the basic knowledge of CNM needed to be an effective therapist. There are indications that CNM is becoming increasingly more common, which only raises the concern that most mental health curricula do not address CNM (Weitzman, 2006). The results presented highlight the importance of education and training for improving CNM client outcomes. Therefore, one of the most critical recommendations for clinicians is to include CNM issues in professional education and training, and increase their knowledge and understanding of CNM through continuing education, training, supervision, and consultation (*guideline 1*).

It is also important to note that all the analyses of the present study pointed to the applicability of LGB resources for CNM clients. With guidelines for treatment based off APA endorsed recommendations for practice with LGB clients, simply swapping the sexual

orientation language for relationship orientation language (i.e., heterosexual for monogamous, etc.) led to the development of 13 CNM practices that accounted for approximately half (50%) of the variance in therapist helpfulness scores for CNM clients. All the individual practices examined were also associated with therapist helpfulness in the predicted direction (exemplary were positively correlated, inappropriate negatively correlated), and nearly all the open-responses regarding the helpful/unhelpful things their therapist(s) did were represented in the 13 CNM practices. While additional research is needed to clarify similarities and distinctions of sexual and relational orientation, the results of the present study point to the promise of utilizing LGB resources when creating guidelines for treatment with CNM clients.

Initial guidelines were proposed based on the results of this study and my review of the existing literature regarding CNM specifically, and sexual minorities more broadly. The guidelines were proposed as means of encouraging other scholars to contribute to the eventual establishment of APA-sanctioned guidelines for psychological practice with CNM clients. One such suggestion made in the guidelines is for the APA to create a task force for non-monosexist research and to establish an initiative that CNM individuals be included in mainstream psychological research, or expanding the charge of the task force for non-heterosexist research to be inclusive of all sexual minorities. Adopting a non-monosexist task force, CNM initiative, and empirically driven guidelines for practice would permit greater liberty for individuals to adequately consider all their romantic relationship options while effectively confronting anti-CNM biases that persist in a number of clinicians.

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Appendices

Appendix A: CNM Therapy Experience Survey

CNM Therapy Experience Survey

Welcome! This survey is in collaboration with researchers from the University of Kansas and the University of Michigan.

This project is the beginning of an ongoing research effort to understand more about the community of individuals who engage in consensual, nonexclusive intimate and sexual relationships. We undertake this effort in order to better understand this community, its beliefs, practices, and desires. You will be asked questions about your relationship(s), internalized perceptions of consensual non-monogamy (including, but not limited to, swinging, polyamory, open-relationships/marriages), and other attitudes toward romantic relationships.

We deeply appreciate your willingness to share your information in furtherance of this important pursuit. Please be assured that all responses are confidential. No individually identifying information is collected; everyone's data is anonymous. It is possible, however, with internet communications, that through intent or accident someone other than the intended recipient may see your response. You are also free to withdraw at any time.

In most cases, the wording of the questions and possible answers you'll see are taken directly from previous studies on this topic. We ask you to do your best to respond as accurately as you can within the limitations imposed on us as researchers. If you do not fit neatly into the categories listed, please just make your best guess, and explain any problematic feedback in the "additional comments box" at the end of the survey.

This survey takes most people 20-30 minutes to complete. Please be sure to take it in one sitting while you are undisturbed and can privately answer the questions. We deeply appreciate your participation in this educational endeavor; thank you.

We anticipate that participating in this study will cause little to no risks. The content of the questionnaire may cause some discomfort due to the personal nature of the topic. If you are uncomfortable with any of the questions, either in the questionnaire or interview, you may skip them or let the investigator know that you'd prefer not to reply. Although participation may not benefit you directly, we believe that the information obtained from this study will help us gain a better understanding of consensual non-monogamy.

Many of the questions you will be asked today are from validated scales that other researchers use; however, these have not been applied to non-monogamous relationships. We understand that some of the questions may seem unusual; however, please try your best to answer the questions. And, if needed, please feel free to use the text boxes for extra space to explain your answer.

If you would like additional information concerning this study before or after it is completed, feel free to contact the researchers (see below). If you have questions about your rights as a research participant, you may contact the Human Subjects Committee Lawrence Campus (HSCL); University of Kansas; 2385 Irving Hill Road; Lawrence, Kansas 66045-7563; (785) 864-7429 or 864-7385; email irb@ku.edu.

