AN EXPLORATION OF RELATIONAL THERAPISTS' ATTITUDES, KNOWLEDGE, AND PRACTICES WITH CONSENSUALLY NONMONOGAMOUS CLIENTS

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ABSTRACT

Previous research suggests one in five United States (U.S.) adults will engage in consensual nonmonogamy (CNM) in their lifetime (Haupert et al., 2017). Despite a significant number of adults engaging in CNM relationships, there is considerable stigma regarding CNM status. Clients that identify as CNM are marginalized in the process of psychotherapy (Henrich & Trawinski, 2016; Kisler & Lock, 2019;Schechinger et al., 2018). One previous study found that one-third of clients who identify as consensually nonmonogamous reported experiencing inappropriate therapy practices (Schechinger et al., 2018). Inappropriate therapy practices included their therapist pathologizing their relationship structure or expressing judgmental attitudes around their CNM relationship. Clients who experienced inappropriate practices were significantly more likely to terminate therapy prematurely. The present study measures relational therapists' (n = 775) attitudes, monogamism sensitivity, and knowledge regarding consensual nonmonogamy. Treatment practices when working with clients who identify as CNM were also be explored through open-ended questions. A simple linear regression revealed that knowledge of CNM predicted favorable attitudes toward CNM. Furthermore, monogamism sensitivity strengthened the relationship between knowledge and attitudes. Specialized training was not significant in predicting knowledge of CNM or attitudes toward CNM. Thematic analysis revealed four categories related to working with CNM clients in therapy. These categories were general treatment, helpful practices, unhelpful practices, and perpetuating stigma. Results of both the qualitative and quantitative data suggest relational therapy training programs should better prepare clinicians in working with clients who identify as consensually nonmonogamous. Specifically, in addressing how monogamism influences therapists 'clinical judgement.

CHAPTER 1: STATEMENT OF THE PROBLEM

Consensual nonmonogamy (CNM) is an umbrella term that encompasses a variety of intimate relationship statuses such as swinging, polyamory, open relationships, and other agreed upon nonmonogamous structures (Haupert et al., 2017; Moors et al., 2017). CNM relationships are distinct from nonconsensual nonmonogamy (e.g., infidelity) because all participants agree to having non-monogamous concurrent or future sexual or romantic relationships (Conley et al., 2013b). Researchers suggests that one in five single adults in the United States (U.S.) have engaged in some form of CNM in their lifetime – and that as many as 4-5% of all individuals in the U.S. are currently participating in a CNM relationship (Haupert et al., 2017; Levine et al., 2018).

Haupert et al.'s (2017) study found that engagement in CNM relationships is not influenced by a variety of demographic characteristics including age, educational level, income level, religious identities, political affiliation, and race. This finding came in light of initial research which suggested CNM engagement tended to only exist among white, middle class, college-educated individuals (Sheff & Hammers, 2011). However, Rubin et al. (2014) found that white individuals and racial/ethnic minority individuals were equally likely to report engaging in CNM at similar rates. The authors suggested the recruitment methods of previous studies underrepresented the diversity of people engaging in CNM (Rubin et al., 2014). Others have suggested that racial/ethnic minority individuals experience barriers to participating in CNM due to their marginalization. Researchers had found that CNM people of color report that tokenism, discrimination, and community rejection are concerns related to participating in CNM community events (Sheff & Hammers, 2011). It is also worth noting, some scholars suggest emerging adults, ages 18 to 29, are more likely to engage in CNM compared to other age groups in the U.S. (Sizemore & Olmstead, 2017).

There appears to be an intersectionality between CNM status and the lesbian, gay, and bisexual (LGB) communities. Multiple studies suggest that LGB individuals report higher rates of CNM compared to heterosexual individuals (Green et al., 2016; Haupert et al., 2017; Sizemore & Olmstead, 2017). Considering that globally polygamy is a common pattern of engaging in relationships, however, overly emphasizing this statistic may further stigmatize individuals who are apart of both CNM and LGB communities. In clinical settings it is important

for therapists to consider if their client system holds multiple marginalized identities since this may compound the stigma they experience. Scholars debate how to categorize CNM and most consider it a relational orientation or structure (Schechinger, 2016; Twist et al., 2021). Additionally, most scholars agree that individuals in CNM relationships are a part of the larger gender and sexual minority communities (Schechinger, 2016). Overall, individuals in CNM relationships are apart the minoritized gender, sexual, erotic, and/or relationally diverse (GSERD) communities (Twist, 2021).

Despite an increasing amount of research related to CNM structures being conducted, monogamous couples have been the center of literature on intimate relationships and saturates the field of relational therapy approaches (Conley et al., 2012; Kolmes & Witherspoon, 2017). Monogamy also permeates as the societal norm for relationship structure in the U.S. (see Day et al., 2011). Due to monogamy permeating as the societal norm, CNM relationships face a substantial amount of stigma. Studies have found that generally people in the U.S. tend to favor monogamy and hold unfavorable views towards CNM (Conley et al., 2012, 2013a). Participants in one study identified monogamous relationships as more likely to promote happiness and sexual satisfaction than CNM relationships (Conley et al., 2013a). Additionally, a sample of U.S. participants identified that monogamy is advantageous for reducing the spread of sexually transmitted infections (STIs), despite evidence that CNM individuals engage in a greater number of safer sex practices compared to sexually unfaithful monogamous individuals (Conley et al., 2012). These findings suggest that laypersons are misinformed about CNM relationships. These negative stereotypes may result from a variety of factors including inaccurate media representation and limited education about CNM relationships.

Meyer (2003) found that sexual minorities were more likely to experience mental health disorders compared to heterosexual individuals. Meyer (2003) posits that minority stress - including stigma, prejudice, and discrimination, cultivate a hostile environment that contributes to mental health issues in sexual minorities. Minority stress is one factor that contributes to individuals with marginalized sexual identities seeking out therapy at a significantly greater rate than heterosexual individuals (Cochran et al., 2003). Recent research suggests that discrimination, harassment, and violence related to CNM status (i.e., CNM-related minority stress) is associated with increased psychological distress, such as symptoms of depression and anxiety (Witherspoon, 2018). This finding suggests that therapists working with clients in CNM

relationships should consider the additional stress that CNM clients may face due to marginalization.

There is significant need for therapists to work towards a greater sensitivity to the diversity of intimate relationship structures. Schechinger et al. (2018) explored CNM clients' therapy experiences, including how stigma may manifest in therapist behaviors. These researchers found that one-third of participants identified their therapist as knowledgeable of CNM structures. Approximately one-third of participants, however, reported inappropriate therapy experiences (e.g., therapist assuming monogamy). These inappropriate therapy experiences were linked to an increased likelihood that the client prematurely terminated therapy (Schechinger et al., 2018).

Clyde et al. (2019) encouraged relational therapists to prepare for a variety of shifts in client needs that may correspond to contemporary social trends. These authors suggested that the field of couple and family therapy should prepare for an increasing number of clients to identify as CNM. Current clinical recommendations for working with CNM clients are broad, such as the therapist exploring personal beliefs regarding monogamy (Girad & Brownlee, 2015). More specific clinical recommendations for working with CNM clients are currently being explored by a task force led by American Psychological Association (APA; see Sprott & Schechinger, 2019).

The relational therapy literature lacks a specific approach to working with client who identify as. Additionally, the American Association of Marriage and Family Therapy (AAMFT) do not provide as any official clinical guidelines or best practices document relational therapists working with clients who identify as CNM. Relational therapists are in the unique position to assist clients with relationship difficulties and address concerns related to intimate relationships. Therefore, it is especially critical that relational therapists are engaging in affirmative and knowledgeable practices with CNM clients. This author of the current study aims to explore relational therapists' knowledge, attitudes, monogamism sensitivity, and therapy practices when working with clients who identify as CNM. Given that CNM clients experience marginalization in therapy, including a significant number of clients reporting non-affirming practices conducted by their therapist (see Schechinger et al., 2018), it is critical to explore therapists' practices in working with clients that identify as CNM. By exploring practices and knowledge surrounding CNM relationships, members of our field can better address current therapist limitations and increase efficacy when working with CNM clients.

CHAPTER 2: SIGNIFICANCE OF THE PROBLEM

Evidence suggests approximately 20% of individuals in the U.S. will engage in consensual nonmonogamy in their lifetime (Haupert et al., 2017). This statistic is calculated combining sub-types of CNM, which includes individuals who engage in one-time CNM sexual encounters and individuals who consider CNM a major aspect of their identity. Importantly, in the following chapter the author reviews the literature that emphasizes how CNM relational orientations are diverse in definition by both individuals participating in CNM relationships and academic literature about this population. Previous researchers suggest there is substantial stigma towards CNM in laypersons (Conley et al., 2013a; Hutzler et al., 2015). Stigma is one aspect of the minority stress model which argues that societal prejudice contributes to psychological distress in individuals who hold marginalized identities, including CNM individuals (Meyer, 2003; Witherspoon, 2018).

Historically, there is evidence that therapists further perpetuate minority stress towards CNM clients because they hold negative attitudes toward CNM (Hymer & Rubin, 1982; Knapp, 1975). In a newer study, researchers suggest that multicultural competency is associated with greater knowledge of CNM and less bias towards CNM in a sample of therapists (Baluck, 2020). The American Association of Marriage and Family Therapy (AAMFT; 2020) encourages relational therapists to fight prejudice and provide high quality care to diverse family structures. Given that therapists may be perpetuating harmful practices it is necessary to continue exploring therapist attitudes toward CNM. In the present study, the author further explores the relationship between attitudes toward CNM, knowledge of CNM, monogamism sensitivity, and therapy practices for CNM clients.

Relationship Structure Terminology

Researchers recognize that relational labels are embraced by individuals and groups in diverse ways (Conley et al., 2012; Haupert et al., 2017; Moors et al., 2017). Relational orientation is the persistent pattern of romantic and/or sexual attraction (Twist et al., 2018; Blumer et al., 2014). The discussion of terminology is meant to clarify common meanings of relational orientations that inform the present study. Importantly, the meaning of language is

socially constructed among individuals; however, discourse is often permeated by individuals in power. Social constructionism posits that language and interactions with others create an individual's perception of reality and how individuals understand the world and themselves (Gergen, 1985; Galbin, 2014). The language used to describe relational orientations demonstrates the societal norms that have permeated through discourse over time. For instance, the term nonmonogamy highlights how people conceptualize this term for what it is *lacking.*

Ansara (2020) argues that the relational orientation of "polyamory" is a less couple-centric way of describing CNM relationships and often is used as an umbrella term for individuals engaging in multi-partnered relationships. In the present study, the researcher uses the term consensual nonmonogamy (CNM), which has primarily been constructed by researchers to conceptualize individuals in multi-partnered relationships. This decision was made to be inclusive of individuals who embrace a variety of labels to describe their relational orientation. In particular, previous researchers have used this term to describe polyamorous, open, and swinging relationships (Conley et al., 2013b). This umbrella term allows researchers to communicate about a large population, however, sub-communities of the CNM population may have their own nuances that cannot be captured by this terminology. Furthermore, previous authors argue that the moral qualifier of, "consensual," demonstrates couple-centric bias (Ansara, 2020). Thus, the use of the term consensual nonmonogamy or CNM may be a limitation of this work, however, it seems to capture the relational orientations of interest most accurately. The aim of the researcher of the current project is to collect information about relational therapists' attitudes toward multi-partnered relationships broadly rather than measure their attitudes toward a specific sub-type of CNM. Overall, researchers' conceptualization of relationship arrangements informs both research findings, the way these findings can be interpreted, and informs how the researcher conceptualizes these constructs in the current study.

Monogamy…

Historically monogamy emerged in western societies in relation to Judeo-Christianity and patriarchal households (Stelboum, 1999). Stelboum (1999) argues that marriage, the joining of two people in a social and legal dependence, was the institutionalization of monogamy. This author emphasizes how traditionally marriage was a union between men and women. Women were considered men's property and sexual fidelity of women was a societal expectation which

relates to current societal norms around monogamy and sexual promiscuity. Conley et al. (2013b) and Stelboum (1999) emphasize how scientists tried arguing that monogamy was more natural than other relationship arrangements by comparing humans to other animal species. Few species, however, are monogamous, and making comparisons across different species reflected a human centered way of thinking (Stelboum, 1999).

Conley et al. (2013b) reviews expectations around modern monogamy. Monogamous relationships may mean a long-term exclusive commitment represented in the institutionalization of marriage. Most individuals, however, assume their romantic relationship is monogamous even if not considered a lifelong commitment. Pinkerton and Abramson (1993) discuss three patterns of monogamy. These three patterns describe the different meaning individuals tend subscribe to, including: lifelong monogamy (one sexual partner), complete promiscuity (no commitment to sexual partners), and serial monogamy (several mutually monogamous, non-concurrent partners over time). Conley (2013b) argue that most individuals in western societies when referring to themselves as monogamous can be categorized under the serial monogamy pattern.

…As a Structure

Moors et al. (2017) explains that relationships that are romantic and/or sexual can operate under certain expectations that are conveyed directly through explicit conversations or indirectly through assumptions. Monogamy is generally considered the relationship rule that two partners operate under when they commit to being sexually and relationally exclusive (Conley et al., 2013b; Haupert et al., 2017). The United States Centers for Disease Control and Prevention (CDC; 2020) has highlighted the sexual exclusivity in their definition of mutual monogamy, “Mutual monogamy means that you agree to be sexually active with only one person, and that person has agreed to be sexually active only with you (para. 4).”

…As a Worldview

Researchers have emphasized that monogamy is considered the standard intimate relationship agreement within the U.S. and the majority of the western part of the world (Day et al., 2011; Perel, 2006). Day et al. (2011) found that beliefs about committed relationships are maintained at least partially because of people’s connection to institutions that legitimize

relationship arrangements like governments and religious organizations. Marriage, for instance, is the legal union between two people. Although marriage is frequently regarded as a celebration of love, it has considerable legal ramifications. Additionally, matrimony between two people is emphasized in a variety of religious texts (Conley et al., 2013b; Day et al., 2011). Since religious views impact the ways in which people live on a daily basis, it is not surprising that monogamy is a prominent societal discourse. DePaulo and Morris (2005) argue that one of the most dominant reasons people defend the importance of committed relationships between two people is because individuals in the U.S. tend to hold marriage and family as a cultural worldview (e.g., marriage and child-rearing are built into the premise of the so-called "American Dream"). People likely maintain their devotion to monogamous relationships because these types of relationships are supported by sociopolitical institutions (Day et al., 2011). For example, mononormativitiy is exemplified through the legal impossibility of recognizing more than two parents on a birth certificate (Kean, 2015).

Haupert et al. (2017) emphasizes that sexual monogamy is the idea of being sexually exclusive while social monogamy refers to connection between two individuals that is emotionally intense and connected to building a family together. Both researchers and laypersons do not always separate sexual monogamy from social monogamy. The fusion of these two constructs in previous literature and in present day situations means that the individuals featured in research on intimate relationships may have various interpretations of monogamy not captured by research (Haupert et al., 2017). Individuals that do not pursue any sort of exclusive intimate relationship (social or sexual) may also be considered non-normative. DePaulo and Morris (2005) found that there is stigma towards single adults, particularly single adult women. This finding further suggests the dominance of beliefs supporting monogamous relationships. Long-term monogamous relationships are embedded into macro-level systems for creating families. Therefore, people may view single adult women as less valuable for not demonstrating this norm (DePaulo & Morris, 2005).

Although monogamy in romantic and sexual relationships is deeply rooted in the legal and religious institutions within the U.S., researchers reveal that it is common for this exclusivity to be broken (Emmers-Sommer et al., 2010). Perel (2006) argues that sexual desire is hard to maintain for most long-term partners and infidelity is not a rare phenomenon. Conley et al. (2013b) consider infidelity to be when one partner breaks the arrangement of being sexually or

romantically exclusive. Researchers suggest that infidelity is common in monogamous relationships (e.g., Blow & Hartnett, 2005). In one sample of undergraduates in committed relationships, 40% of participants reported being aware that a relationship partner had cheated on them and 19% reported they were unsure whether have had a partner ever cheat on them (Emmers-Sommer, et al., 2010).

Monogamism

Monogamism is the systemic oppression of multi-partnered relationships while mono-partnered relationships are privileged throughout micro and macro systems (Ansara, 2020; Blumer et al., 2014; Twist et al., 2018). As discussed above embracing monogamy as a worldview within the U.S. leads to mononormativitiy. Monogamism is likely the underlying bias that contributes to negative attitudes and limited education related to CNM relationships in therapists. More specifically, couple-centric bias is a specific type of mononormative bias in which people believe it is natural for all people to deeply desire having a couple relationship and all other relational orientations are unnatural (Ansara, 2020).

