National Louis University

Digital Commons@NLU

Dissertations

8-2022

Exploring Clinical Implications of Consensual Non-Monogamy: A Proposed Intake Assessment Tool

Rebecca Tuttle

Follow this and additional works at: https://digitalcommons.nl.edu/diss

Part of the Clinical Psychology Commons

Recommended Citation

Tuttle, Rebecca, "Exploring Clinical Implications of Consensual Non-Monogamy: A Proposed Intake Assessment Tool" (2022). *Dissertations*. 682.
https://digitalcommons.nl.edu/diss/682

This Dissertation - Public Access is brought to you for free and open access by Digital Commons@NLU. It has been accepted for inclusion in Dissertations by an authorized administrator of Digital Commons@NLU. For more information, please contact digitalcommons@nl.edu.

Exploring Clinical Implications of Consensual Non-Monogamy:

A Proposed Intake Assessment Tool

Rebecca Tuttle

Florida School of Professional Psychology at National Louis University

Gary Howell, Psy.D.
Chair

Patricia Dixon, Psy.D.
Member

A Clinical Research Project submitted to the Faculty of the Florida School of Professional Psychology at National Louis University in partial fulfillment of the requirements for the degree of Doctor of Psychology in Clinical Psychology.

Tampa, Florida
August, 2022

The Doctorate Program in Clinical Psychology
Florida School of Professional Psychology
at National Louis University

CERTIFICATE OF APPROVAL

Clinical Research Project

This is to certify that the Clinical Research Project of

Rebecca Tuttle, M.A.

has been approved by the
CRP Committee on August 10, 2022
as satisfactory for the CRP requirement
for the Doctorate of Psychology degree
with a major in Clinical Psychology

Examining Committee:

Committee Chair: Gary Howell, Psy.D.

Patricia Dixon, PsyD

Member: Patricia Dixon, Psy.D.

Abstract

Relationships in the United States are often assumed to adhere to heteronormative and mononormative standards, which is problematic because a significant minority of individuals are neither heterosexual nor monogamous (approximately 4.5% and 4% of the United States population, respectively). As a result of mononormative biases in particular, alternatives to monogamy, such as consensually non-monogamous relationships, are often socially stigmatized and clinically pathologized. The existing research on consensually non-monogamous individuals indicates, despite negative assumptions, those who engage in consensually non-monogamous relationships demonstrate psychological well-being, physical health, and levels of relationship satisfaction comparable to their monogamous counterparts. While engaging in consensually non-monogamous relationships is not in and of itself pathological, individuals in consensually non-monogamous relationships are often stigmatized and discriminated against by others, including the general population and healthcare providers. Furthermore, individuals in consensually non-monogamous relationships do not benefit from the legal protections (e.g., employment, housing, marriage benefits) monogamous individuals are privileged with. Therefore, bias and discrimination can lead to clinically significant psychological distress (e.g., minority stress, internalized stigma), which is unique to the consensually non-monogamous population. This distress may be compounded by multiple intersecting minority identities, lack of access to appropriate (e.g., validating, non-pathologizing) mental and physical healthcare, and perpetuation of heteronormative and mononormative biases in healthcare systems. In identifying issues that are unique to the consensually non-monogamous population and recognizing areas of growth in the mental health field, suggestions for clinical practice and systemic reform have been provided, and an inclusive intake assessment tool was created.

EXPLORING CLINICAL IMPLICATIONS OF CONSENSUAL NON-MONOGAMY:

A PROPOSED INTAKE ASSESSMENT TOOL

Copyright ©2022

Rebecca Tuttle, M.A.

All rights reserved

DEDICATION

To my family, my partner, and my best friends: I am eternally grateful for your infinite love and support. I would not be here without each and every one of you. My success is your success.

Donde hay mujer no hay miedo.

ACKNOWLEDGEMENTS

I would like to express my appreciation for every one of the supervisors, professors, and mentors I have had over the past five years; I have benefited from my interactions with each of you, both personally and professionally.

Specifically, I would like to thank Dr. Jenna Elwart, my first clinical supervisor, who demonstrated to me the power of authenticity, open-mindedness, and passion for clinical work.