Or, if you have questions about this study, please contact Heath Schechinger or Amy Moors:

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Department of Psychology in Research Education
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For the next few questions, we are going to ask you about your current romantic relationship(s) or most recent relationship(s). We would like to get a better understanding of how you define your relationships and the different types of romantic relationships that people engage in. Please feel free to add any information you think would be important for us to know.

1. Are you currently in a romantic relationship(s)?

Yes

No

Not sure:

2. Please read over the following relationship descriptions. Select the one that BEST defines your current relationship(s). The definition does not need to match perfectly with your current situation, just choose the one that is MOST SIMILAR. Feel free to elaborate if desired.

Open relationship/marriage: My partner and I are open to having sexual relationships with people outside of our relationship. The relationships we have outside of our primary relationship are intended to be sexual only and do not involve long-term romantic or emotional involvement with another person. We each independently pursue relationships outside of our primary relationship independently of one another- that is, we do not become closely involved with the people our partner dates and may prefer not to talk about them. For example, my partner might go on dates without me and may not discuss these dates with me. I may go on dates without my partner and not discuss those dates. We understand that our relationship is not monogamous and have come to a mutual agreement to practice consensual non-monogamy

Swinging or ‘in the lifestyle’: My partner and I sometimes engage in sex with other people outside of our relationship and we typically have these encounters at parties or in other social settings. We consider these encounters to be an enjoyable pastime that we can participate in as a couple. The relationships we have outside of our primary relationship are intended to be sexual and not long-term romantic or emotional involvement. We might refer to ourselves as swingers

or in the lifestyle. We understand that our relationship is not monogamous and have come to a mutual agreement to practice consensual non-monogamy.

Polyamory: My partner(s) and I see ourselves as people who have close emotional, romantic and sexual relationships with more than one person. All of my partners understand that our relationship(s) are not monogamous. That is, all relationship partners have agreed to be non-monogamous. We think it is important that any relationships we have are not just sexual, but also romantic/emotional. We might refer to ourselves as engaging in polyamory or polyfidelity. Each of the following relationship configurations would be consistent with this relationship style (though others are of course possible):

*A committed couple has loving relationships with one or more people outside of the primary relationship.

*Multiple relationships partners are equally attached to each other and may or may not be sexually or romantically involved with other members of the group.

Monogamy: You and your partner have agreed to have a sexual and romantic relationship with only each other. This may include a specific conversation about monogamy or may be implied in your relationship, but you define your relationship as monogamous.

Other: If any of the above relationship configurations do not best explain your current or most recent relationship, please explain:

3. We would like to know if you have ever seen a therapist, clinician, or counselor, and if so, in what capacity. Please describe your prior experience with therapy.
 - A. I have never sought counseling or psychotherapy
 - B. I have had one to four sessions of counseling or psychotherapy
 - C. I have had five to 20 sessions of counseling or psychotherapy
 - D. I have had more than 20 sessions of counseling or psychotherapy

4. In your therapy session(s), was your romantic relationship ever a topic of conversation?
Note: This does not necessarily mean that you sought out therapy because of romantic relationship issues. You could have been seeing a therapist for a variety of other reasons, but your romantic relationship(s) came up in conversation.
 - A. Yes
 - B. No

For the following set of questions, we will ask you about the nature of your interactions with your therapist/s.

When using the term relationship orientation, we are referring to your preferred relationship structure (e.g., swinging, polyamory, open-relationship).

Directions: The following items pertain to your experience with a therapist/s.

Please note that we are going to ask you about your experiences with your past and current therapist/s:

In the box below, please give a brief description of each therapist:

- A. Most recent or current therapist:
- B. First therapist:
- C. Most helpful therapist:
- D. Worst or most harmful therapist:

Please also indicate which therapist is your most recent therapist if any of these titles overlap. For instance, your *most helpful* therapist is also your most *recent* therapist or your *worst or most harmful* therapist was your *first* therapist. **Please only answer the questions once for each therapist** (i.e., if your most *recent* therapist is your most *helpful*, you only need to complete the survey for your most *recent* therapist).