Relatedly, monogamous privilege, is the "unearned benefits afforded those with a monogamous and/or mono-partnered relational orientation, which also defines the relational orientation norm" (Blumer at al., 2014, p. 30). An example of monogamous privilege is not being accused of being unethical or immoral because of my relationship orientation (Davis, 2011). Additionally, monogamous privilege is evident in the visibility of mono-partnered relationships (Blumer et al., 2014). Monogamous bias is evident through macro system structures (e.g., laws related to marriage). Monogamism, however, is often subtly communicated through the interactions we have with others. Even the conceptualization that CNM is the opposite of the more dominant relationship arrangement of monogamy is evidence of monogamism in the U.S. (van Tol, 2017). It is critical to recognize the validity of diverse relational orientations rather than arguing that any one relational orientation is more natural than another. Barker and Iantaffi (2019) encourage considering monogamy and non-monogamy on a spectrum which allows individuals to consider how they may identify their romantic and sexual patterns.

Monogamism and Relational Therapy

The field of relational therapy reflects the discourse about intimate relationships and is based on mononormative assumptions (for review see van Tol, 2017). The couple-centric bias is evident in the description of marriage/couple and family therapy to describe the field of conducting relational therapy. The language of these titles emphasizes the field's lack of inclusivity to individuals in CNM relationships. Ansara (2020) argues that therapists continue to exclude multi-partnered individuals in favoring couple-centric language to describe graduate programs in relational and sex therapy. Similarly, the interventions and assessment tools often taught in graduate programs for relational therapy maintain a couple-centric bias. For example, genograms which are a way of mapping familial relationships and transgenerational themes, assume mono-partnered relationships. Inherently, these tools assume the client system seeking relational therapy is a couple rather than a multi-partnered relationship (Ansara, 2020).

Relational therapy approaches inherently view nonmonogamy as nonconsensual (i.e., infidelity). Kolmes and Witherspoon (2017) recognize that two evidence-based models used with intimate relationships is the work of John Gottman who developed Gottman Method's Couple Therapy and Sue Johnson's emotionally focused therapy (EFT). These evidence-based approaches are based in mononormative assumptions. The field lacks evidence-based applications of these approaches or novel approaches for CNM clients. Clinicians specializing in working with CNM communities have found both Gottman and EFT interventions can be helpful when working with CNM clients (Kolmes & Witherspoon, 2017). Ansara (2020) highlights how both Gottman and EFT creators have not done research on multi-partnered relationships, thus demonstrating the exclusivity evident in the field.

Consensual Nonmonogamy

Consensual nonmonogamy (CNM) is an umbrella term to describe relationship structures in which "all individuals involved make consensual agreements to engage [or not] in concurrent romantic and/or sexual relationships"(Moors et al., 2017, p. 56). Relationship orientations that fall under the consensual nonmonogamy umbrella vary greatly in terms of the relationship rules partners agree upon. CNM relationships emphasize that all partners are aware and agree to the arrangement, typically through explicit communication (Matsick et al., 2014; Moors et al., 2017).

As previously discussed, intimate relationships can vary in terms of both sexual exclusivity and romantic/emotional exclusivity. In the dominant definition of monogamy two partners have decided to be both sexually and romantically exclusive in structure. Primarily three main sub-types of CNM, which vary in terms of the relationship rules all partners agree upon, are noted in the literature. These three sub-types include swinging, polyamory, and open relationships (Conley et al., 2013a; Matsick et al., 2014). Each sub-type of CNM differs in the degree in which partners intend for emotional and sexual involvement to be a part of their multiple relationships. People involved may concentrate on love over sex with multiple partners or vice versa (Matsick et al., 2014)Individuals in CNM relationships may use completely different terms to describe their intimate relationship structure (Parsons et al., 2013). For example, Dan Savage (2011) used a term 'monogamish' to describe a couple opening up their relationship sexually in one of his advice columns. Similarly, Haupert et al.'s (2017) approximation on the number of people engaging in CNM relationships includes couples who engage in occasional CNM sexual experiences but are primarily monogamous romantically. It is important to recognize that some individuals may be defined as engaging in a CNM relationship by academic literature, however, in their own definition they may consider themselves monogamous. Briefly the sub-types of CNM recognized in previous literature will be discussed. A discussion of polygamy will also be included.

Polygamy

Although western societies, such as the U.S.s, have established that monogamy is the dominant relational orientation, globally this is not the case. In many geographic regions polygamy is the norm for pursuing intimate relationships (Al-Krenawi & Graham 2006; Barker, 2018). Polygamy is the practice of having multiple spouses including the forms of both polygyny and polyandry (Blumer et al., 2014). Most often polygamy involves a man having multiple wives (i.e., polygyny; Al-Krenawi & Graham, 2006). These relationships are both romantic and sexual nature. Polygamy is practiced across several hundred societies within Africa, Asia, Oceania, the Middle East, and the Americas. Estimates suggest that in parts of these regions, up to 50% of the marriages are multi-partnered (Al-Krenawi & Graham, 2006). Polygamy is often affiliated with religious beliefs (Conley et al. 2017). Some previous authors do not include this relational orientation under the CNM umbrella since it appears in some societies women are forced into

marriages thus calling into question the consensual aspect of the relationship (Conley et al., 2017). Importantly, people can be forced into nonconsensual dyadic marriage as well which indicates the lack of consent is not due relationship structure but patriarchy oppressing gender minorities (Stelboum, 1999). It is critical readers do their own research given the global prevalence of polygamy. For more information on working with polygamous families in the U.S. see Al-Krenawi, 1998.

Swinging

Swinging, or people who consider themselves, 'swingers,' may be more likely to describe their structure as an intimate relationship that is romantically/emotionally exclusive while being sexually open. For instance, swinging historically involves an established dyad (e.g., spouses) opening up their relationship sexually (for review Matsick et al., 2014). Swinging behaviors may include partners engaging in sex outside an established dyadic relationship while in social settings like parties and conventions. In some instance, partners view swinging as an activity that they can engage in together (for review see Matsick et al., 2014).

Open Relationships

Another sub-type of CNM relationships, open relationships, has a less definitive definition across scholarship. Although open relationships are recognized as a main sub-type of CNM arrangements, this term is not necessarily consistently used across researchers and certainly used by individuals to describe a variety of CNM relationships (Haupert et al. 2017;Matsick et al., 2014). For instance, some academics have stated open relationship is an umbrella term that encompasses a variety of CNM structures (see Kurdek & Schmitt, 1986). Other researchers have emphasized that open relationships often involve a primary partner in terms of romantic/emotional intimacy but involve having multiple sexual partner(s) (; Haupert et al. 2017; Matsick et al., 2014).

Unlike swinging arrangements, where established sexual partners pursue additional sexual partners as a shared experience, open relationships are usually pursued separate from the presence of a primary partner. Researchers have emphasized that across all of these sub-types of CNM relationships that a connecting feature of CNM arrangements is the lack of sexual

exclusivity between two people that is highly emphasized in monogamous relationships (Conley et al., 2013b; Matsick et al., 2014).

Polyamory

Researchers have emphasized that people in polyamorous relationships (sometimes referred to as polyam) are more likely to describe their multiple relationships as involving both a sexual and romantic dimension to them (Conley et al., 2013a; Matsick et al., 2014). Polyamorous relationships may involve multiple relationships that are romantic and sexual in nature. Additionally, polyamorous structures are more likely to describe their relationships as long-term and may commit to having exclusive non-dyadic arrangements (e.g., triad – when three people are in a committed romantic and/or sexual relationship with each other; Matsick et al., 2014). It is critical to acknowledge that many individuals use the term polyamory as an umbrella to describe individuals who engage in multi-partnered relationships (Ansara, 2020). Authors, however, have emphasized that polyamory is often not hierarchical other subtypes of CNM. For instance, open relationships often involve having a dyadic base while polyamory frequently rejects this couple-centric structure all together (Ansara, 2020). Recognizing that polyamory rejects familial structuring that is embedded within the language throughout the U.S., authors have identified there needs to be additional language to describe the experiences of polyamorous folks. For example, “the term polycule is used to describe polyamorous and multi-partnered people’s relational networks of kinship bonds”(Ansara, 2020, p. 4).

Stigma and Consensual Nonmonogamy

Conley et al. (2013a) conducted four studies that explored laypersons attitudes toward CNM relationships. The results of these studies suggest that the stigma toward CNM is pervasive while halo effects (i.e., positive cognitive bias) surround monogamous relationships. In one study, Conley et al. (2013a) asked participants (n = 1,101) to rate the likeliness that a relationship arrangement (i.e., monogamous or CNM) would provide certain benefits (e.g., provides closeness), as well as arbitrary qualities (e.g., promotes paying taxes on time). Importantly, participants read short vignettes that described the individuals engaging in each relationship type as happy and agreeing to the arrangement. The sample clearly favored monogamous

relationships as more likely to cultivate a variety of relationship characteristics as compared to CNM relationships. The relationship relevant characteristics included emotional considerations such as trust, respect, and closeness, as well as perceived health benefits like preventing STIs and providing physical safety. Additionally, this same study found that participants tended to perceive monogamous relationships as more likely to produce arbitrary characteristics like being a dependable dog walker (Conley et al., 2013a). These researchers found that participants that identified themselves in CNM relationships also tended to favor monogamy in relationship relevant characteristics. This finding may demonstrate that individuals participating in CNM relationships internalize societal stigma (Conley et al., 2013a).

The model of minority stress argues that individuals with marginalized sexual identities internalize negative societal attitudes. This internalization of harmful notions related to their identity is a proximal pathway that can contribute to adverse mental health outcomes and decrease self-esteem (Meyer, 2003). In individuals who are LGB this proximal process also includes the fear of rejection and concealment of their identity. The results of Conley et al. (2013a) suggest that these same proximal processes likely occur in CNM individuals. The need for concealment may be related to concern about how family, friends, and co-workers will respond to their relationship structure.

Conley et al. (2013a) suggest that a part of the public's commitment to monogamy is driven by the stigma associated with CNM structures. By embracing a monogamous relationship, individuals avoid the negative societal liabilities associated with being a part of a marginalized group. In another qualitative study, Conley et al. (2013a) asked participants to identify the benefits of monogamy. These researchers collected data from 3,780 participants and analyzed the data for codes in 5% of this sample (n = 189). Several themes emerged around the perceived benefits of monogamy. These themes included that monogamy promotes commitment, trust, and health benefits (e.g.., less risk of STIs).

As previously discussed, CNM relationships vary in terms of the relationship rules participants agree upon. The level of emotional and/or sexual exclusivity diverges across the three main sub-types of CNM relationships (i.e., swingers, polyamory, and open relationships). Conley et al. (2013a) did not measure the participants' beliefs regarding CNM relationships by sub-type, but rather attitudes toward CNM as an umbrella category.

Hutzler et al. (2015) conducted two studies exploring attitudes toward polyamory. In the first study, the researchers surveyed 100 residents of the U.S. The researchers were interested in participant characteristics and their association with attitudes toward polyamory. Political conservatism and religiosity were associated with more negative attitudes toward polyamory. Although most participants were familiar with polyamory (60% of the sample), participants held a variety of misconceptions toward polyam individuals including that they are immoral, untrustworthy, and sexually permissive. The misconceptions identified in Hutzler et al. (2015) were similar to the misconceptions identified in Conley et al. 2013a.

The second study conducted by Hutzler et al. (2015) randomly assigned 196 participants to two groups to examine if stigma towards CNM was reduced if participants were introduced to knowledge about polyamory prior to measuring attitudes and characteristics. The experimental group was introduced to information about polyamory and information that challenged negative assumptions about polyamory prior to measuring participants attitudes towards polyamory. The other group did not receive any additional information and completed the same questionnaires. As predicted, participants who received the experimental manipulation tended to hold positive attitudes toward polyamory compared to participants who did not receive the manipulation. In both studies, having a personal connection with someone who is polyamorous was associated with positive attitudes toward polyamory. Overall, findings from these studies suggest that greater knowledge of an outgroup can reduce prejudice (Hutzler et al., 2015).

Matsick et al. (2014) explored if beliefs about CNM arrangements varied by subtypes. Participants were given definitions of each sub-type of CNM arrangement. For instance, individuals in open relationships were, “those who desire to have sexual relationships with someone other than their primary partner [for example, with someone other than their spouse or significant other]” (Matsick et al., p.343). The participants in this study rated relationship arrangements on an assortment of positive and negative attributes (e.g., moral/not moral).

Results revealed that participants tended to view persons in swinging and open relationships more negatively than those in polyamorous relationships (Matsick et al., 2014). This finding is consistent with previous research that attitudes toward CNM may vary by the relationship arrangement even within the CNM community. Klesse (2006) interviewed 44 people in CNM relationships. These interviews revealed that some participants in polyamorous relationships described swingers as promiscuous and as individuals who are only interested in

short-term gratification (Klesse, 2006). These findings suggest that the societal expectation to be in a long-term *committed* relationship (even if not dyadic) is an especially salient ideology related to intimate relationships.

Media and Consensual Nonmonogamy

Media portrayals and online representations of CNM relationships provide information to the general public about diverse relationship structures. Researchers suggest there is an increased in interest in CNM in the U.S. in recent years (Moors, 2017). Moors (2017) examined Google searches related to CNM from 2006 to 2015. This study revealed an increase in searches related to polyamory and open relationships over that decade. In her examination of Google trends Moors (2017) reported that spikes in searches related to CNM may have a relationship with stories about CNM being published in popular media outlets. For example, Moors (2017) analysis revealed an increase in searches related to open relationships in 2011. In that year, the *New York Times* published a story interviewing Dan Savage, a popular sex columnist, who discussed how opening a monogamous relationship may be helpful for some couples (Moors, 2017). Researchers recognize these trends in Google searches may be unrelated to media coverage. It is important, however, to consider how the media's narratives on intimate relationships can influence therapist beliefs, as well as the beliefs of the clients they serve.

Researchers recognize how stories related to CNM featured in popular media like the *New York Times* and *Rolling Stone* have portrayed CNM positively (Conley et al., 2013a; Moors, 2017). The media can also be a source of perpetuating stereotypes. Jenkins (2016) argues that headlines and images related to polyamorous relationships continue to hypersexualize this community. Jenkins (2016) explains her experience being interviewed by *Cosmopolitan UK*. Jenkins expressed that the headline and image perpetuated stigma related to CNM relationships by disseminating the narrative that individuals in CNM relationships engage in group sex.

Séguin (2019) explored attitudes toward CNM by examining the themes of 432 comments left on three articles related to polyamory. Thematically many comments were coded into categories like valid, beneficial, and acceptable. The researcher also found, however, that many comments responded to polyamory negatively. Séguin (2019) categorically labeled these comments as expressing views of polyamory as unsustainable, perverse, amoral, unappealing, and deficient.

Inaccuracy of Stigma

Conley et al. (2013a) demonstrated through a variety of studies that people in the U.S. hold positive views of monogamy and negative views of CNM. One stereotype that was especially pervasive in this study was the belief that monogamy was protective against STIs. The sexual promiscuity society attaches to CNM exists across literature and is likely connected to the cultural norm for long-term sexual exclusivity highlighted in monogamy.

Moors et al. (2017) emphasizes how this stereotype is quite unwarranted and in actuality research suggests that monogamous relationships that are "pseudo' because one partner is sexually unfaithful are at higher risk of spreading STIs than CNM relationships. Conley and colleagues (2012) found that individuals in CNM relationships practice safer sex than those is pseudo monogamous relationships. Specifically, pseudo monogamous individuals were less likely to use condoms and other barrier methods during vaginal or anal sexual intercourse, as well as, less likely to use barriers when utilizing sex toys than individuals in CNM relationships. In this same study sexually unfaithful individuals in monogamous relationships were less likely than individuals in CNM relationships to get tested for STIs and communicate with all partners about implementing protection during sexual encounters (Conley et al., 2012).

Importantly, researchers demonstrate how individuals in CNM relationships have fulfilling emotional and sexual relationships (Mogilski et al., 2015; Moors et al., 2017; Rubel & Bogaert, 2015). Moors et al. (2017) reviewed the results of a variety of studies related to relationship structures. Moors and colleagues surveyed 175 participants in CNM relationships and asked participants to list up to five benefits of their relationship arrangement. These qualitative responses were coded for themes. Three benefits that are unique to CNM relationships across different arrangements (i.e., three main sub-types and non-labeled CNM relationships) included: diversified need fulfillment, activity variety, and personal growth/development. Diversified need fulfillment referred to responses that indicated that relationship satisfaction was tied to having multiple partners. Activity variety referred to nonsexual activities such as going on dates and engaging in novel activities. Lastly, personal growth and development was common among respondents who felt their CNM arrangement allowed them greater autonomy and freedom from restrictions present in monogamous relationships (Moors et al., 2017). Additional themes identified by participants that converge with themes identified by people in monogamous relationships included family/community

benefits, trust, sex, love, communication, and commitment (Conley et al., 2013a; Moors et al., 2017).