I would also like to acknowledge Dr. Tony Bandele, my most recent clinical supervisor, who beautifully models grace, humor, and professionalism while simultaneously and continually encouraging me to create and engage in a meaningful life. Thank you.

To Drs. Gary Howell and Patricia Dixon: this project would not exist without you. Thank you for your guidance, your patience, and the enthusiasm you shared with me on this journey.

Finally, to Dr. Rowena Ramnath: you helped me find joy and impacted my life in more ways than you could ever know. I am forever grateful to you.

TABLE OF CONTENTS

Page

Abstract i

Copyright Notice ii

Dedication iii

Acknowledgements iv

Table of Contents v

CHAPTER I: INTRODUCTION 1

Terminology 1

Demographics 5

Age 5

Sex and Gender Identity 6

Sexual Orientation 7

Race and Ethnicity 8

Highest Level of Education and Income/Socioeconomic Status (SES) 8

Political Affiliation 9

Religious Affiliation 9

Prevalence of CNM 10

Statement of the Problem 11

Research Questions 11

Research Procedure 12

CHAPTER II: HISTORICAL AND CONTEMPORARY VIEWS OF CNM 13

Biological and Evolutionary Perspectives 13

The Pursuit of Pleasure 15

Monogamy as a Social Construct 15

History of CNM in the United States.. 16

Contemporary Views on Relationship Structure in the United States 18

Cultural Differences 19

Views of CNM: Inside and Out 19

CNM in the Media 20

General Public 22

Inside the CNM Community 25

Healthcare Professionals 26

CNM and the Law 28

CHAPTER III: PSYCHOLOGICAL AND PHYSICAL HEALTH IN THE CNM COMMUNITY 31

Psychological Health 31

Sexual Identity Development.. 32

Fixed or Fluid 32

Models of Sexual Identity Development 37

Cass’s Gay and Lesbian Identity Development Model................. 38

Comments on Cass’s Model 39

Fassinger’s Model of Gay and Lesbian Identity Development 41

Comments on Fassinger’s Model.. 42

Identity Development Milestones Meta-Analysis 44

Meta-Analysis Comments... 45

Multidimensional Model of Heterosexual Identity Development 46
Comments on Heterosexual Identity Model 48
Hughes's Model of Kink Identity Development........................... 48
Comments on Hughes's Model... 49
Finding the 'Right' Language 50
Intersecting Identities.. 52
Minority Stress.. 54
Internalized Stigma 56
Rejection Identification.. 57
Attachment and CNM 58
Attachment Theory 59
Adult Attachment.. 63
Attachment in CNM Individuals.. 66
Attachment Styles: Clinically Relevant Correlations 68
Relationship Satisfaction 70
Love and Emotional Intimacy.. 70
Sexual Satisfaction and Frequency 71
Commitment 72
Trust 73
Jealousy.. 73
Conflict Resolution Styles 75
Variability Between CNM Relationship Styles 75
Overall Relationship Satisfaction 76

Physical Health in CNM Individuals ... 77
CHAPTER IV: BARRIERS TO CARE, DETRIMENTAL PRACTICES, AND SUGGESTED PRACTICES ... 80
Barriers to Care ... 81
Common Therapist Mistakes ... 83
Suggestions for Clinical Practice ... 84
Suggestions for Systems ... 86
CHAPTER V: CLINICAL IMPLICATIONS AND A PROPOSED INTAKE ASSESSMENT TOOL ... 88
Intake Assessment ... 89
Identifying Information ... 89
Presenting Concerns ... 92
Psychiatric History ... 92
Risk Assessment ... 93
Brief Trauma Assessment ... 93
Psychosocial History ... 94
Physical Health ... 97
Substance Use ... 97
Resources ... 98
Considerations for Additional Assessments ... 98
Steps Toward Inclusive Care ... 100
Future Directions ... 101
References ... 104

Appendix A CNM-Affirming Semi-Structured Intake Assessment 126

Appendix B Proposed Training for Systems: The Significance of CNM-Inclusive Intake Forms 143