5. Your therapist gave some indication that he or she had automatically assumed you were monoagamous, before you indicated your relationship orientation. (yes/no)
6. Your therapist indicated that he or she believed that non-monogamy is bad, sick, or inferior. (yes/no)
7. Your therapist discounted, argued against, or pushed you to renounce your non-monogamous lifestyle/identity. (yes/no)
8. Your therapist blamed your problems on your relationship orientation or insisted on focusing on relationship orientation without evidence that your relationship orientation was relevant to your problems. (yes/no)
9. Your therapist suddenly refused to see you any more after you disclosed your relationship orientation. (Do not include cases where the therapist made a sensitive and appropriate referral to a therapist who was especially skilled in your expressed areas of concern.) (yes/no)
10. Your therapist lacked the basic knowledge of consensual non-monogamy issues necessary to be an effective therapist for you and/or you had to be constantly educating him or her about these issues. (yes/no)
11. Your therapist pressured or advised you to come out to someone in spite of the fact that you believed it was too risky. (yes/no)
12. Your therapist did not recognize the importance of consensual non-monogamous relationships and/or did not appropriately support these relationships. (yes/no)
13. Your therapist apparently did not understand the problems of societal prejudice against consensually non-monogamous individuals. (yes/no)
14. Your therapist was quite knowledgeable about consensual non-monogamy communities and other resources (so that he or she could have put you in touch with useful books or important community resources). (yes/no)

15. Your therapist never made an issue of your relationship orientation when it was not relevant. (yes/no)
 16. Your therapist was not afraid to deal with your relationship orientation when it was relevant. (yes/no)
 17. Your therapist helped you feel good about yourself as a consensually non-monogamous person. (yes/no)
-

18. Approximately how many sessions did you work with this therapist?
 19. What was the sex of this therapist? (male, female, other, or unknown)
 20. In your therapy session/s, was a romantic relationship concern ever been a topic of conversation? (yes or no)
 21. What was the sexual orientation of your therapist? (heterosexual, lesbian, gay, bisexual, other, or unknown)
 22. What was the relationship orientation of your therapist? (monogamous, non-monogamous, or unknown)
 23. When you sought out this counselor, did screen based on how supportive he or she would be of your relationship orientation/lifestyle? (yes or no)
 24. Did you terminate or end sessions with a therapist because of a bad experience that was based on your non-monogamous relationship(s) or identity? (yes or no)
-

25. Please rate how harmful or helpful your therapists were using the scale below.
Destructive ----- Not at all Helpful ----- Fairly Helpful ----- Very Helpful

- A. Most recent or current therapist
 - B. First therapist
 - C. Most helpful therapist
 - D. Worst or most harmful therapist
-

In the previous questions, we were trying to understand if you've experienced any stigma or prejudice from your therapist or counselor based on your non-monogamous relationship(s). In order to understand this better, if there are any VERY HELPFUL things or VERY UNHELPFUL things your therapist has done or said that pertain to your non-monogamous relationship or non-monogamous lifestyle, please describe below.

26. Very Helpful Things
27. Very Unhelpful Things

Appendix B: Relationship Definitions

Open relationship/marriage

My partner and I are open to having sexual relationships with people outside of our relationship. The relationships we have outside of our primary relationship are intended to be sexual only and do not involve long-term romantic or emotional involvement with another person. We each independently pursue relationships outside of our primary relationship independently of one another- that is, we do not become closely involved with the people our partner dates and may prefer not to talk about them. For example, my partner might go on dates without me and may not discuss these dates with me. I may go on dates without my partner and not discuss those dates. We understand that our relationship is not monogamous and have come to a mutual agreement to practice consensual non-monogamy

Swinging or ‘in the lifestyle’

My partner and I sometimes engage in sex with other people outside of our relationship and we typically have these encounters at parties or in other social settings. We consider these encounters to be an enjoyable pastime that we can participate in as a couple. The relationships we have outside of our primary relationship are intended to be sexual and not long-term romantic or emotional involvement. We might refer to ourselves as swingers or in the lifestyle. We understand that our relationship is not monogamous and have come to a mutual agreement to practice consensual non-monogamy.

Polyamory

My partner(s) and I see ourselves as people who have close emotional, romantic and sexual relationships with more than one person. All of my partners understand that our relationship(s) are not monogamous. That is, all relationship partners have agreed to be non-

monogamous. We think it is important that any relationships we have are not just sexual, but also romantic/emotional. We might refer to ourselves as engaging in polyamory or polyfidelity. Each of the following relationship configurations would be consistent with this relationship style (though others are of course possible):

*A committed couple has loving relationships with one or more people outside of the primary relationship.

*Multiple relationships partners are equally attached to each other and may or may not be sexually or romantically involved with other members of the group.

Monogamy

You and your partner have agreed to have a sexual and romantic relationship with only each other. This may include a specific conversation about monogamy or may be implied in your relationship, but you define your relationship as monogamous.