Although the stigma related to CNM relationships is pervasive, the stereotypes and beliefs regarding CNM relationship arrangement are based unfounded assumptions. Rubel and Bogaert (2015) conducted a systematic review of literature related to CNM, psychological constructs, and relationship satisfaction. Across studies individuals in CNM relationships did not vary significantly from individuals in monogamous relationships on overall psychological well-being and relationship adjustment. Additionally, there were no significant group differences in terms of jealousy, sexual satisfaction, and relationship stability (Rubel & Bogaert, 2015).

This finding is consistent with other researchers that have found that individuals in monogamous relationships and individuals in CNM relationships are satisfied with their relationships at similar levels (Mogilski et al., 2015). Moreover, CNM relationships may promote greater relational satisfaction than monogamous relationships for some individuals. Mogilski et al. (2015) found that participants in monogamous relationships reported less satisfaction in the amount of communication and openness they had with their partner, compared to participants in CNM relationships.

Measuring Constructs Related to Consensual Nonmonogamy

Related to the exploration of the public's attitudes toward CNM is the way in which researchers' measure constructs related to intimate relationships. There is a need to caution the generalizability of findings. For instance, Matsick et al. (2014) identified that the sample was a convenient sample that composed of mostly white and heterosexual individuals. Similarly, Moors et al. (2013) addresses concerns related to Conley, Moors, and colleagues (2013a) studies of stigma towards CNM relationships. One consideration is that these researchers measured attitudes toward CNM relationships broadly rather than specific attitudes that may exist in sub-types of CNM. Séguin (2019) argues that previous research related to CNM stigma frequently relies on researcher presumed attitudes rather than participant reported attitudes due to the qualitative methods used.

Conley and colleagues (2013a) recognize the lack of communication between the researchers and participants likely exacerbates the halo effect surrounding monogamy and stigma related to CNM. The reliance of vignettes and hypothetical others presents difficulties in widely

using these measures to rapidly measure beliefs about consensual nonmonogamy. Cohen and Wilson (2017) created a scale meant to capture attitudes toward CNM quickly. These researchers have found the scale to be reliable and valid. Cohen and Wilson (2017) believe this scale is meant to be used in a variety of contexts.

Overall, researchers studying intimate relationships have assumed monogamy subtly through the use of language within measures of relationship satisfaction and adjustment (Conley et al., 2017). Conley et al., (2017) argue that research related to intimate relationships contain bias related to monogamy. Almost all romantic relationship adjustment scales contain the term "partner" rather than "partners," which highlights how researchers do not consider multiple-partner relationships to be a valid relational orientation. The research related to attitudes about CNM is growing. The researcher in the present study seeks to add to this growing body of research by exploring relational therapists' attitudes toward CNM relationships and if their attitudes relate to therapy practices.

Minority Stress Framework

Across the literature, people in CNM relationships report satisfaction in their intimate relationships (Mogilski et al., 2015; Moors et al., 2017; Rubel & Bogaert, 2015). The pervasive stigma and lack of legal protections for people in CNM relationships, however, places individuals in a marginalized position (Conley et al., 2013a; 2013b). Conley et al. (2013b) suggest that a part of the public's commitment to monogamy is driven by the stigma associated with CNM structures. By embracing a monogamous relationship, individuals avoid the negative societal liabilities associated with being a part of a marginalized group. Therapists should be aware of the impact that social disapproval and discrimination related to a client's identity can have on mental health outcomes.

Fleckenstein et al. (2013) surveyed over 4,000 individuals in polyamorous relationships and approximately 25.8% reported experiencing some form of discrimination in the past decade and another 20.8% of the sample indicated they were uncertain if they had experienced discrimination. The researchers highlight that this is significantly higher than the national average – which is approximately 5.5% in the general U.S. population (Fleckenstein et al., 2013). Meyer (2003) argues that *minority stress* is the accumulation of additional stress related to belonging to a marginalized group. For example, LGB individuals are at risk of experiencing

significant prejudice, discrimination, and internalized stigma that can negatively impact both physical and psychological well-being (Balsam, 2005; Cochran, 2003; Meyer, 2003). Being marginalized by society and internalizing this stigma provides a liable explanation as to why sexual minorities experience psychological distress at higher rates than heterosexual individuals. Balsam (2011) highlights that people in the lesbian, gay, bisexual, transgender, queer, asexual (LGBTQA+) communities that are also persons of color have multiple marginalized identities. Therefore, individuals with various marginalized identities may experience microaggressions or other forms prejudice at higher rates than other groups.

Similarly, polyamorous women were more likely than polyamorous men to report discrimination in the last decade (Fleckenstein et al., 2013). This finding suggests that holding various marginalized identities while being in a CNM relationship may increase the likelihood of experiencing minority stress. Recently, researchers have applied a minority stress framework to CNM populations (Schechinger et al., 2018; Witherspoon, 2018). Witherspoon (2018) found that individuals in CNM relationships who experienced discrimination and harassment related to CNM-status were more likely to experience negative mental health outcomes (i.e., report greater symptoms of depression and anxiety). Simultaneously, this same study found that individuals in CNM relationships have protective factors such as supportive communities and mindfulness that may mitigate the impact of marginalization (Witherspoon, 2018).

Overall, minority stress is an important concept when considering individuals in CNM relationships who are seeking therapy. The lack of visibility often involved in CNM relationships due to societal norms means therapists have to ensure that they create a therapy environment where clients can disclose their minority relational status (Blumer et al., 2014; Twist et al., 2021). CNM status places individuals at higher risk of stigma and discrimination, clinicians need to be aware of how these stressors may negatively impact the mental health outcomes of their clients. Therapists have an opportunity to fight prejudice and give CNM clients an opportunity to build resiliency.

Therapy Experiences of Consensually Nonmonogamous Clients

Negative attitudes towards individuals in CNM relationships is quite robust in the general public (Cohen & Wilson, 2017; Conley et al. 2013; Fleckenstein et al., 2013). There is evidence that clients who identify as CNM also frequently experience prejudice from their therapists

related to their relational orientation (Ley, 2009; Weitzman, 2009). Contemporary research related to therapy experiences of CNM clients is beginning to reveal how therapists can increase sensitivity in working with this population.

Schechinger et al. (2018) used a minority stress framework to explore how CNM clients perceived therapist behaviors. These researchers used both quantitative and open-ended questions to determine if participants viewed therapist practices as affirming or not affirming to their CNM identity. Participants were also asked about their therapeutic outcomes and the researchers explored how therapist behaviors related to therapy outcomes (Schechinger et al., 2018).

Results of Schechinger et al. (2018) indicated that CNM clients found their therapist was especially helpful if they demonstrated behaviors that indicated a non-judgmental attitude toward their CNM identity and were knowledgeable regarding CNM relationships. Inappropriate practices were identified by participants as behaviors that indicated pathologizing CNM and assuming monogamy status. Participants of this study collectively reported more frequent affirming therapy experiences but only one-third of participants identified their therapist as knowledgeable of CNM practices. Additionally, approximately one-third of participants reported inappropriate therapy experiences. These inappropriate therapy experiences were linked to an increase likelihood that the client prematurely terminated therapy (Schechinger et al., 2018).

The results of Schechinger et al. (2018) share themes with previous research. Henrich and Trawinski, (2016) interviewed 12 individuals in polyamorous relationships who sought therapy. These clinicians identified three main thematic challenges that emerged through these interviews and in their clinical work with polyamorous clients. These challenges included: therapists having insufficient knowledge related to polyamory, client marginalization, and therapist bias. Additionally, Kisler and Lock (2019) found that polyamorous clients would like their therapists to be aware of the stigma associated with polyamory and have knowledge surrounding how individuals navigate creating polyamorous arrangements.

The previous literature reviewed above demonstrates that therapists may lack knowledge related to working with CNM clients. Therapists, like laypersons, are influenced by monogamous bias that can detrimentally impact the therapeutic relationship they form with CNM clients (Henrich & Trawinski, 2016; Kisler & Lock, 2019; Schechinger et al., 2018). There is significant need for therapists to work towards greater sensitivity to the diversity of intimate

relationship structures. Schechinger et al., (2018) posits that therapists are positioned to either help combat or maintain the minority stress CNM clients face.

Therapist Attitudes toward Consensual Nonmonogamy

Two relatively dated studies explored therapists' explicit attitudes towards CNM (Hymer & Rubin, 1982; Knapp, 1975). Both of these studies suggest that therapists held unfavorable attitudes toward CNM at this time. Knapp (1975) surveyed 190 clinical members of the American Association of Marriage and Family Counselors on their attitudes and practices when working with clients who engage in open marriages, swinging, and undisclosed affairs. This study explored therapist attitude toward the relationship arrangement personally and professionally. Knapp (1975) found that approximately 33% of the sample identified individuals in open relationships as neurotic. In terms of swinging, 58% of the sample identified themselves as personally non-approving and 38% professionally non-supportive. For sexually open marriages, 28% of the sample was personally non-approving and 16% identified themselves professionally non-supportive. For undisclosed affairs, 37% were personally non-approving and 25% as professionally non-supportive. These results suggest this sample of therapists perceived swinging more negatively than open relationships and affairs. Some participants identified themselves as neutral/ambivalent towards CNM. Several participants responded to open-ended questions and claimed they were able to maintain neutrality as a therapist working with CNM despite disapproving of CNM personally (Knapp, 1975).

Hymer and Rubin (1982) also examined therapist attitudes toward open marriages, swinging, and extramarital sex. Similar to Knapp (1975), swingers were perceived most negatively by the sample. Many therapists described individuals who engage in swinging as pathological, fearing intimacy and commitment, and having regressive desires. Although open relationships were perceived favorably compared swinging and extramarital sex; responses suggested therapists also attributed negative characteristics to this groups such as fear of commitment (Hymer & Rubin, 1982).

Recently, Grunt-Mejer and Łyś (2019) examined current therapists and prospective therapists' attitudes toward monogamy, polyamory, swinging, and cheating. This study sampled 324 European psychologists or graduate level students studying psychology. Grunt-Mejer and Łyś (2019) examined beliefs through a hypothetical clinical vignette where participants rated the

hypothetical clients in different relationship arrangements. Participants tended to rate CNM clients lower in terms of relationship satisfaction, morality, and cognitive aptitude. Participants also tended to identify CNM arrangements as related to the client's presenting problem. When the vignettes included monogamous clients, the presenting problem was not associated with the relationship arrangement which suggests therapists pathologize CNM (Grunt-Mejer and Łyś, 2019). Pathologizing CNM was one of the therapist behaviors identified in Schechinger et al. (2018) as harmful and associated with CNM clients prematurely terminating therapy.

Baluck (2020) measured therapists' attitudes toward CNM in a sample of 127 therapists and graduate therapists in training for a variety of psychotherapy degrees in the U.S. The participants in this sample varied in terms of degree attained. The sample was primarily made up of therapists who obtained their degree in clinical psychology (34%) or counseling/counseling psychology (25%). Baluck measured attitudes toward CNM and polyamory and explored how these attitudes related to a variety of other variables including CNM-specific knowledge, general multicultural competency, and exposure to CNM clients. Participants were presented with a theoretical clinical vignette where the client was described as monogamous, polyamorous, or in an open relationship. Participants were asked a series of questions related to how they perceived this client's symptom severity and romantic relationship satisfaction. They also were asked about their own comfort level providing treatment for the client (Baluck, 2020).

In this study therapists' knowledge of CNM was positively associated with general multicultural competency. Both CNM knowledge and multicultural competency were positively associated with favorable attitudes toward CNM. Unexpectedly, multicultural competency did not moderate the relationship between CNM knowledge and attitudes toward CNM (Baluck, 2020). The results of this study revealed that being exposed to CNM (i.e., quantity of experience working with CNM clients) did not have a significant relationship with holding favorable attitudes toward CNM. The author suggested this may be due to measuring this variable quantitatively rather than qualitatively. This study also found that participants who indicated therapist discomfort and perceived incompetency in the vignette were significantly more likely to hold negative attitudes toward CNM and lack knowledge of CNM (Baluck, 2020). In the present study, the researcher is interested in measuring monogamism in and exploring if this cultural sensitivity measure moderates the relationship between these variables. The present study

predicts a more specific measure related to cultural sensitivity of diverse relationship orientations will have a stronger relationship with knowledge of CNM and attitudes toward CNM.

Clinical Sensitivity

Literature in the field of psychotherapy is beginning to address working with CNM clients. One of the major recommendations is to not pathologize CNM (Girad & Brownlee, 2015; Kolmes & Witherspoon, 2017; van Tol, 2017). This recommendation is especially necessary since Schechinger et al. (2018) identified a frequent non-affirming therapy experience was participants' CNM identity being pathologized. For instance, several participants reported that their therapist told them that CNM reflects the client's inability to commit to relationships. This is a common stereotype that is evident in the public's attitudes toward CNM (Conley et al., 2013a).

Literature emphasizes that relational therapies such as Gottman and Emotion-Focused Therapy follow mono-normative assumptions. Kolmes and Witherspoon (2017) identify these relational modalities as potentially viable for CNM clients seeking relational therapy. Kolmes and Witherspoon (2017) recommend clinical caution when applying treatment modalities. Clinicians with significant experience working with CNM clients recognize that practice-based evidence is more appropriate since the field lacks systematic evidence of current treatment approaches or novel modalities for CNM structures (Henrich and Trawinski, 2016;Kolmes & Witherspoon, 2017). Additionally, Kauppi (2021) has recently published a tool kit informed by her clinical work with polyamorous folks. This tool kit has specific interventions, self-of-the therapist activities, and a summary of information regarding CNM relationships.

Examining beliefs about monogamy is another recommendation emphasized by a variety of literature (Girad & Brownlee, 2015; van Tol, 2017). Since the public generally favors monogamous relationships (Conley et al., 2013a; Day et al., 2011) a majority of therapists likely assume monogamy is the relationship structure their clients identify with. Underlying bias related to CNM likely contributes to non-affirming therapy practices reported by CNM clients. Importantly, scholars have created a variety of resources for therapists working with clients who hold diverse relational orientations

Clinicians who are in monogamous relationships should explore their privilege and utilize Davis' (2011) Monogamous Privilege Checklist. In addition, the monogamism measure

developed by Twist and colleagues (2018) measures cultural sensitivity related to diverse relational orientations. This may be a helpful assessment for therapists to use to understand how monogamy bias impacts their work with clients and areas for further growth. Twist et al. (2021) also includes a variety of resources related to relational diversity that may be helpful for therapists interested in learning about effectively treating clients who identify with a variety of relational orientations. Additionally, relational therapists have the opportunity to convey that their practice is inclusive towards diverse relationship orientations. For instance, van Tol (2017) recommends using inclusive language such as relationship counseling, instead of couple or marital counseling on websites when the clinician has the power to do so (e.g., private practice).

Other therapists specialize in working with individuals in CNM relationships. The National Coalition of Sexual Freedom provides The Kink and Poly Aware Professional Directory (KAP, 2020). This directory is a resource for individuals interested in finding an affirming therapist or other professionals that are dedicated to being informed about the diversity of sexuality. These professionals are not guaranteed to have the advertised credentials and potential clients may be unable to find a provider near their geographic region.

Present Study

In the present study, the researcher addresses the deficit in research regarding relational therapists' knowledge, attitudes, and reported therapy practices when working with CNM clients. The researcher is interested in replicating and extending results revealed by Baluck (2020). Baluck (2020) revealed that multicultural competency did not significantly moderate the relationship between CNM knowledge and attitudes toward CNM, however, multicultural competency was positively associated with both knowledge and favorable attitudes toward CNM. In the present study, the researcher measures therapists' sensitivity to monogamism since this is a more specialized measurement of cultural sensitivity relevant to this population. Measuring attitudes toward CNM is especially warranted in a sample of relational therapists since these professionals specialize in providing support to intimate relationships. Relational therapists are dedicated to providing high quality treatment to diverse family structures as evidenced by statements given by the AAMFT (2020). The researcher in the present study uses multiple methods to answer the research questions provided below. The researcher collects quantitative data and qualitative data concurrently to provide thorough results. The purpose of

this design is to gain a better understanding of how therapist attitudes toward CNM impacts their clinical work with clients. The inclusion of open-ended questions enriches the results and discussion in how relational therapists can work towards greater inclusivity in practice.

Guiding Research Questions & Related Hypotheses

Research questions were developed based on the extant literature. The following hypotheses will be tested.

Research Question One: What is the association between knowledge of CNM and attitudes toward CNM?

Hypothesis One: Greater knowledge of CNM will predict positive attitudes toward CNM.

Research Question Two: Does monogamism sensitivity moderate the relationship between CNM knowledge and attitudes toward CNM?

Hypothesis Two: As monogamism sensitivity increases the relationship between knowledge of CNM and attitudes towards CNM also increases.

Research Question Three: Is there a significant difference between therapists who receive specialized training in CNM compared to therapists who have not received specialized training in CNM in their attitudes toward CNM and CNM knowledge?

Hypothesis Three: Therapists with specialized training will have more positive attitudes toward CNM compared to therapists without specialized training.

Hypothesis Four: Therapists with specialized training will have greater CNM knowledge compared to therapists without specialized training.

Research Question Four: What are relational therapists' practices when working with CNM clients?

Hypothesis Five: The emerging themes about therapy practices will help clarify how knowledge, attitudes, and competency working with CNM clients manifest during the process of therapy from the perspective of the therapist. These themes may reveal if relational therapists are perpetuating CNM stigma in therapy.

CHAPTER 3: METHODOLOGY

Participants

Prior to recruitment, the researcher received approval from the Purdue University Institutional Review Board (IRB) for all study materials and procedures (IRB #2021-116). Based upon a power analysis the minimum number of participants necessary for the quantitative analyses was 107 participants (Faul et al., 2007; 2009). Thus, the researcher intended to recruit a minimum of 200 participants.

To be eligible to participate, participants were required to self-identify as current or prospective relational therapists. Participants were encouraged to be licensed marriage and family therapists or graduate students studying marriage and family therapy and/or couple and family therapy. The informed consent operationalized a relational therapist as a therapist whose caseload is composed of at least 30% of relational cases (e.g., couples). Student therapists were welcome to participate. Inclusion criteria required that the participant currently provides therapy to at least one case. The present study was interested in recruiting therapists that specialize in relational therapy since there is a deficit in research about attitudes toward CNM in a present-day sample of relational therapists. Other inclusion criteria included that all participants were at least 18 years or older.

Data collection occurred through Qualtrics, a program that allows researchers to create an online survey and collect participants' responses in August 2021. Participants were recruited using snowball sampling, posting the survey on therapist social media accounts along with requesting the survey be shared with others who met the inclusion criteria. A call for participants was also posted on couple and family therapy-specific webpages at Purdue University Northwest and on a discussion board for the family therapy section of the National Council for Family Relations. Across all these recruitment approaches participants who completed the survey were encouraged to recruit other eligible participants such as colleagues or students in the field. The survey advertisement that was distributed included the title of this study along with describing the purpose of this study as gathering relational therapists' attitudes toward CNM. Additionally, the survey advertisement included a short description of the inclusion criteria, approximate length of time needed to finish the survey, and a request for

individuals to share the survey with others who met the inclusion criteria. Please see Appendix A for a copy of the survey advertisement. Participant confidentiality was ensured by not collecting identifying information such as names or addresses.

Procedure

Interested participants clicked on the survey link. The initial page informed the participant of the purpose of the study, the researcher's contact information, followed by informed consent for them to accept. Participants were eligible to enter a raffle for one of 20 Amazon gift cards worth $20. Consent was required to be given before participants continued to the survey. If the participant indicated that they did not want to participate in the study by selecting "no" on the informed consent, they were be directed to a page thanking them for their consideration in the study. If the potential participant consented to the study by selecting "yes," they moved onto the questionnaires. After completing the questionnaires, the participants moved onto a message thanking them for their participation, contact information for the primary investigator, and were then given instructions for how to enter the gift card raffle. Each participant was informed that their responses to the study were in no way linked to the information provided for the gift card drawing. The participants were linked to a completely independent survey to enter the gift card drawing by providing their email address.

Materials

A variety of information was collected from the participants in order to answer all research questions. Participants were first asked to respond to demographic questions. Then participants responded to scales that measure the following variables: attitudes toward CNM, knowledge of CNM, monogamism, and three-open ended questions that measure therapy practices.

Demographic Questionnaire

Participants were asked to identify general demographic questions including age, gender identity, race/ethnicity, sexual orientation, relationship status, relationship structure, and

religious/spiritual practice. Participants were then asked questions related to therapist characteristics. These items include their highest level of education attained, credentials (e.g., LMFT), degree Type (e.g., Master of Science in Couple and Family Therapy), and how long they have you been working with clients in years (e.g., 3 years). The participants were also asked to identify their theoretical orientation. Participants were also asked to identify if they have experience treating clients who identify as CNM as a yes or no question. The demographic questionnaire is included in Appendix B.

Specialized Training

Specialized training working with CNM clients is a yes/no question included in the demographic question block of the survey. This item is the independent variable in hypothesis three and hypothesis four. Participants who answer yes were prompted to elaborate about this training by selecting if they attended a conference training, completed an online training, sought out supervision with a clinician who specializes in working with CNM clients, sought out information online (e.g., reading research articles), or other which allows the participant to provide context to their answer. Participants were able to select more than one answer. This information contextualized specialized training and provided greater information for the discussion of the results. This item is included in the Qualtrics survey in Appendix B.

Consensual Nonmonogamy Attitude Scale (CNAS)

The Consensual Nonmonogamy Attitude Scale (CNAS) is an eight-item assessment developed by Cohen and Wilson (2017). The CNAS measures an individual's explicit agreement to a variety of statements related to relationship orientation. This measure uses a 7-Point Likert-type scale from 1 (strongly disagree) to 7 (strongly agree). Three items are reverse coded (e.g., "Intimate relationships with more than one person are too complicated") while the other five items measure the extent to which the individual believes CNM relationship structures are satisfactory (e.g., "It is possible to have several satisfying intimate relationships at the same time"). Previously the CNAS has yielded high internal consistency with a Cronbach alpha of .91. An exploratory factor analysis demonstrated a single factor structure with all item loadings being within acceptable limits (.63 to .94). A confirmatory factor analysis indicated good model fit

(Cohen & Wilson, 2017). Attitudes toward consensual nonmonogamy are the dependent variable in hypothesis one, two, and three. The CNAS is included in the Qualtrics survey in Appendix B.

CNM Knowledge Questionnaire

The CNM Knowledge Questionnaire is a 24-item measure developed by Baluck (2020). This questionnaire was intended to measure a therapist's awareness of information and statistics about consensual nonmonogamy. Baluck (2020) reports designing items based on literature that suggests laypersons and therapists hold a variety of beliefs that perpetuate stigma and stereotypes towards CNM. Items are identified as true or false. Example items include, "Among individuals infected with sexually transmitted diseases, those who engage in CNM are more likely to pass those diseases on to their partners as compared to those in monogamous relationships," and "Monogamous relationships tend to last longer than CNM relationships." Reliability and validity have yet to be reported, however Baluck (2020) used this questionnaire to measure knowledge about CNM in a sample of therapists and it was positively correlated with related measures (e.g., CNAS). Knowledge of CNM is the independent variable in hypothesis one and hypothesis two, as well as the dependent variable in hypothesis four. The CNM Knowledge Questionnaire is included in the Qualtrics survey in Appendix B.

Monogamism Measure

The monogamism measure is a 40-item scale developed by Twist et al. (2018). This instrument measures clinicians' cultural sensitivity to minority relational orientations. This measure contains three subscales: awareness, knowledge, and skills. Fourteen items measure awareness of monogamism (e.g., "I am comfortable with multi-parents having the same parenting rights as two parents.") The awareness subscale is ranked on a 4-point-Likert scale from 1 (*strongly disagree*) to 4 (*strongly agree*). Twelve items measure knowledge of monogamism which asks participants to rate their understanding of various terms related to diverse relationship orientations (e.g., "consensual nonmonogamy"). The knowledge subscale is ranked on a 4-point Likert scale from 1 (*very limited*) to 4 (*very good*). Seventeen items are included in the skills subscale which measures a clinician's ability to reduce monogamism in clinical practice. This subscale asks participants to rank their capacity to complete certain skills

(e.g., “Not assume that someone who presents for couples therapy has only one partner”). Items on the skills subscale are ranked on a 4-point Likert scale from 1 (v*ery limited*) to 4 (*very good*). The monogamism measure yielded high internal consistency on all three subscales in a previous sample of mental health professionals. The awareness subscale yielded a Cronbach’s alpha of .89 while both the knowledge and skills subscales yielded a Cronbach’s alpha of .96. In addition, this measure has high face validity and was pilot tested at a training of mental health professionals (Twist et al., 2018). Monogamism is the moderator included in hypothesis two. The monogamism measure is included in the Qualtrics survey within Appendix B.

Reported Therapy Practices

The open-ended questions are based off previous studies that have explored therapy experiences of CNM clients (Schechinger et al., 2018) and sexual minorities (Liddle, 1996). Participants were asked to identify if the participant has experience working with CNM clients. The responses to these questions were coded to answer the fourth research question.

If participants identified that they do not have experience working with CNM clients then hypothetical questions were asked. These open-ended questions are phrased hypothetically to encourage participants to answer regardless of clinical experience working with CNM clients.

- How would you effectively work with a client system who identifies as consensually nonmonogamous? Please explain how you measure effectiveness of treatment.
- What do you think would be particularly helpful for clients who identify as consensually nonmonogamous?
- What do you think would be particularly unhelpful for clients who identify as consensually nonmonogamous?

If the participant indicates having experience working with CNM clients, they were directed to answer the following open-ended questions.

- How do you effectively work with a client system who identifies as consensually nonmonogamous? Please explain how you measure effectiveness of treatment.
- What do you think is particularly helpful for clients who identify as consensually nonmonogamous?

- What do you think is particularly unhelpful for clients who identify as consensually nonmonogamous?

Data Analysis Strategy

Multiple Methods

In this study, the researcher collected both quantitative and qualitative data in one-phase. The quantitative and qualitative data were analyzed separately. A side-by-side comparison of the quantitative results and qualitative results are further explained in the discussion section. This comparison allows for similarities and differences between the close-ended and open-ended data to be highlighted. Multiple methods are advantageous since the researcher has a more complete understanding of a phenomenon (Brannen, 2007). The design has both generalizable qualities of quantitative research and more nuanced qualities of qualitative research. In the present study, the researcher was interested in understanding of how attitudes toward CNM and education around CNM inform therapy practices. By qualitatively asking about therapy practices, the researcher is extending previous research, which included only quantitative variables (i.e., Baluck, 2020).

It is critical to recognize that quantitative data is weighed more than qualitative data in the present study. Four out of five hypotheses are quantitative in nature. Additionally, the quantitative analyses were completed prior to the qualitative analyses. The constructs measured in the quantitative data included attitudes, knowledge, specialized training, and monogamism all influence the themes that were coded within the thematic analysis. Despite these limitations, this methodology overall strengthens the results of this project. The data analysis plan below addresses how the researcher answers each research question and corresponding hypothesis.

Quantitative Analyses

The data analysis plan addressed each research question and corresponding hypotheses. Hypothesis one was tested by conducting a simple linear regression. For the first regression the independent variable was knowledge of CNM, and the dependent variable was attitudes toward CNM. Hypothesis two was tested using Model 1 in PROCESS (Hayes, 2012), which is a macro for examining path analysis-based models in the Statistical Package for

the Social Sciences (SPSS). For this analysis, the independent variable was knowledge of CNM, the moderator will be monogamism, and the dependent variable will be attitudes towards CNM. Initially, the researcher intended for the path analysis to be tested using 5,000 bootstrap resamples. The macro also automatically generates 95% bias-corrected bootstrapped confidence intervals to aid in interpretation. Due to a high number of participants completing the survey bootstrap samples were not completed when running the linear regression for hypothesis one and hypothesis two.

It was originally proposed that hypothesis three would be tested by running a simple linear regression with specialized training in CNM as the independent variable and attitudes towards CNM as the dependent variable. Hypothesis four was originally proposed to be conducted using a simple linear regression with specialized training in CNM as the independent variable and knowledge of CNM as the dependent variable. Due to high number of participants identifying as receiving specialized training in working with CNM and having only two options for the independent variable it seemed an independent t-test would better fit the goal of examining if specialized training influences scores on the CNAS and CNM knowledge questionnaire.

An independent samples t-test was used to examine hypothesis three within SPSS. For hypothesis three, it was predicted that individuals who received specialized training would have significantly higher means on the CNAS compared to those who did not complete specialized training working with CNM clients in clinical settings. The test variable was the CNAS. The grouping variable was specialized training. Since specialized training is a categorical variable it was dummy coded to ensure accurate results. Specialized training was dummy coded with “no” being coded as zero and “yes” being coded as one.

Similarly, an independent samples t-test was used to examine hypothesis four within SPSS. Hypothesis four predicted that individuals who endorsed receiving specialized training working with CNM would have a significantly higher mean on the knowledge of CNM questionnaire compared to those who did not complete specialized training working with CNM clients in clinical settings. The test variable selected was knowledge of CNM questionnaire. The grouping variable was specialized training. Specialized training was dummy coded identically to hypothesis three.

Qualitative Data Strategy

Hypothesis five used thematic analysis to identify major and minor themes in the open-ended questions exploring hypothetical therapy practices when working with CNM clients (Braun & Clarke, 2006). Previous thematic analyses in CNM clients (Schechinger et al., 2018) and sexual minorities (Liddle, 1996) helped identity which specific therapy practices clients with marginalized identities find particularly helpful and/or harmful. Thematic analysis was chosen because this allows the researcher to examine what types of practices therapists believe are helpful and harmful when working with CNM clients.

275 participants answered at least one open-ended question. This means 35% of participants completed an open-ended question. This is lower than expected based on similar studies (e.g., Schechinger et al., 2018) who reported a 60% completion rate of open-ended questions. Approximately 25% of responses to the open-ended questions were randomly selected and read three times by two coders. In total 70 responses to the open-ended questions were coded.

To begin this process, ten responses were coded by both coders to create individual codebooks. Each coder independently created a list of major and minor themes. The identification of major and minor themes was completed by hand without the assistance of a computational program. Throughout a thematic analysis, inter-rater reliability is not examined using quantitative statistical procedures rather through consensus and critical examination of the data. Reliability between raters was determined by reading each response at least three times prior to coding. The coders simultaneously reviewed the first 10 items and then discussed and identified patterns when creating the codebook. In this phase coders decided on themes that fit the data and mostly included major themes (Braun & Clark, 2006).

After coding the same initial responses, each coder independently coded 30 independent responses using the collective codebook. When reviewing the independent responses, the coders met halfway through to adjust the collective codebook. The coders also engaged in critical discussion when they finished initially coding all responses. During these meetings the coders discussed if the codes identified were actually exemplified across data. In addition, themes were reworked, discarded, and new themes were created throughout this process aligning with Braun and Clark's (2006) methodology. Data was also re-read, and codes were adjusted as needed at the last data meeting. The chair of this thesis, a professor in couple and family therapy, served as

an auditor during this process to be called upon if consensus could not be reached between the coders. To increase reliability and validity both coders provided reflexivity statements and completed the monogamism measure which is included below.

Reflexivity Statements

Coder One

The author of this project, Alexia Kingzette, is of European American ancestry (primarily Hungarian). What follows is her statement of reflexivity: I am a graduate student working towards my master's degree in couple and family therapy at Purdue University Northwest. I am passionate about the field of couple and family therapy being equipped to help diverse family structures. This desire is in part fueled by my own experience growing up in a blended family. I grew up and remain a resident of the Chicago suburbs. Some identities I hold that are central to my experience include that I am white cisgender woman. I am currently in a monogamous long-term relationship.

My interest in studying therapist attitudes toward CNM was initially fueled by anecdotes from close friends who report having negative experiences in therapy related to their CNM identity. I found it compelling that the literature further suggests that many CNM individuals have experienced stigma in a variety of contexts, including therapy. My limitations for this work include that I have not participated in a CNM relationship therefore I am operating from an inherently outsider's perspective. The strengths I bring to the project are my commitment to learning, growing, and advocating for the field of relational therapy to be culturally sensitive. As I move forward with this project, I will continue to remain reflexive to ensure the results of this study are reliable and valid.

The following are my scores on the monogamism measure. On the awareness subscale I scored a 52. On the knowledge subscale I scored 38. On the skills subscale I scored 47. The total score on the monogamism measure was 137.

Coder Two

The second coder is also a master's level graduate student in couple and family therapy. The following is their statement of reflexivity: I am a graduate student currently pursuing a

degree in couple and family therapy at Purdue University Northwest. I am a white queer individual who currently works at a therapy practice in Chicago, Illinois that specializes in gender and sex therapy. I have had both personal and professional experiences regarding consensual nonmonogamy. I became interested in working with CNM relationships in a therapeutic setting after becoming aware of research discussing the stigma and discrimination that those in CNM relationships experience. As someone who has been a part of CNM relationships and who has worked with CNM clients, I am sure to be aware of any biases I hold regarding monogamy. The second coder scored 54 on the awareness subscale, 41 on the knowledge subscale, and 56 on the skills subscale. This coder's total score on the monogamism measure was 151.

CHAPTER 4: RESULTS

Sample Characteristics

775 participants completed the online survey, passed both attention checks, and finished necessary items on the survey. Participants in the final sample had to complete all items related to the quantitative hypotheses. Participants were not required to answer demographic or qualitative questions to be included in the sample. In the report of descriptive statistics 2,980 individuals accessed the online survey and completed a significant proportion of the survey. There were two attention checks. 1502 participants passed the first attention check. 1293 participants passed the second attention check. Due to having a high number of participants it was decided to list wise delete cases for missing data for quantitative variables. 775 participants ended up being the final sample size after cleaning the data.