Other

If any of the above relationship configurations do not best explain your current or most recent relationship, please explain:

Appendix C: Liddle's (1996) Exemplary/Inappropriate Practices with LGB Clients

Inappropriate Practices

1. Your therapist gave some indication that he or she had automatically assumed you were heterosexual, before you indicated your sexual orientation.
2. Your therapist indicated that he or she believed that a gay or lesbian identity is bad, sick, or inferior.
3. Your therapist discounted, argued against, or pushed you to renounce your self-identification as a lesbian or gay man.
4. Your therapist blamed your problems on your sexual orientation or insisted on focusing on sexual orientation without evidence that your sexual orientation was relevant to your problems.
5. Your therapist suddenly refused to see you any more after you disclosed your sexual orientation. (Do *not* include cases where the therapist made a sensitive and appropriate referral to a therapist who was especially skilled in your expressed areas of concern.)
6. Your therapist lacked the basic knowledge of gay and lesbian issues necessary to be an effective therapist for you and/or you had to be constantly educating him or her about these issues.
7. Your therapist pressured or advised you to come out to someone in spite of the fact that you believed it was too risky.
8. Your therapist did not recognize the importance of lesbian and gay relationships and/or did not appropriately support these relationships.
9. Your therapist apparently did not understand the problems of societal prejudice against

gay men and lesbians and/or internalized homophobia.

Exemplary Practices

10. Your therapist was quite knowledgeable about the lesbian and gay communities and other resources (so that he or she could have put you in touch with useful books or important community resources).
11. Your therapist never made an issue of your sexual orientation even when it was not relevant.
12. Your therapist was not afraid to deal with your sexual orientation when it was relevant.
13. Your therapist helped you feel good about yourself as a gay man or lesbian.

Appendix D: The 13 CNM Practices

Inappropriate practices.

1. Your therapist gave some indication that he or she had automatically assumed you were monoagamous, before you indicated your relationship orientation.
2. Your therapist indicated that he or she believed that non-monogamy is bad, sick, or inferior.
3. Your therapist discounted, argued against, or pushed you to renounce your non-monogamous lifestyle/identity.
4. Your therapist blamed your problems on your relationship orientation or insisted on focusing on relationship orientation without evidence that your relationship orientation was relevant to your problems.
5. Your therapist suddenly refused to see you any more after you disclosed your relationship orientation. (Do not include cases where the therapist made a sensitive and appropriate referral to a therapist who was especially skilled in your expressed areas of concern.)
6. Your therapist lacked the basic knowledge of consensual non-monogamy issues necessary to be an effective therapist for you and/or you had to be constantly educating him or her about these issues.
7. Your therapist pressured or advised you to come out to someone in spite of the fact that you believed it was too risky.
8. Your therapist did not recognize the importance of consensual non-monogamous relationships and/or did not appropriately support these relationships.
9. Your therapist apparently did not understand the problems of societal prejudice against consensually non-monogamous individuals.

10. Your therapist made an issue of your relationship orientation even when it was not relevant.

Exemplary practices.

11. Your therapist was quite knowledgeable about consensual non-monogamy communities and other resources (so that he or she could have put you in touch with useful books or important community resources).

12. Your therapist was not afraid to deal with your relationship orientation when it was relevant.

13. Your therapist helped you feel good about yourself as a consensually non-monogamous person.

Appendix E: APA (2012) Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients

Attitudes toward homosexuality and bisexuality.

Guideline 1. Psychologists strive to understand the effects of stigma (i.e., prejudice, discrimination, and violence) and its various contextual manifestations in the lives of lesbian, gay, and bisexual people.

Guideline 2. Psychologists understand that lesbian, gay, and bisexual orientations are not mental illnesses.

Guideline 3. Psychologists understand that same-sex attractions, feelings, and behavior are normal variants of human sexuality and that efforts to change sexual orientation have not been shown to be effective or safe.

Guideline 4. Psychologists are encouraged to recognize how their attitudes and knowledge about lesbian, gay, and bisexual issues may be relevant to assessment and treatment and seek consultation or make appropriate referrals when indicated.

Guideline 5. Psychologists strive to recognize the unique experiences of bisexual individuals.

Guideline 6. Psychologists strive to distinguish issues of sexual orientation from those of gender identity when working with lesbian, gay, and bisexual clients.

Relationships and families.

Guideline 7. Psychologists strive to be knowledgeable about and respect the importance of lesbian, gay, and bisexual relationships.