The data was tested for outliers and normality. Univariate skewness was not a problem for nearly all variables needed for quantitative analyses (i.e., skewness index < |3.00|; Kline, 2011), nor was univariate kurtosis (i.e., kurtosis index < |10.00|; Kline, 2011). Importantly, one item did not meet the qualifications for normality. The item that asked participants to identify if they have received specialized training in working with CNM clients indicated that 90.3% of the sample had received specialized training in working with CNM clients. The high number of participants identifying “yes” led skewness not meeting the typical criteria for this item (skewness = 2.73). Kurtosis also did not meet Kline’s recommendation for normality (kurtosis index = 5.48). This was expected due to nature nominal of including a nominal variable that only has two categories.

Descriptive Analyses

Demographic Characteristics

Participants were aged 21 to 53 years with a mean age of 30. 25 years (SD = 4.96). 386 participants identified their racial identity as White (49.8%), 165 as Black, African American, or Afro-Caribbean (21.3%), 103 as Asian (13.3%), 52 as Latinx or Hispanic (6.7%), and 69 participants (8.8%) identified in other racial/ethnic

categories. 398 participants identified their gender identity as cisgender man (51.5%), 356 identified as a cisgender woman (45.9%), and 21 (2.7%) identified in other categories (non-binary, transgender, other, or did not respond). In terms of sexual orientation 473 participants identified as heterosexual (61.0%), 154 as bisexual (19.8%), 109 as gay (14.1%), 45 (5%) identified their sexual orientation in other categories (i.e., lesbian, pansexual, asexual, more than one, other, or did not respond). Please see Tables 1 through 3 for a further breakdown of these demographic characteristics

The mean of 3.6 indicates most participants earn between $35,000 and $74,999 (SD = 1.35). Table 4 provides a greater breakdown of the annual income earned by the participants. In terms of marital status, 378 identified their marital status as married (48.8%). Table 5 providers more information about the marital status of the sample. In terms of relational orientation 313 (40.4%) of the sample identified as monogamous, 150 participants (19.4%) identified as CNM, 104 participants (13.4%) of the sample identified themselves in an open relationship, and 208 (26.8%) identified in other categories explained further in Table 6. In terms of educational background, 370 participants (48.1%) identified with earning their bachelor's degree with work toward master's degree. Table 7 provides further details regarding the highest degree attained by participants. Table 8 provides additional information regarding participants' religious and spiritual identities.

The most frequent degree type participants either held or were working toward is a master's degree in Clinical Mental Health Counseling with 246 participants selecting this degree. Table 9 provides further details on the degree type participants either held or were working towards. The most frequently selected credential participants either held or were working toward was a Licensed Clinical Psychologist with 312 participants selecting this credential. Table 10 provides further details on the credentials participants held or were working toward. The most frequently selected clinical orientation was Emotionally Focused Therapy with 70 (9%) participants identifying this as their main theoretical orientation. The most frequently selected specialized training opportunity participants completed was completing an online training on this clinical population with 365 participants selecting this option. Table 11 provides further information on the specialized training opportunities they completed.

Table 1. Race (*n* = 775)

Racial Identity	Frequency	Percentage
White	386	49.8%
Black, African American, or Afro-Caribbean	165	21.3%
Asian	103	13.3%
Latinx or Hispanic	52	6.7%
American Indian or Alaskan Native	26	3.4%
Native Hawaiian or Pacific Islander	21	2.7%
Other (Middle Eastern, Multiracial, more than one racial category)	22	2.7%

Table 2. Gender Identity (*n* = 773)

Gender Identity	Frequency	Percentage
Cisgender Man	398	51.5%
Cisgender Woman	356	45.9%
Other Categories (Non-binary, transgender, other/not listed, or more than one)	19	2.3%

Table 3. Sexual Orientation (*n* = 773)

Sexual Orientation	Frequency	Percentage
Heterosexual	473	61.0%
Bisexual	154	19.9%
Gay	109	14.1%
Other	37	6.5%

Table 4. Income (*n* = 772)

Income	Frequency	Percentage
Less than $20,000	68	8.8%
$20,000 - $34,999	94	12.1%
$35,000 - $49,999	186	24.0%
$50,000 - $74,999	199	25.7%
$75,000 - $99,999	183	23.6%
$100, 000 and over	42	5.4%

Table 5. Marital Status (*n* = 773)

Status	Frequency	Percentage
Married	378	48.8%
Single	115	14.8%
Dating, living alone	85	11.0%
Dating, living with partner/s	74	9.5%
Separated	63	8.1.%
Widowed	58	7.5%

Table 6. Relational Orientation (*n* = 772)

Status	Frequency	Percentage
Monogamous	313	40.4%
Consensually Nonmonogamous	150	19.4%
Open relationship	104	13.4%
Polyamorous	71	9.2%
Swinging	71	9.2.%
More than one	60	7.7%
Other/not listed	3	0.4%

Table 7. Highest Level of Education (*n* = 769)

Education	Frequency	Percentage
Bachelor's Degree with work toward Master's	370	48.1%
Master's Degree	150	19.4%
Master's Degree with some additional coursework toward a Doctorate Degree	148	19.1%
Doctorate	49	6.3%
Other/not listed	9	1.2%

Table 8. Level of Religiosity (*n* = 770)

Response	Frequency	Percentage
Yes, spiritual	287	37.0%
Yes, religious	212	27.4%
Yes, both	188	24.3%
No, neither	83	10.7%
Other/not listed	9	1.2%

Table 9. Degree Type Participants Hold or Are Working Toward

Response	Frequency	Percentage
Master's in Couple and/Marriage and Family Therapy	229	29.5%
Master's in Clinical Mental Health Counseling	246	31.7%
Master's in Social Work	205	26.5%
Doctorate in Psychology (PsyD)	213	27.5%

Note: Participants could select multiple degrees therefore n is greater than 775.

Table 10. Credentials Participants Hold or Are Working Toward

Response	Frequency	Percentage
LMFT	161	20.8%
LMFTA	174	22.5%
LCSW	197	25.4%
NCC	176	22.7%
LMHC	139	17.9%
LMHCA	104	13.4%
Therapist Under Supervision	53	6.8%
Licensed Clinical Psychologist	312	40.3%
Other /Not Listed	26	3.4%

Note: Participants could select multiple licenses therefore n is greater than 775.

Table 11. Specialized Training working with CNM Clients

Response	Frequency	Percentage
Attended at least one conference training on this clinical population.	350	45.1%
Completed an online training on this clinical population.	365	47%
Received supervision from a clinician who specializes in working with CNM or polyamorous clients.	343	44.2%
Sought out additional information through reliable sources (e.g., reading research articles about this population)	176	22.7%
Other	4	Less than 1%

Note: Participants could select multiple trainings therefore n is greater than 775.

Quantitative Analyses

Control Variable

Previously researchers have indicated age is a relevant variable in being open to participating in CNM and having positive attitudes toward CNM clients (Sizemore & Olmstead, 2017; Clyde et al., 2019). In hypothesis one and two the age of participants was controlled for due to this demographic characteristic being a potential confounding variable. In the sample participants were aged 21 to 53 years with a mean age of 30.25 years (SD = 4.96). 736 participants provided their age. Missing data was filled in with the mean age of 30.25 years.

Hypothesis One

Hypothesis one tested if knowledge of CNM predicted attitudes toward CNM. A simple linear regression was carried out to test if CNM knowledge significantly predicted attitudes toward CNM while controlling for the age of the participant. The results of the regression indicated that the model explained 4% ($R^2 = .04$) of the variance. The model was significant, $F(2,772) = 15.95$, $p < .001$. It was found that knowledge significantly predicted attitudes ($\beta 1 = .30$, $p < .001$). The final predictive model was proportion of attitudes = 30.58 + (.30*knowledge).

Hypothesis Two

Hypothesis two was tested using Model 1 in PROCESS (Hayes, 2012), which is an SPSS macro for examining path analysis-based models. For this analysis, the independent variable was knowledge of CNM, the moderator was monogamism, and the dependent variable was attitudes towards CNM. A covariate controlled for in the path analysis was the age of participants. The researcher initially considered analyzing this path analysis using 5,000 bootstrap resamples, however since a high number of participants completed the survey, it was decided to not analyze the data with bootstrap resamples. The moderation effect of monogamism on the association between knowledge of CNM and attitudes toward CNM emerged as significant. $R^2 = .14$, $F(4, 770) = 31.30$, $p < .001$.

Hypothesis Three

Hypothesis three examined if specialized training in working with CNM clients predicted positive attitudes toward CNM. The original data analysis strategy proposed that a simple linear regression would examine if specialized training significantly predicted attitudes toward CNM. Due to a high number of participants reporting that they have received some type of training in working with CNM clients, an independent t-test was conducted to identify if there is a significant difference between groups. 700 participants reported receiving specialized training compared to 75 participants reporting not receiving specialized training in working with CNM clients. There was no significant effect of specialized training on attitudes toward CNM, $t(773) = .52$ $p = .45$. Participants receiving specialized training had mean score of 30.92 on the CNAS ($SD = 6.63$) while participants who reported having no specialized training had a mean score 30.51 ($SD = 7.05$). The effect size was non-significant with Cohen's d = 0.05.

Hypothesis Four

Hypothesis four tested if specialized training in working with CNM clients predicted knowledge of CNM. The original data analysis strategy proposed that a simple linear regression would examine if specialized training significantly predicted knowledge of CNM. Due to a high number of participants reporting that they have received some type of training in working with CNM clients, an independent t-test was conducted to identify if there is a significant difference between groups. 700 participants reported receiving specialized training compared to 75 participants reporting not receiving specialized training in working with CNM clients. There was a significant effect of specialized training on knowledge of consensual nonmonogamy, $t(773) = -.45$, $p < .001$. Participants receiving specialized training had a mean score of 9.98 on the CNM knowledge questionnaire ($SD = 3.76$) while participants who reported having no specialized training had a mean score 10.20 ($SD = 4.85$). The effect size was non-significant with Cohen's d = -0.05.

Additional Quantitative Analyses

Due to a high number of participants identifying their relational orientation as CNM, t-tests were conducted to determine if there were significant differences between participants who identified as monogamous compared to those who identified as CNM on the CNAS, CNM knowledge questionnaire, and monogamism measure. The CNM combined participants who identified in the following relational orientation categories: consensually nonmonogamous, open relationship, polyamorous, swinging, and more than one. Participants who identified their relational orientation as other/not listed were excluded from these analyses

CNAS

An independent t-test was conducted to identify if there is a significant difference between monogamous and CNM participants on the CNAS. The two groups were the 313 participants who identified as monogamous compared to 456 who identified as CNM. There was a significant effect of relational orientation on attitudes toward CNM, $t(767) = -7.21$, $p < .001$. Monogamous participants had a mean score of 28.85 on the CNAS ($SD = 7.60$) while CNM participants had a mean score 32.29 ($SD = 4.85$). The effect size was medium, Cohen's d = -0.54.

CNM Knowledge Questionnaire

An independent t-test was conducted to identify if there is a significant difference between monogamous and CNM participants on the CNM knowledge questionnaire. The two groups were the 313 participants who identified as monogamous compared to 456 who identified as CNM. There was a significant effect of relational orientation on knowledge of CNM, $t(767) = -8.35$, $p < .001$. Monogamous participants had a mean score of 8.65 on the CNM knowledge questionnaire ($SD = 4.18$) while CNM participants had a mean score 10.92 ($SD = 3.33$). The effect size was medium with Cohen's d = -0.54.

Monogamism

An independent t-test was conducted to identify if there is a significant difference between monogamous and CNM participants on the monogamism measure. The two groups

were the 313 participants who identified as monogamous compared to 456 who identified as CNM. There was not a significant effect of relational orientation on monogamism, $t(767) = 0.12$, $p = 0.91$. Monogamous participants had a mean score of 101.79 on the monogamism measure ($SD = 0.63$) while CNM participants had a mean score 101.69 ($SD = 0.49$). The effect size was non-significant with Cohen's d = 0.17.

Qualitative Analyses

Themes

Five categories were identified within the data. These themes were *incomprehensible, treatment generally, helpful practices, unhelpful practices, and perpetuating stigma.* There is an overlap across themes due to the way in which questions were asked and how participants responded to questions. The last three major themes will be further discussed due to

Incomprehensible

If the participant's response was difficult to understand by both coders the response was coded as incomprehensible. This code was given due to the inability to ask participants about the context of their response due to the nature of survey research.

Treatment Generally

Treatment generally was the category that most frequently emerged in response to the first question which asked, "How do you effectively work with a client system who identifies as consensually nonmonogamous? Please explain how you measure effectiveness of treatment." Although this category emerged across all three open-ended questions, two major themes were identified within this category. The first major theme in this category is *measuring effectiveness.* Minor themes included numerous ways participants measure effectiveness when working with CNM clients. Some participants were more formal in measuring outcomes and identified specific assessments. Other participants identified more

informal ways of receiving feedback from their clients such as resolving their presenting problem or teaching them specific skills.

The other major theme identified within this category was *basic therapy skills.* This major theme was identified when participants identified following general ethical recommendations such as respecting their clients' autonomy or remaining professional. In addition, this major theme was evident when participants discussed basic therapy techniques such as conveying empathy. One example of this major theme is when one participant stated, "Investigate their background, understand and respect their ideas." Additional exemplars and minor themes are included in Table 12.

Helpful Practices

The helpful practices category emerged in response to the question, "What do you think is particularly helpful for clients who identify as consensually nonmonogamous?" Three major themes were identified within this category: *education and knowledge*, *cultural sensitivity in the therapy room*, and *clinical experience.* The major theme of *education and knowledge* was coded when participants responded in doing additional research and self-of the therapist work outside of the therapy room. In addition, minor themes within this major theme included if therapists had awareness of specific facts or concepts related to the CNM communities.

The second major theme *cultural sensitivity* was coded when participants identified how they affirmed CNM clients within the therapy room. Minor themes included how participants specifically interact with CNM client systems. Lastly, *clinical experience* was coded when participants discussed clinical techniques such specific modalities or interventions that participants consider beneficial for CNM clients. Further details of this category such as exemplars and minor themes are included in Table 13.

Unhelpful Practices

The unhelpful categories emerged in response to the question, "What do you think is particularly unhelpful for clients who identify as consensually nonmonogamous?" Two major themes were identified within this category: *pathologizing CNM relationships* and *limited knowledge of CNM relationships*. The major theme of *pathologizing CNM relationship*s was

coded when participants acknowledged that maintaining a negative bias toward CNM clients is harmful. In addition, minor themes of this major theme included if the participant recognized that encouraging the client system to change their relational orientation is harmful for CNM clients.

The major theme of *limited knowledge of CNM relationships* was coded when participants identified that a lack of information about this population prevents therapists from effectively working with CNM clients. In addition, a frequent minor theme was when participants recognized that arguing about values or enforcing their own values on CNM clients is problematic. Further details of this category such as exemplars and minor themes are included in Table 14.

Perpetuating Stigma

This category emerged across various responses. This category was identified when participants purposefully or unconsciously provided responses that were negatively prejudiced toward CNM clients. Two major themes were identified within this category: *actively holding negative bias* and *using couple-centric language.* The major theme of *actively holding negative attitudes* was coded when participants identified stereotypes about individuals in CNM relationships or identified how they favored monogamous relationships. Using *couple-centric language* was used when the participant unconsciously used language that was not inclusive toward multi-partnered relationships. In terms of minor themes of *couple-centric language*, coders noted if the participant unintentionally engaged in this behavior or if coinciding with negative beliefs about this population. Further details of this category such as exemplars and minor themes are included in Table 15.

Table 12. Treatment Generally: Major/Minor Themes for Qualitative Data

Major Themes	Example Responses	Minor Themes
Measuring Effectiveness of Treatment	"I seek informal feedback from clients at beginning and end of sessions. I use process and outcome measures like the ORS/SRS." "Reduce Stress." "Measuring effectiveness would again depend on the issue they are coming to therapy for. Nonmonogamous clients don't only come to therapy for reason related to nonmonogamy." "Teach them some interpersonal skills."	• Process/Outcome measures • Intake procedures • Psychological Outcomes • Helping with presenting problem • Helping clients express emotions/needs • Skills
Basic Therapy Skills	"Investigate their background, understand and respect their ideas." "Understand and agree with them." "I remain hope and curious about what the client system is bringing to therapy or hoping to change. I keep in mind that there is robust research around function of a system as more important than form/structure of a system and work with clients to co-create goals around what healthy functioning looks like to them."	• Professionalism • Respecting Autonomy • Empathy

Table 13. Helpful Practices: Major/Minor Themes for Qualitative Data

Major Themes	Example Responses	Minor Themes
Education and Knowledge	"Starting work with such clients needs to be founded in respect and understanding of how mononormativity may affect them and challenging any such beliefs that may appear within yourself, so you are not placing them upon the client." "People in non-monogamous relationships were less jealous of their partners, more trusting, and more sexually satisfied."	• Mononormativity • Challenging internal beliefs • Self-of-the-therapist work • Doing research outside of session • Demonstrating knowledge about CNM relationships
Cultural sensitivity in therapy room	"Moral support, constant communication." "Start the conversation about non-monogamy and relationship needs by asking open-ended questions applicable to all clients. Ask your client what their relationship agreement looks like. How much time do you want to spend together? What is cheating? Where do you want this relationship to go?" "Get to know their system, and then adjust their relationship from their point of view, as measured by their therapeutic feedback."	• Non-pathologizing stance • Non-judgmental stance • Not making assumptions • Asking open ended questions • Showing respect • Cultural humility • Specific behaviors • Collaborative
Clinical experience	"Well, it depends on what they are coming to therapy for, if they are wanting relational or individual therapy, etc." "Many new clients are referred by old clients who have finished their treatment with me and have no doubts about my professionalism." "Humanistic, feministic approach with lots of cultural humility. I use EFT that I adapt with feminist principles and attachment interventions."	• Theoretical Approach • Modality Dependent • Referrals • Facilitating dialogue about boundaries in CNM relationship

Table 14. Unhelpful Practices: Major/Minor Themes for Qualitative Data

Major Themes	Example Responses	Minor Themes
Pathologizing CNM Relationships	"Urge them to change in a short time." "CNM is generally judged, indicates that the CNM is wrong or not ideal" "Assuming all their issues are related to their relationship structure."	• Misunderstanding client's relational orientation • Negative Stigma • Encouraging monogamy • Shaming clients for relational orientation • Asking client system to change relational orientation
Limited knowledge of CNM relationships	"Assumptions, not doing your own research, not challenging mononormative beliefs you hold from the influence of larger systems." "It's especially unhelpful if you're arguing with them about some values." "Try to get them to change their mind about non-monogamy." "Try to change their perception."	• Lack of challenging mononormativity • Specific Theories • Unnecessary questions • Arguing about values

Table 15. Perpetuating Stigma: Major/Minor Themes for Qualitative Data

Major Themes	Example Responses	Minor Themes
Actively holding negative bias	"I think it would be most helpful for them to be aware of the disadvantages of non-monogamy and some of the consequences of non-monogamy." "Because there are so many problems with non-monogamy." "From the perspective of human nature, monogamy stabilizes the sexual harmony between husband and wife in the family. "It's easy to get STDS." "Multiple Sexual Partners are not healthy.	• Favoring monogamous relationships • STD's/STI's • Wanting clients to change relationship structure • Limited education/experience
Couple-Centric Language	"Both parties agree to a polyamorous relationship." "Tell them non-monogamous couples are more likely to get STDS." "I have had limited experience with CNM clients but have found communication to be especially important with CNM couples."	• Unintentional • Coincides with activity holding negative bias

CHAPTER 5: DISCUSSION

There is a lack of research exploring therapists' attitudes toward multi-partnered relationships. Results of dated studies suggested therapists held negative biases toward clients in CNM relationships (Hymer & Rubin, 1982; Knapp, 1975). In several recent studies, researchers suggest therapists continue to perpetuate bias toward CNM clients in therapeutic settings (Grunt-Mejer & Łyś, 2019; Schechinger et al., 2018). In the more recent research, researchers suggest greater knowledge contributes to positive attitudes toward CNM relationships in samples of both therapists and laypersons (Baluck, 2020; Hutzler et al., 2015). The purpose of this study was for the researcher to replicate and extend findings that knowledge of CNM predicts positive attitudes toward CNM relationships in a sample of relational therapists.

Additional analyses were done to explore how monogamism, the specific bias favoring monogamous relationships compared to multi-partnered relationships, influences the relationship between knowledge and attitudes. Previous research suggests having clinical experience with clients who identify as CNM does not necessarily predict greater knowledge or positive attitudes toward this population (Baluck, 2020). The present study further explored if specialized training working with CNM clients predicts attitudes and knowledge of this population. Open-ended questions were asked to provide greater context to how relational therapists work with CNM clients.

Hypothesis One

Hypothesis one was supported by the results of its respective simple linear regression. Knowledge of CNM predicted positive attitudes toward CNM. Previous researchers suggested that therapists' knowledge of CNM was positively associated with general multicultural competency and favorable attitudes toward CNM (Baluck, 2020). Importantly, findings in the present study replicated that the same relationship appears to exist in a sample of therapists and therapists in training who have clinical experience working with relational cases.

In addition, Hutzler et al. (2015) found that when laypersons are introduced to accurate information about polyamory, they were more likely to hold favorable attitudes toward this group. Similarly, the results of hypothesis one in the present study further suggest

knowledge of CNM combats prejudice in relational therapists. Greater knowledge and favorable attitudes would likely contribute to more affirming therapy treatment as evidenced by the results of previous research exploring CNM clients therapy experiences (Schechinger et al. 2018). Interestingly, only 4% of the variance was explained by this regression. This further demonstrates that it is critical to examine which specific factors may strengthen the relationship between knowledge of CNM and attitudes toward CNM.

Hypothesis Two

Hypothesis two was supported by the results of its respective path analysis. The relationship between knowledge of CNM and attitudes toward CNM was significantly moderated by monogamism sensitivity. The results of hypothesis two further support previous literature that have purposed that monogamism is a critical underlying bias in the field of relational therapy (Ansara, 2020; Blumer et al., 2014; Twist et al., 2018). Monogamism sensitivity addresses multiple ways in which CNM bias influences therapeutic treatment. This measure attends to how monogamism involves a lack of awareness of relevant concepts and clinical skills in therapists. This path model also explained a greater percentage of variance compared to the linear regression in hypothesis one (i.e., 14%).

Baluck (2020) found that multicultural competency did not significantly moderate the relationship between knowledge of CNM and attitudes toward CNM in a sample of therapists. Monogamism sensitivity is a specific measure of clinical sensitivity that identifies how CNM bias manifests in therapists internally and through interactions in clinical settings. It appears multicultural sensitivity may be too broad to conceptualize the specific ways CNM-bias impacts clinical outcomes in therapy. The result of the present study further supports that monogamism sensitivity s a relevant variable in helping therapists gain knowledge about CNM. The results of the qualitative data also identified that some participants believed it is especially important for therapist to be aware of mononormativitiy and harmful if therapists do not engage in self- reflection to address how mononormativity impacts their clinical work (see example responses in Tables 13 and 14).

Hypothesis Three and Hypothesis Four

Hypothesis three was not supported by the results of the independent sample t-test. It was hypothesized that participants who received specialized training would have significantly greater positive attitudes toward CNM compared to those who did not complete specialized training. Participants who reported receiving specialized training had a mean score of 30.92 on the CNAS while participants who reported having no specialized training had a mean score 30.51. There was no significant difference between means.

Similarly, hypothesis four was not supported by the results of an independent sample t-test. It was hypothesized that participants who received specialized training would have greater knowledge of CNM compared to those who did not complete specialized training. Surprisingly, a significant difference between means was found with individuals receiving specialized training having a mean score of 9.98 on the CNM knowledge questionnaire compared to those who reported having no specialized training having a mean score 10.20. The t-test revealed that individuals who received specialized training had a lower mean score on the knowledge questionnaire. Although there was a significant difference between groups the effect size was insignificant which indicates that the specialized training group was overpowered which likely resulted in the statistically significant t-test.

It was expected that individuals with specialized training would have greater comprehension of working with individuals who identify as CNM therefore having higher scores on both the knowledge questionnaire and CNAS. Four examples of specialized training were included: attending at least one conference training, completing an online training, receiving supervision, and seeking out information from reliable sources. The most frequently selected item was completing at least one online training. Previous research suggests even brief information on CNM can lead to favorable attitudes toward consensual nonmonogamy (Hutzler et al., 2015). In a sample of therapists, working with a greater number of CNM clients did not predict greater knowledge working with CNM clients (Baluck, 2020). The present study expected specialized training may be critical variable in improving both knowledge and attitudes toward CNM in a sample of therapists.

Despite the effect being in an unexpected direction, the difference in means was less than a point and lacked a significant effect size. These results still have noteworthy implications. The mean scored in both groups reveal that participants lacked knowledge in CNM

with this questionnaire having a possible total score of 24. The low scores among both groups indicate that participants had limited knowledge of CNM. Given the previous evidence that both laypersons and therapists perpetuate stigma toward CNM relationships it was expected that participants may have low scores on this measure (Conley et al., 2013a; Grunt-Mejer & Łyś, 2019; Schechinger et al., 2018).

The lack of support for both hypothesis three and four could be a result of the sample characteristics. The two groups did not receive an equal number of participants. 700 participants identified themselves as receiving specialized training compared to 75 participants identifying themselves as not receiving specialized training. This was unexpected given the pervasive stigma toward CNM relationships in the U.S. (Conley et al., 2013a). Selection and response bias could be reasons for the skewed sample. The sample characteristics are further discussed in the limitations section as a potential explanation for insignificant results.

Additionally, previous research suggested that having a greater number of CNM clients did not predict knowledge or attitudes toward CNM (Baluck, 2020). This was unexpected given that another study found that individuals who have a personal relationship with someone who identifies as polyamorous were more likely to have positive attitudes toward polyamory (Hutzler et al., 2015). Baluck (2020) identified that measuring experience working with CNM clients quantitatively may have contributed to not detecting a significant relationship between number of CNM clients and knowledge of CNM. In the present study specialized training was also measured quantitatively with only two options to respond (i.e., 0 = no; 1 = yes). It is possible that both exposure to CNM clients in a clinical setting and receiving specialized training influence knowledge and attitudes toward CNM, however, these constructs may be better detected through qualitative methods.

Discussion of Additional Quantitative Analyses

The additional t-tests revealed that a therapist's relational orientation may have a significant effect on both attitudes toward CNM and knowledge of CNM. Participants who identified as CNM had significantly higher means on the CNAS and CNM knowledge questionnaire compared to participants who identified as monogamous. These t-tests indicate that individuals who engage in CNM relationships may be doing additional work to disrupt biases toward CNM relationships. These results make sense given CNM-identified clinicians have lived

experience and may experience minority stress related to their relational orientation themselves. However, one previous researcher found that polyamorous individuals tend to a have a negative perception of individuals in open and swinging relationships (Klesse, 2006). It is important to consider that CNM is not a homogeneous community and includes individuals in multiple communities.

One previous study found that overall affirming therapist behaviors were found in a sample of CNM-identified clients who tended to screen for CNM-affirming therapists, which indicates clinical and lived experience may increase the likelihood to engage in affirming behaviors (Schechinger et al., 2018). Surprisingly, there was no significant difference between scores on the monogamism measure based on relational orientation of the clinician. The monogamism measure includes items asking about a clinician's comfort engaging with specific CNM sub-populations and understanding of a variety of CNM communities, including polygamous families. Additionally, the monogamism measure may be a more thorough measure how clinicians disrupt both monogamous privilege and CNM oppression. However, monogamism is engrained in individuals of the U.S., regardless of relational orientation (Ansara 2020; van Tol, 2017). Overall, more research is needed to make stronger conclusions regarding if relational orientation has a significant effect on attitudes, knowledge, monogamism, and therapist behaviors.

Qualitative Results

Through the quantitative aspect of this study, the researcher was interested in determining the relationship between attitudes toward CNM, knowledge of CNM, monogamism sensitivity, and specialized training. Via the qualitative aspect of this study, the researcher explored how these constructs and other behaviors are exhibited when relational therapists work with CNM clients.

General Treatment

The category of general treatment emerged across responses but was especially prominent in response to the first open ended question. This question asked how participants approach treatment working with CNM clients and measure efficacy of treatment.

The major theme of *measuring effectiveness* reflected that therapist have a variety of methods across treatment populations. Of particular interest, some participants identified changing their assessment materials to be inclusive toward CNM clients. Additionally, many therapists seemed to use the same assessment methods (e.g., client systems' verbal feedback) regardless of the client systems' identity. Previous authors have suggested adjusting measuring of romantic relational satisfaction to be inclusive toward individuals in CNM relationships (van Tol, 2017).

The other major theme identified within this category was *basic therapy skills.* This major theme was identified when participants identified following general ethical recommendations or using common factor skills in therapy with CNM clients. It should be noted very few participants identified their theoretical orientation as being a part of their treatment approach in working with CNM clients. This may reflect that most treatment approaches do not consider multi-partnered relationships. Due to psychotherapy theories being exclusionary toward CNM relationships, therapists may be practice-informed rather than evidenced-informed when working with CNM clients which has been discussed by clinicians who primarily work with CNM clients (Kolmes & Witherspoon, 2017).

Helpful and Unhelpful Practices

The major themes of *education and knowledge, cultural sensitivity in the therapy room,* and *clinical experience* emerged in response to therapists identifying helpful practices when working with CNM clients. These themes are similar to those identified by CNM clients in previous studies (Kisler and Lock, 2019; Schechinger et al., 2018). Schechinger et al. (2018) found that CNM clients identified their therapist as helpful when they were non-judgmental toward their CNM identity and were knowledgeable regarding CNM relationships. In the present study one of the most frequent minor themes within *cultural sensitivity in the therapy room* was therapists exemplifying their support and being non-judgmental toward the CNM client system.

Additionally, the major theme of *education and knowledge* was coded when participants responded that they would engage in additional research outside of therapy and participate in self-of-the-therapist work outside of the therapy room. Although qualitatively some therapists were aware of accurate information about the CNM communities, other responses acknowledged

that therapists in the sample are unaware of information regarding this population. The quantitative results further highlight that some participants had limited information regarding the CNM communities. It was expected that there would be a mix of therapists ranging in those with expertise working with CNM clients, those lacking information about this population but being willing to learn, and those who actively hold negative biases toward this population. Previous research indicates that monogamy is maintained as the societal norm in the U.S. due to Christianity being the dominant religion and marriage only being legal between two partners (Day et al., 2011; DePaulo & Morris, 2005).

Similarly, *pathologizing CNM relationships* and *limited knowledge of CNM relationships* were the major themes that emerged when asking participants what would be unhelpful for CNM clients in therapy. The major theme of *pathologizing CNM relationship*s was coded when participants acknowledged that favoring monogamous relationships is detrimental for CNM clients. It appears therapists are aware of the factors that impact CNM clients' treatment outcomes in therapy. In one sample of CNM clients, they identified how harmful it is when their therapist assumes monogamy and expresses judgement toward their relational orientation. Additionally, if participants reported inappropriate therapy behaviors, they were more likely to prematurely terminate treatment (Schechinger et al., 2018).

In one study CNM clients collectively reported more frequent affirming therapy experiences but only one-third of participants identified their therapist as knowledgeable of CNM practices (Schechinger et al., 2018). The results of the present study indicate some relational therapists have awareness of monogamism and appear to be engaging with CNM client systems in affirming ways. The results of the present study suggest, however, that only a minor portion of relational therapists are knowledgeable about the CNM communities and are engaging in affirming therapeutic treatment practices.

Perpetuating Stigma

The major theme of *actively holding negative bias* was identified throughout various responses to the open-ended questions. Previous research found that anti-CNM bias was present in a notable number of therapists in westernized countries (Grunt-Mejer and Łyś, 2019; Hymer & Rubin, 1982; Knapp, 1975). Hymer and Rubin (1982) found that therapists often described individuals in open relationships as fearing commitment. Similarly, Knapp (1975) found

that 38% of relational therapists sampled were professionally non-supportive toward swinging and 16% identified themselves professionally non-supportive toward open relationships. In the present study, participants tended to have low scores on the CNM knowledge questionnaire which was further exemplified when participants perpetuated stigma in their open-ended responses.

In the present study, one of the most frequent stereotypes exemplified in the data was participants believing CNM relationships are at risk of spreading STIs. Some participants identified how they would verbalize this belief to a CNM client system. The belief individuals in CNM relationships are more likely to contract STIs is based on stereotypes about CNM relationships which have been identified in samples of laypersons in recent years (Moors, 2017). Conley et al. (2012) found that individuals in CNM relationships practice safer sex than those is pseudo monogamous relationships. Additionally, Levine et al. (2108) found that participants in open relationships reported more frequent condom use compared to monogamous participants. Despite research identifying the inaccuracy of this stereotype, therapists in the present study continued to hold this inaccurate stereotype about individuals engaging in CNM.

Additionally, *couple-centric langua*ge was identified throughout both affirming and non-affirming responses to the open-ended questions. The field of relational therapy is based on mononormative assumptions (Ansara, 2020; van Tol, 2017). The couple-centric language present in a variety of responses is a result of the field of relational therapy being designed for monogamous relationships. Participants were required to have clinical experience working with relationships and were trained in programs that privilege monogamous relationships. Due to mononormative assumptions guiding the field of relational therapy it is expected that some participants may unconsciously use couple-centric language. Furthermore, the qualitative results indicate the field of relational therapy would benefit from using language that is inclusive of diverse relationship structures.

Theoretical Support

The meaningful results of hypothesis one and hypothesis two suggest participants who have greater knowledge of CNM relationships and awareness of monogamism are likely to hold favorable attitudes toward CNM. Additionally, descriptive analyses showed that both

participants who received specialized training and who did not receive specialized had low collective means on the knowledge of CNM questionnaire. In fact, those who stated they received specialized training had significantly lower scores. This may indicate that endorsing specialized training is not a strong enough experience to combat stigma toward CNM.