Guideline 8. Psychologists strive to understand the experiences and challenges faced by lesbian, gay, and bisexual parents.

Guideline 9. Psychologists recognize that the families of lesbian, gay, and bisexual people may include people who are not legally or biologically related.

Guideline 10. Psychologists strive to understand the ways in which a person's lesbian, gay, or bisexual orientation may have an impact on his or her family of origin and the relationship with that family of origin.

Issues of diversity.

Guideline 11. Psychologists strive to recognize the challenges related to multiple and often conflicting norms, values, and beliefs faced by lesbian, gay, and bisexual members of racial and ethnic minority groups.

Guideline 12. Psychologists are encouraged to consider the influences of religion and spirituality in the lives of lesbian, gay, and bisexual persons.

Guideline 13. Psychologists strive to recognize cohort and age differences among lesbian, gay, and bisexual individuals.

Guideline 14. Psychologists strive to understand the unique problems and risks that exist for lesbian, gay, and bisexual youths.

Guideline 15. Psychologists are encouraged to recognize the particular challenges that lesbian, gay, and bisexual individuals with physical, sensory, and cognitive–emotional disabilities experience.

Guideline 16. Psychologists strive to understand the impact of HIV/AIDS on the lives of lesbian, gay, and bisexual individuals and communities.

Economic and workplace issues.

Guideline 17. Psychologists are encouraged to consider the impact of socioeconomic status on the psychological well-being of lesbian, gay, and bisexual clients.

Guideline 18. Psychologists strive to understand the unique workplace issues that exist for lesbian, gay, and bisexual individuals.

Education and training.

Guideline 19. Psychologists strive to include lesbian, gay, and bisexual issues in professional education and training.

Guideline 20. Psychologists are encouraged to increase their knowledge and understanding of homosexuality and bisexuality through continuing education, training, supervision, and consultation.

Research.

Guideline 21. In the use and dissemination of research on sexual orientation and related issues, psychologists strive to represent results fully and accurately and to be mindful of the potential misuse or misrepresentation of research findings.

Appendix F: APA (2015) Guidelines for Psychological Practice with Transgender and Gender Nonconforming Clients

Guideline 1

Psychologists understand that gender is not a binary construct but is instead on that allows for a range of gender identities, and that a person's gender identity may not align with sex assigned at birth.

Guideline 2

Psychologists recognize that gender identity and sexual orientation are both distinct and interrelated constructs.

Guideline 3

Psychologists recognize that gender identity intersects with other cultural identities and may not always be the most salient aspect of a TGNC person's life, experiences, or current concerns.

Guideline 4

Psychologists recognize the impact of stigma, prejudice, discrimination, and violence on the lives and mental health of TGNC people.

Guideline 5

Psychologists recognize how their understanding of and attitudes about gender identity and gender expression may impact the quality of care they provide TGNC clients and their families.

Guideline 6

Psychologists recognize that TGNC individuals supported in their gender identity and gender expression are more likely to experience positive life outcomes.

Guideline 7

Psychologists strive to create TGNC-affirmative environments and assist their clients in accessing and navigating systems.

Guideline 8

Psychologists recognize that mental health concerns may impact the course of psychological assessments and interventions with TGNC clients.

Guideline 9

Psychologists working with TGNC individuals recognize the importance of an interdisciplinary approach to providing care and strive to work collaboratively with other providers.

Guideline 10

Psychologists working with TGNC children and adolescents acquire the requisite knowledge, skills, and awareness.

Guideline 11

Psychologists strive to understand the impact that changes in gender identity and gender expression can have on romantic and sexual relationships.

Guideline 12

Psychologists strive to understand how parenting and family building take a variety of forms in the lives of TGNC people.

Guideline 13

Psychologists strive to understand the unique experiences of middle-aged and older TGNC adults.

Guideline 14

Psychologists respect the welfare and rights of TGNC participants in research, strive to represent results accurately, and be aware of the potential misuse or misrepresentation of findings.

Guideline 15

Psychologists strive to include issues of gender identity and gender expression in professional education and training.

Guideline 16

Psychologists strive to reduce stigma and related challenges to health that affect TGNC people and to promote positive social change.