Furthermore, a variety of participants reported negative perceptions of individuals in CNM relationships. The open-ended responses revealed that some participants believe stereotypes related to CNM status and used stigmatizing language (e.g., "Tell them non-monogamous couples are more likely to get STDS.") Dated studies suggested a high proportion of therapists would professionally disapprove of clients in various forms of CNM structures based on therapists' responses to open-ended questions (Hymer & Rubin, 1982; Knapp, 1975). Newer research indicates that laypeople in the U.S. commonly believe in negative stereotypes about individuals in CNM relationships, one especially salient stereotype is that individuals in CNM relationships are more likely to have STIs (Conley et al., 2012; 2013a). The results of the present study further suggest that a portion of therapists and therapists in-training continue to believe negative stereotypes about CNM-identified individuals. Some participants in the present study indicated they may even express these stereotypes toward CNM-identified clients (e.g., "I think it would be most helpful for them to be aware of the disadvantages of non-monogamy and some of the consequences of non-monogamy.")

Discrimination, harassment, and violence related to CNM status (i.e., CNM-related minority stress) is associated with increased psychological distress, such as symptoms of depression and anxiety (Witherspoon, 2018). Minority stress framework posits that stigma, prejudice, and discrimination, cultivate a hostile environment that contributes to mental health issues in sexual minorities. Minority stress is one factor that contributes to individuals with marginalized sexual identities seeking out therapy at a significantly greater rate than heterosexual individuals (Cochran et al., 2003). Due to a lack of research on the number of CNM clients who attend therapy, it is difficult to know the specific number of individuals identifying in minority relational orientation categories seek out therapy treatment. Initial research, however, suggests when therapists perpetuate this stigma n CNM individuals they are more likely to prematurely terminate therapy (Schechinger et al., 2018).

Both the quantitative and qualitative results reveal some relational therapists are perpetuating stigma toward CNM clients. The findings in the current study

further exemplify how therapists may contribute to minority stress experienced by CNM identified clients. Future research should explore how negative therapy experiences impact mental health symptoms in CNM identified clients. As discussed throughout this project, the stigma toward CNM clients in the field of relational therapy may be the result of couple-centric bias evident throughout society in the U.S. (Ansara, 2020). Dominant discourse throughout macro and micro systems in the U.S. have created negative perceptions of CNM and privilege dyadic couple relationships. These results indicate how powerful language is in creating meaning, which aligns with the paradigms of social constructionism (Galbin, 2014; Gergen, 1985). Importantly, the results of the present study also identify that some relational therapists are combatting stigma and creating safety for CNM clients in therapy. Based on the qualitative themes identified throughout the open-ended responses these individuals have awareness of mononormativity and how it impacts both themselves and their clients.

Clinical Implications

One major implication of this study is the support it gives to the idea that monogamism is a critical factor in increasing both knowledge of CNM relationships and favorable attitudes toward this population. Monogamism sensitivity is a more nuanced measure of cultural sensitivity that impacts a clinician's ability to work with CNM clients compared to general cultural competency (Baluck, 2020). Monogamism addresses how negative bias toward CNM relationships and positive bias toward monogamous relationships influences clinical judgement. Laypeople in the U.S. continue to favor monogamous relationships and maintain hypercritical views on CNM relationships (Conley et al., 2013a). The measure for monogamism sensitivity was designed specifically for therapists and has been demonstrated to be psychometrically valid in a sample of therapists (Twist et al., 2018). Couple and family therapy training programs may benefit from encouraging students to consider how monogamism influences their approach to therapy. It may be helpful for clinicians to complete this measure throughout their training program to increase recognition of how monogamism continues to be influential in their personal and professional lives.

Despite the third and fourth hypotheses not being significant, the results still have relevancy for the field of relational therapy. Most participants reported engaging in some specialized training, however the scores on the knowledge questionnaire were low. The

low scores on the CNM knowledge questionnaire could be due to the one-item measure of specialized training may not have the psychometric strength to detect what type of training leads to greater knowledge and favorable attitudes toward CNM. Based on the significant moderation model and the frequency of mononormativity identified in the open-ended response, however, it appears that therapists engaging in self-reflection is a critical factor in therapists providing affirming therapeutic treatment. In previous literature, researchers have suggested that clinicians engage in self-reflection as necessary to provide effective treatment toward CNM clients (Girad & Brownlee, 2015; Kauppi, 2021). Overall, it seems an important step in being able to work effectively with CNM clients in therapeutic settings, is to actively reflect on your own assumptions about this population.

Finally, the responses to the open-ended questions revealed how prominent couple-centric bias is in a sample of relational therapists. Relational therapy training programs overwhelmingly tend to teach interventions and assessment tools that primarily use language privileging couples (Ansara, 2020). The results of the present study suggest that training programs should consider creating more inclusive assessment tools to help relational therapists become increasingly competent in working with CNM relationships.

Limitations

When interpreting the results from this study, they must be considered along with the following limitations. The sample characteristics should be noted as a significant limitation of this study. There were a high number of therapists in training who answered questions, which means the results of the study may be more representative of therapists in training rather than experienced clinicians. Also, approximately half of the participants identified themselves as participating in a CNM relationship recently. This number of participants engaging in a CNM relationship is high compared to recent approximations that indicate 20% of the U.S. population will engage in a CNM relationship at some point in their lifetime (Haupert et al., 2017). Additionally, the groups included in hypotheses three and four were not equal, with 90% of the sample identifying themselves as receiving specialized training in working with CNM clients. All three of these factors limit the generalizability of the results of this study.

Furthermore, individuals in the study may have internalized stigma toward CNM relationships exemplified by participants overall limited knowledge of CNM. Previous authors

have argued that negative perceptions of CNM are one reason people do not identify with relational orientations outside of monogamy (Conley et al., 2013a). Additionally, one study found that polyamorous individuals had negative perceptions of swingers (Klesse, 2006). Another study found that individuals in the U.S. tend to have negative perceptions of individuals in swinging and open relational arrangements (Matsick et al., 2014). Although the characteristics of the present study suggest that internalized stigma may be contributing to low scores on the CNM knowledge questionnaire, the additional analyses revealed CNM participants had significantly higher scores on the CNAS and CNM knowledge questionnaire. These significant t-tests indicate that CNM clinicians may be doing more internal work to be affirming toward this clinical population compared to monogamous clinicians. Several clinicians who concentrate on working with CNM-identified clients have encouraged self-reflection as key aspect of disrupting biases toward marginalized clinical populations (Blumer et al., 2014; Kauppi, 2021; Kolmes & Witherspoon, 2017).

Additionally, participation in the survey was at risk of self-selection bias. Participants chose to participate in the survey and were informed in the consent documentation of the types of questions asked in the survey. Individuals may have been more likely to participate if they have awareness of CNM, passion to work with this population in therapy, or identify as CNM themselves. Furthermore, participants were encouraged to distribute the survey link to other clinicians who met criteria for participation. The survey could have been distributed to non-therapists, as well. The survey could also have been completed by robots due to the lack of two-factor authentication. Attention checks and data cleaning attempted to ensure the data included in analyses was reliable. It should also be noted that most of the sample (i.e., 90.3%) identified receiving specialized training in working with CNM clients. This further suggests the survey was impacted by self-selection bias. Response bias is also a limitation of the present study. Participants may have felt obligated to identify themselves as receiving specialized training due to their own moral convictions. Baluck (2020) also acknowledged that measuring therapists' experience with CNM clients quantitatively may have limited her results as well.

Moreover, the qualitative questions were asked in a survey format. The researcher could not ask follow-up questions or ask for clarity on the participant’s responses. This limits the accuracy of the thematic analysis. Furthermore, there was a low response rate to the qualitative

questions compared to items measuring the quantitative component of the study with only one-third of participants going on to complete the open-ended survey questions. Previously, researchers have qualitatively explored CNM clients' therapy experiences through interviews (Henrich and Trawinski, 2016).

Lastly, another limitation is the methodology itself. The multiple methods allowed for both quantitative and qualitative data to be collected and presented in the results. Due to the researcher having background knowledge on CNM this could influence the types of themes created when completing the thematic analysis. Furthermore, the methodology of the study did not specifically connect how the quantitative variables and qualitative themes relate to each other. Future studies may explore if attitudes toward CNM, knowledge of CNM, and monogamism sensitivity predict specific therapist behaviors by mixing the different types of data.

Future Directions

The goal of the researcher in this study was to replicate and extend the results of previous studies that found knowledge of CNM predicts attitudes toward CNM (Baluck, 2020; Hutzler et al., 2015). In the present study, the researcher wanted to primarily identify this same relationship between knowledge and attitudes in a sample of relational therapists. The researcher in the present study also examined how monogamism influences the relationship between knowledge and attitudes. Additionally, the researcher explored how specialized training and therapist reported behaviors may influence knowledge of CNM and attitudes toward CNM. The variables chosen in this study were based on the sparse research that explored therapists' attitudes toward CNM (Baluck, 2020; Grunt-Mejer and Łyś, 2019).

Due to the exploratory nature of the present study, it may be best for future studies to focus on certain aspects of the present study's findings to inform their research design. Future researchers can contribute to the literature by utilizing clinical vignettes to explore attitudes toward CNM in therapists. Vignettes have been frequently used in both laypersons and therapists (Baluck, 2020; Conley et al., 2013a; Grunt-Mejer & Łyś, 2019). The present study relied on participants interpreting the open-ended questions correctly, which may have influenced the themes exemplified in the data. Clinical vignettes followed by open-ended questions may provide greater clarity and be less open to response bias. Clinical vignettes also

may provide better examples of therapist's potential practices or behaviors when engaging with clients who identify as CNM.

The researcher utilized both quantitative and qualitative methods in the current study. Mixed methods approaches could connect qualitative themes to quantitative results. This may reveal the specific mechanisms in which attitudes, monogamism, and knowledge are connected to helpful or harmful therapist behaviors. Additionally, future researchers could engage in observational research, where therapists and therapist interns are observed working with case scenarios involving CNM clients. This would allow researchers to better understand the process of therapists engaging in specific behaviors in a therapeutic setting. Previously researchers have mostly relied on surveys and participant reported behaviors to inform their conclusions about variables (Baluck, 2020; Grunt-Mejer and Łyś, 2019). Future research may also explore how mental health symptoms in CNM-identified clients are impacted by the quality of therapeutic treatment including the client's perception of their therapist's competency working with CNM clients.

Additionally, an experimental design could provide greater control of variables and participants would be able to provide stronger conclusions. For instance, one previous study provided laypeople with information about polyamory before measuring attitudes (Hutzler et al., 2015). These researchers discovered that those provided brief information were more likely to have favorable attitudes. A similar study in a sample therapist may be informative.

Lastly, research may benefit from doing interviews with both CNM-identified clients and relational therapists. One study interviewed polyamorous identified individuals who had engaged in psychotherapy revealed several critical themes (Henrich &Trawinski, 2016). One benefit of interviews is it allows the voices of the participants to be clearer. Additionally, interviews with relational therapists can provide information about their training experiences and allow them to give more detailed responses to questions.

Conclusion

Previous research has found relationships that knowledge of CNM significantly predicts attitudes toward CNM in a sample of therapists. In the present study, the researcher found this same relationship in a sample of therapists who have clinical experience working with relationships. The researcher also found that monogamism sensitivity has a meaningful role in

improving therapeutic treatment of CNM clients. No significant differences were found between participants who received specialized training compared to those who did not receive specialized training in working with CNM clients. Such low means on the knowledge questionnaire across both groups indicates that relational therapists need to improve their understanding of this population. Although some open-ended responses were encouraging, an abundance of responses reflected therapists continuing to hold negative biases toward CNM relationships. All these results indicate that therapist training programs across fields need to consider the experiences of individuals in multi-partnered relationships. Ultimately larger systemic changes would help improve the treatment of CNM identified clients. It is also critical that therapists self-reflect on their own experiences with CNM and the assumptions they hold regarding diverse relational orientations. Therapists should also continue to educate themselves. Formal training might dispel potential misconceptions and fill gaps in knowledge regarding CNM. Completing this self-of-the-therapist work and improving competency will serve therapists and CNM clients positively.

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APPENDIX A. SURVEY ADVERTISEMENT

Hello, my name is Alexia Kingzette, a graduate student working toward my M.S. in Couple and Family Therapy at Purdue University Northwest. I am reaching out to other therapists and therapist interns to gather participants for my thesis study. Masters and doctoral students who are currently seeing clients are eligible to participate as well. One requirement for the study is that you have clinical experience working with relational cases (e.g., couples). If you are interested, please see the study's description below. Thank you for your time.

An Exploration of Relational Therapists' Attitudes, Knowledge, and Practices with Consensually Nonmonogamous Clients (IRB #2021-116)

This is a survey about relational therapists' knowledge and attitudes toward consensually nonmonogamy. If you are currently practicing as a therapist and are interested in participating in this study, follow the survey link below. It will take about 15 to 20 minutes to complete the survey. After you complete the survey, you will have the option to enter in a drawing to receive one of twenty $20 Amazon gift cards. You must complete the survey to be eligible for compensation. Your responses will not be connected to your drawing entry. Thank you for considering participating in this study. If you are willing, please share this survey with other currently practicing relational therapists you know. If you have any questions, please reach out to the Principal Investigator of this project, Dr. Kevin C. Hynes, Assistant Professor of Couple and Family Therapy at Purdue University Northwest via email at hynesk@pnw.edu or by phone at 219-989-2587.

https://purdue.ca1.qualtrics.com/jfe/form/SV_b2xxTifNszpxRiK

Thank you!

APPENDIX B. SURVEY

Start of Block: Consent Documentation

Key Information

Please take time to review this information carefully. This is a research study (IRB #2021-116). Your participation in this study is voluntary which means that you may choose not to participate at any time without penalty or loss of benefits to which you are otherwise entitled. You may ask questions to the researchers about the study whenever you would like. If you decide to take part in the study, you will be asked to sign this form, be sure you understand what you will do and any possible risks or benefits.

What is the purpose of this study?

You are being asked to participate in a study designed by Dr. Kevin Hynes and Alexia Kingzette of Purdue University. We want to better understand the experiences therapists and their attitudes toward consensual nonmonogamy. We would like to enroll 200 people in this study.

What will I do if I choose to be this study?

If you choose to participate, you acknowledge that you are 18 years of age or older and a therapist or therapist in training, who currently provides services to at least one client. Participants must have experience treating relational cases and estimate that approximately a third of their cases are relational (i.e., couples, families, co-parents, polyamorous folks, etc.) You will be asked to complete an online survey about your attitudes toward different relationship orientations (e.g., polyamory), a cultural sensitivity questionnaire, and knowledge questionnaire. Additionally, the survey asks about your therapy practices, and demographic questions, such as age, gender, and employment status. Your participation will be in no way linked to your employment. You are free to not respond to any questions that make you uncomfortable. You are free to withdraw your participation at any time.

How long will I be in the study?

Participation in the survey is expected to last between 15– 20 minutes.

What are the possible risks or discomforts?

Breach of confidentiality is always a risk with data, but we will take precautions to minimize this risk as described in the confidentiality section. To minimize this risk, only researchers listed above will access the data from this study, and no personally identifying information will be collected during the study. The

researchers imbedded validity checks in the survey, if you do not answer these validity checks correctly your survey may be rejected and you will be unable to be eligible for the reward.

If any questions within this survey cause you emotional distress, you can visit http://www.psychologytoday.com to find someone to speak to about any distress that may come to participating in this survey. For additional resources related to providing care to a client who identifies as consensually nonmonogamous please see https://www.kapprofessionals.org/

Are there any potential benefits?

You will not directly benefit from this study. You will have a chance to take part in research, and your participation may, thus, contribute to the scientific understanding of the experiences of therapists.

Will I receive payment or other incentive?

You can enter for a drawing for an Amazon gift card worth $20. We estimate the odds of winning will be 1 in 10.

Are there costs to me for participation?

There are no anticipated costs to participate in this research.

Will information about me and my participation be kept confidential?

The project's research records may be reviewed by departments at Purdue University responsible for regulatory and research oversight. The researchers will not have access to your IP address, and, therefore, cannot connect your answers to any identifying information. Data will be kept in a data file that is password protected, and only the Principal Investigator and the second researcher indicated at the top of this form will have access to any data.

What are my rights if I take part in this study?

You do not have to participate in this research project. If you agree to participate, you may withdraw your participation at any time without penalty.

Who can I contact if I have questions about the study?

If you have questions, comments, or concerns about this research project, you can talk to one of the researchers. Please contact Dr. Hynes via email at hynesk@pnw.edu or by phone at 219-989-2587.

To report anonymously via Purdue's Hotline see www.purdue.edu/hotline

If you have questions about your rights while taking part in the study or have concerns about the treatment of research participants, please call the Human Research Protection Program at (765) 494-5942, email (irb@purdue.edu) or write to:
Human Research Protection Program - Purdue University
Ernest C. Young Hall, Room 1032155 S. Grant St.
West Lafayette, IN 47907-2114

Documentation of Informed Consent

I have had the opportunity to read this consent form and have the research study explained. I have had the opportunity to ask questions about the research study, and my questions have been answered. I am prepared to participate in the research study described above.

O Yes. (1)

O No. (2)

Skip To: End of Survey If Key Information Please take time to review this information carefully. This is a research study (... = No.

End of Block: Consent Documentation

Start of Block: Demographic Questions

Q3 How old are you?

_____

Q5 How do you describe your gender identity?

- O Cisgender woman (1)
- O Cisgender man (2)
- O Genderqueer, gender fluid, or non-binary (3)
- O Transgender woman (4)
- O Transgender man (5)
- O More than one (6)
- O Other/not listed (7)

Q6 How do you describe your sexual orientation?

- O Heterosexual (1)
- O Lesbian (2)
- O Gay (3)
- O Bisexual (4)
- O Pansexual (5)
- O Asexual (6)
- O Queer (7)
- O More than one (8)
- O Other/not listed (9)

Q7 With which ethnic and racial group(s) do you identify?

- O Black, African American, or Afro-Caribbean (1)
- O Asian (2)
- O Latinx or Hispanic (3)
- O American Indian or Alaskan Native (4)
- O Native Hawaiian or Pacific Islander (5)
- O Middle Eastern or Arab-American (6)
- O White (7)
- O Multiracial (8)
- O More than one (9)
- O Other/not listed (10)

Q54 What is your annual income?

- O Less than $20,000 (1)
- O $20,000 - $34,999 (2)
- O $35,000 - $49,999 (3)
- O $50,000 - $74,999 (4)
- O $75,000 - $99,999 (5)
- O Over $100,000 (6)
- O Prefer not to answer (7)

Q8 What is your current relationship status?

- O Married (1)
- O Widowed (2)
- O Single (3)
- O Separated (4)
- O Dating, living alone (5)
- O Dating, living with partner/s (6)
- O Other/not listed (7)

Q9 Which of the following best defines your current (or most recent) sexual and/or romantic relationship structure?

- O Monogamous (1)
- O Consensually nonmonogamous (2)
- O Open relationship (3)
- O Polyamorous (4)
- O Swinging (5)
- O More than one (6)
- O Other/not listed (7)

Q10 Do identify as spiritual or religious?

- O Yes, spiritual (1)
- O Yes, religious (2)
- O Yes, both (3)
- O No, neither (4)

Skip To: Q12 If Do identify as spiritual or religious? = No, neither

Q11 What is your religion?

- O Christian (1)
- O Buddhist (2)
- O Hindu (3)
- O Muslim (4)
- O Jewish (5)
- O Sikh (6)
- O Prefer not to answer (7)
- O Other/not listed (8)

Q12 What is the highest level of education you have attained?

- O Bachelors' Degree (1)
- O Bachelors' Degree, with work toward Masters' (2)
- O Masters' Degree (3)
- O Masters' Degree, with some additional coursework towards a doctorate degree in C/MFT, counseling, educational psychology, or social work (4)
- O Doctorate (5)
- O Other/not listed (6)

Q13 What degree type do you hold or are working toward? Please select all that apply.

- ☐ Masters in Couple/Marriage and Family Therapy (2)
- ☐ Masters in Clinical Mental Health Counseling (3)
- ☐ Masters in Social Work (4)
- ☐ Doctorate in Psychology (PsyD) (5)
- ☐ Doctorate in Clinical Psychology (Ph.D.) (7)
- ☐ Doctorate in Couple/Marriage and Family Therapy (8)
- ☐ Other (9)

Q14 What credentials do you currently hold or are working toward? Please select all credentials that apply.

- ☐ LMFT (2)
- ☐ LMFTA (3)
- ☐ LCSW (4)
- ☐ NCC (5)
- ☐ Licensed Clinical Psychologist (6)
- ☐ LMHC (7)
- ☐ LMHCA (8)
- ☐ Therapist under Supervision (9)
- ☐ Other/Not listed (10)

Q15 How long have you been working with clients? Please answer in years.

_____

Q16 Which of the following best describes your theoretical orientation or the types of interventions you most often use with clients?

- O Structural (1)
- O Strategic (2)
- O Milan (3)
- O Feminist (4)
- O Solution-Focused/SFBT (5)
- O Collaborative Language Systems (CLS) (6)
- O Narrative (7)
- O Gottman Method (8)
- O Emotionally Focused Therapy (9)
- O Psychoanalytic (10)
- O Humanistic (11)
- O Existential (12)
- O Eclectic/Integrative (13)
- O Interpersonal (14)
- O Person-Centered (15)
- O Motivational Interviewing (16)
- O Multicultural (17)
- O Cognitive Behavioral (18)
- O Psychodynamic (19)
- O Third Wave (ACT, Mindfulness) (20)
- O Other/Not listed (21)

Q17 How many clients have you seen who identified as polyamorous or who were involved in a consensually nonmonogamous relationship (e.g., a relationship in which sexual and/or emotional/romantic involvement with additional partners is permitted in some form)?

_____

Q18 Have you received specialized training in working with clients who identify as consensually nonmonogamous?

O Yes (1)

O No (0)

Skip To: Q19 If Have you received specialized training in working with clients who identify as consensually nonmo... = Yes

Q19 Please select all specialized training opportunities you have participated in related to working with consensually nonmonogamous clients.

☐ Attended at least one conference training on this clinical population. (1)

☐ Completed an online training on this clinical population. (2)

☐ Received supervision from a clinician who specializes in CNM or polyamorous clients. (3)

☐ Sough out additional information through reliable sources (e.g., reading research articles about this population). (4)

☐ Other. Please explain. (5) _____

☐ None, I have received no specialized training related to CNM. (6)

End of Block: Demographic Question

	Strongly Disagree (1)	Disagree (2)	Somewhat Disagree (3)	Neutral (4)	Somewhat Agree (5)	Agree (6)	Strongly Agree (7)
You must be in a monogamous relationship to be in love. (1)	O	O	O	O	O	O	O
I can see myself entering into a non-monogamous relationship. (2)	O	O	O	O	O	O	O
A monogamous relationship is the most satisfying type of relationship. (3)	O	O	O	O	O	O	O
Intimate relationships with more than one person are too complicated. (4)	O	O	O	O	O	O	O
It is possible to have several satisfying intimate relationships at the same time. (5)	O	O	O	O	O	O	O

It is possible to date other people while in a loving relationship with your partner. (6)	O	O	O	O	O	O	O
It is possible to have sexual relationships with other people while in a loving relationship with your partner. (7)	O	O	O	O	O	O	O
It is possible for one partner in a relationship to be monogamous while the other partner is not monogamous. (8)	O	O	O	O	O	O	O
Answer disagree to this item. (9)	O	O	O	O	O	O	O

End of Block: CNAS

Start of Block: CNM KQ

Q21 The following questionnaire includes statements about consensual non-monogamy (CNM). An alternative to monogamy, partners in CNM relationships are permitted to engage in some pre-agreed upon forms of sexual and/or emotional intimacy with other people. It is important to note that CNM is not

cheating, as cheating involves deception and is done without one's partner's consent (and often, without one's partner's awareness).

The following items will test your awareness of various statistics and research findings about CNM. Some questions may ask for you clinical opinion based on your knowledge of this issue at this point in time. It is anticipated that many therapists will be unfamiliar CNM, but we ask you to please make your best guess for these items, even if you are unsure, rather than leaving the items blank.

Q22 Compared to those in monogamous relationships, individuals in CNM relationships are more likely to become infected with sexually transmitted diseases.

- O True (0)
- O False (1)

Q23 Individuals who engage in CNM are more likely to have poorer psychological functioning (e.g., lower self-esteem, and higher rates of anxiety and depression) as compared to those in monogamous relationships.

- O True (0)
- O False (1)

Q24 Research shows that for most people, monogamy is superior to CNM and offers unique benefits, whereas CNM does not.

- O True (0)
- O False (1)

Q25 People in monogamous and CNM relationships engage in roughly the same amount of sexual activity overall.

O True (1)

O False (0)

Q26 The vast majority of bisexual and pansexual individuals who engage in CNM report that they are primarily drawn to CNM because they want to be able to be sexually intimate with members of more than one gender simultaneously and CNM allows them to do so without cheating

O True (0)

O False (1)

Q27 Among individuals infected with sexually transmitted diseases, those who engage in CNM are more likely to pass those diseases on to their partners as compared to those in monogamous relationships.

O True (0)

O False (1)

Q28 The majority of people who have tried CNM relationships say that they would not engage in such a relationship structure again.

O True (0)

O False (1)

Q29 People in CNM relationships report similar levels of overall happiness as compared to individuals in monogamous relationships.

- O True (1)
- O False (0)

Q30 The majority of children raised by openly CNM parents reported that they would have preferred to have been raised in a monogamous household.

- O True (0)
- O False (1)

Q31 Compared to those in monogamous relationships, individuals in CNM relationships are less likely to engage in safer sex practices, such as communicating with their partners about their sexual history, or routinely using condoms or dental dams with their partners.

- O True (0)
- O False (1)

Q32 There are significantly fewer individuals who engage in CNM as compared to those who identify as lesbian, gay, or bisexual.

- O True (0)
- O False (1)

Q33 Compared to those in monogamous relationships, people in CNM relationships have lower levels of relationship satisfaction.

- O True (0)
- O False (1)

Q34 Monogamous relationships tend to last longer than CNM relationships.

- O True (0)
- O False (1)

Q35 Even when the children aren't aware of their parent's CNM relationship status, parents who engage in CNM may lose custody of their children because of their decision to be non-monogamous.

- O True (1)
- O False (0)

Q36 Most of our closest primate relatives are monogamous, which suggests that humans are biologically hardwired to form monogamous relationships.

- O True (0)
- O False (1)

Q37 While it is important for therapists to be affirming, clients who indicate that they are considering trying CNM should be made aware of the risks associated with the CNM lifestyle and encouraged to remain monogamous.

- O True (0)
- O False (1)

Q38 When CNM relationships end, it tends to be because of reasons related to non-monogamy, such as jealousy over other partners.

- O True (0)
- O False (1)

Q39 Lesbians and bisexual women are more likely to engage in CNM as compared to the general population.

- O True (1)
- O False (0)

Q40 Outcomes for children raised by openly CNM parents are generally poorer than those for children raised by monogamous parents.

- O True (0)
- O False (1)

Q41 Most people in CNM relationships who seek therapy do so because of problems related to the practicality of living a CNM lifestyle.

- O True (0)
- O False (1)

Q42 CNM relationships are fairly uncommon and therapists are unlikely to encounter individuals in these kinds of relationships in their clinical work unless they specialize in treating sexual minority clients.

- O True (0)
- O False (1)

Q43 Other than being able to have more than one sexual/romantic partner, the majority of people in CNM relationships say there are no additional benefits to CNM.

- O True (0)
- O False (1)

Q44 Members of the CNM community report higher rates of discrimination than do members of other marginalized groups.

- O True (1)
- O False (0)

Q45 Jealousy is reported to be more problematic in CNM relationships as compared to monogamous ones.

- O True (0)
- O False (1)

End of Block: CNM KQ

Start of Block: Monogamism Measure

Q56. Instructions: This measure is designed to obtain information on the participant’s awareness, knowledge and skills regarding monogamism in practice. All responses are confidential. The measure includes a list of statements and/or questions related to a variety of areas regarding monogamism. Please,

read each statement/question carefully. From the available choices, select the one that best fits your reaction to each statement/question. Thank you in advance for your participation.

Q57. At the present time, please rate your degree of agreement or disagreement with the following statements…

	Strongly Disagree (1)	Disagree	(2)	Agree (3)	Strongly Agree (4)
1. Marriage is conceptualized in virtually the same way across cultures. (1)	O	O		O	O
2. I am comfortable with a law that enables more than two consenting adults to marry each other. (2)	O	O		O	O
3. Aaliyah moved from Kenya with her two husbands, and her marriage to both men should be legally recognized in the U.S. or Canada. (3)	O	O		O	O
4. Romantic relationships involving more than two people are inherently harmful to all of the individuals involved. (4)	O	O		O	O
5. Multi-partner-headed families are more similar to than different from two-person-headed families. (5)	O	O		O	O
6. I am comfortable with multi-parents having the same parenting rights as two parents. (6)	O	O		O	O

7. Legal benefits accorded dyadic relationships should also apply to multi-partnered relationships. (7)	O	O	O	O
8. Calling someone a “polyg” is not emotionally or psychologically harmful. (8)	O	O	O	O
9. Polyamorous relationships are unstable and work better in theory than in practice. (9)	O	O	O	O
10. I am comfortable with a policy that allows Sarah and Mary, who are both spiritual wives of Zachary, to be able to visit him during his hospital stay. (10)	O	O	O	O
11. People who are in polygamous relationships would be happier if they were in monogamous relationships. (11)	O	O	O	O
12. Having a sexual relationship with more than one consenting adult at the same time is considered infidelity or cheating. (12)	O	O	O	O

13. Having more than one legal adult spouse or partner for religious or spiritual reasons should be a right in the U.S. and Canada. (13)	O	O	O	O
14. Answer disagree to this item. (14)	O	O	O	O

Q58

At the present time, please rate your understanding of the following terms...

	Very Limited (1)	Limited (2)	Good (3)	Very Good (4)
Consensual non-monogamy (1)	O	O	O	O
Mononormativity (2)	O	O	O	O
Open relationship (3)	O	O	O	O
Plural Marriage (4)	O	O	O	O
Multi-partnered relationships (5)	O	O	O	O
Polyamory (6)	O	O	O	O
Polygamy (7)	O	O	O	O
Polygyny (8)	O	O	O	O
Relational orientation (9)	O	O	O	O
Swinging (10)	O	O	O	O
Monogamism (11)	O	O	O	O
Monogamous privilege (12)	O	O	O	O

	Very limited (1)	Limited (2)	Good (3)	Very Good (4)
27. Not assume that someone who presents for couples therapy has only one partner. (1)	O	O	O	O
28. Assess the mental health needs of an individual who identifies with a non-monogamous relational orientation. (2)	O	O	O	O
29. Be comfortable interacting with a multi-partnered family. (3)	O	O	O	O
30. Identify the strengths and weaknesses of psychological tests in terms of their use with clients identifying with a minority relational orientation. (4)	O	O	O	O
31. Effectively secure information and resources to better serve people who have a non-monogamous relational orientation. (5)	O	O	O	O
32. Identify instances of monogamism in your clinical practice. (6)	O	O	O	O

33. Design or adapt your forms and other paperwork to include and respect people of all relational orientations. (7)	O	O	O	O
34. Not assume that a person I am working with has either a single parent or two parent/s. (8)	O	O	O	O
35. Effectively secure information and resources to better serve people in multi-partnered families. (9)	O	O	O	O
36. Effectively and respectfully take responsibility for engaging in mononormative practices. (10)	O	O	O	O
37. Treat people in ways that are consistent with their own understanding of romantic and/or sexual relationships. (11)	O	O	O	O
38.Inquire about a person's relational orientation in a manner that is effective and respectful. (12)	O	O	O	O

39. Refrain from making assumptions about the nature of the relationship between people based upon your own perceptions of relationships and families. (13)	O	O	O	O
40. Be comfortable interacting with people who identify as polyamorous. (14)	O	O	O	O

End of Block: Monogamism Measure

Start of Block: Open-Ended Questions

Q49 Do you have experience working with clients who identify as consensually nonmonogamous or polyamorous?

O Yes (1)

O No (2)

Skip To: Q60 If Do you have experience working with clients who identify as consensually nonmonogamous or polyamo... = Yes

Q50 How would you effectively work with a client system who identifies as consensually nonmonogamous? Please explain how you measure effectiveness of treatment.

_____

_____

_____

Q51 What do you think would be particularly helpful when working with clients who identify as consensually nonmonogamous?

_____

_____

_____

Q52 What do you think would be particularly unhelpful when working with clients who identify as consensually nonmonogamous?

_____

_____

_____

Q60 How do you effectively work with a client system who identifies as consensually nonmonogamous? Please explain how you measure effectiveness of treatment.

_____

_____

_____

Q61 What do you think is particularly helpful for clients who identify as consensually nonmonogamous?

_____

_____

Q62 What do you think is particularly unhelpful for clients who identify as consensually nonmonogamous?

_____

_____

_____

End of Block: Open-Ended Questions

Start of Block: Thank you!

Display This Question:

If Key Information Please take time to review this information carefully. This is a research study (... = Yes.

Q64 Thank you for your participation! Please feel free to pass on this survey to other eligible therapists. Please use the following link to enter to win an Amazon gift card.
https://purdue.ca1.qualtrics.com/jfe/form/SV_0NHfQQVI7cUkxi6

End of Block: Thank you!