Appendix G: Consensual Non-monogamy Resources

Books

- Taormino, T. (2013). *Opening up: A guide to creating and sustaining open relationships*. Cleis Press.
- Easton, D., & Hardy, J. W. (2009). *Ethical slut*. Celestial Arts. New York.
- Veaux, F., & Rickert, E. (2014). *More Than Two: A practical guide to ethical polyamory*. Thorntree Press, LLC.
- Perel, E. (2007). *Mating in captivity: Unlocking erotic intelligence*. New York, NY: Harper.
- Ryan, C. (2010). *Sex At Dawn: How We Mate, Why We Stray, And What It Means For Modern Relationships*. New York: Harper.
- Anapol, D. M. (2010). *Polyamory in the 21st Century*. Lanham, MD: Rowman & Littlefield.
- Anapol, D. M. (1997). *Polyamory: The new love without limits: Secrets of sustainable intimate relationships*. San Rafael, CA: IntiNet Resource Center.
- Labriola, K. (2013). *The Jealousy Handbook: Exercises and insights for managing open relationships*. Greenery Press; Csm Wkb edition. ISBN-13: 978-0937609637.

Online Articles

- Alan (2015). All 41 nonfiction books on modern polyamory. <http://polyinthemedia.blogspot.com/2014/08/all-39-nonfiction-books-on-modern.html>
- Anapol (2011). Why Open Marriages Sometimes Work: Open marriage nor monogamy for everyone: <http://www.psychologytoday.com/blog/love-without-limits/201109/why-open-marriages-sometimes-work>
- Bello (2013). Coming Out as a Modern Family: http://www.nytimes.com/2013/12/01/fashion/coming-out-as-a-modern-family-modern-love.html?pagewanted=all&_r=1&_ga=2.111111111.111111111.111111111.111111111
- Brightside (2014). The Greatest Generation (In Bed) – How Millenials Are Changing the Sexual Landscape: <http://www.imgism.com/the-greatest-generation-in-bed-how-millenials-are-changing-the-sexual-landscape/>
- Greenwood (2013). Polyamorist on the Couch: Q&A on What Therapists Should Know About Big Love: http://www.huffingtonpost.com/2013/12/12/polyamory-therapists_n_4427342.html?1386863676#slide=2376805
- Moors, Chopik, Edelstein, & Conley (2014). Consensual non-monogamy: Table for more than two, please. <http://www.in-mind.org/article/consensual-non-monogamy-table-for-more-than-two-please>
- Muise (2012). Opening Up- Challenging Myths about Consensual Non-Monogamy: <http://www.scienceofrelationships.com/home/2012/8/17/opening-up-challenging-myths-about-consensual-non-monogamy.html>
- Oppenheimer (2011). Married with Infidelities: <http://www.nytimes.com/2011/07/03/magazine/infidelity-will-keep-us-together.html?pagewanted=all>
- Papas (2014). New Sexual Revolution: Polyamory May Be Good For You: <http://www.livescience.com/27129-polyamory-good-relationships.html>

- Romano (2013). 3 No Longer a Crowd as Open Relationships See a Boom: <http://nypost.com/2013/10/02/polyamorous-relationships-may-be-the-new-monogamous-marriages/>
- Romano (2013). What's So Bad About an Open Marriage? <http://www.thedailybeast.com/articles/2013/11/11/the-rise-of-polyamory-so-what-if-celebrities-have-an-open-marriage.html>
- Vrangalova (2014). Would You Have an Open Relationship? http://www.psychologytoday.com/blog/strictly-casual/201404/would-you-have-open-relationship?fb_action_ids=10100446842221738&fb_action_types=og.likes

Online Videos

- **Dr. Chris Ryan (2013). TED Talk. Are We Designed to be Sexual Omnivores?** http://www.ted.com/talks/christopher_ryan_are_we_designed_to_be_sexual_omnivores.html
- **Esther Perel (2013). TED Talk. The Secret to Desire in a Long-Term Relationship-** http://www.ted.com/talks/esther_perel_the_secret_to_desire_in_a_long_term_relationship.html
- **Dr. Meg Barker (2013). TED Talk: Re-writing the rules-** <http://www.youtube.com/watch?v=XUOQprqrxFg>
- **Jessica O'Reilly (2015). TED Talk. Monogamish: The New Rules of Marriage-** <https://www.youtube.com/watch?v=0sYguTLPpHE>

Online Resources / Websites

- Polyamory in the News: <http://polyinthemedia.blogspot.com/>
- Loving More Magazine: <http://www.lovemore.com/>
- Polyamory Weekly Podcast: <http://polyweekly.com/>
- OKCupid: <http://www.okcupid.com/>
- More Than Two: <http://www.morethantwo.com/>