CHAPTER I: INTRODUCTION

In recent years, social and scholarly interest in the evolution of interpersonal relationships, specifically about marriage, same-sex relationships, and monogamy versus non-monogamy, has significantly increased (Grunt-Mejer & Campbell, 2016). The United States has observed a rise in divorce and remarriage rates, more frequent cohabitation, and recent legal decisions that validated same-sex marriages. Concurrently, historical relationship rules and expectations that had defined heterosexual monogamy as the only healthy and appropriate relationship structure are actively being challenged and reshaped (Cherlin, 2004; Grunt-Mejer & Campbell, 2016). The shifting of relationship norms has resulted in an increase in social visibility of alternatives to heterosexual monogamy, including consensual non-monogamy (CNM). As the landscape of human relational dynamics continues to evolve, the field of clinical psychology must adapt accordingly.

Terminology

Non-monogamy, in its simplest form, is the opposite of monogamy, which is defined by Merriam-Webster (n.d.) as "the state or practice of having only one sexual partner at a time" (para. 1). However, for the sake of this literature review, the practice of non-monogamy is not confined to sexual experiences. Instead, non-monogamy refers to the nurturing of an intimate connection with more than one concurrent partner, whether it be sexual or emotional in nature. Participants in a non-monogamous relationship may or may not be aware of their non-monogamous status; in colloquial terms, this is readily understood as infidelity or cheating, and may take a variety of forms (e.g., physical, emotional, digital). Conversely, CNM, also known as ethical non-monogamy, relies on consent and therefore requires that all involved partners understand and agree to a relationship dynamic that allows for more than one concurrent partner

(Rubin et al., 2014). Partners in a CNM relationship may engage with each other in a sexual and/or emotional or romantic manner, depending on the relationship agreement that has been established by all participating partners. CNM is an umbrella term that encompasses a variety of relationship styles that fit within this broad definition. Though there are common factors across CNM relationships, it is important to note that there are significant and distinct differences as well. As Hangen and colleagues (2019) stated, "collapsing across all forms [of CNM relationships] would obscure meaningful [and potentially clinically significant] differences" (p. 2). As such, it is important to note that all the data included in this critical review of the literature focus on three of the most researched forms of CNM: *open relationships*, *swinging*, and *polyamory* (Hangen et al., 2019).

Open relationships typically describe long-term, committed couples who agree to engage in *extradyadic sexual activity* (EDSA), or sexual activity with an individual or individuals outside of the primary dyad) as a part of their relationship agreement "while maintaining their dyadic relationship as their primary emotional bond" (Hangen et al., 2019, p. 2). Partners who have agreed to pursue an open relationship frequently agree to a relationship contract that defines the terms of the EDSA, including the acceptable context for EDSA (i.e., deciding when and with whom EDSA is permissible). Therefore, any sexual contact with individuals outside of the dyad's predetermined relationship framework may be considered a violation of the relationship agreement.

Swinging is similar to open relationships in that a primary dyad exists, and EDSA is only approved within certain contexts (e.g., at parties or clubs, while on vacation); however, swinging differs from open relationships in that sexual and/or emotional relations typically exist between two or more dyads (Hardy & Easton, 2017), as opposed to one dyad plus one or more

independent individuals. Swingers may also engage in "complete partner swapping," "[four]-somes with other couples" (Hangen et al., 2019, p. 2), or orgies.

Regarding polyamory, there are clear discrepancies in the term's definition; while some may consider polyamory to "include all forms of sexual relationships other than monogamy . . . others restrict its meaning to committed long-term love relationships" (Hardy & Easton, 2017, glossary). Hangen and colleagues (2019) also use broad terms to define polyamory, suggesting that it describes three or more people who engage in emotional and/or sexual relationships. Despite the discrepancy in current literature, the creators of the term polyamory were slightly more specific in what it was intended to encompass; the term literally translates to *many love* (Anapol, 2010; Hardy & Easton, 2017). For the purposes of this paper and with respect to the origins of polyamory, the term polyamory refers to emotional and/or sexual relationships between three or more people, which may or may not be hierarchical in nature.

Though hierarchical and nonhierarchical relationship subtypes were not a primary focus of this paper and were not specifically explored moving forward, it is important to acknowledge and understand their existence in the CNM community and how they differ from each other. The terms *hierarchical* and *nonhierarchical* are used to distinguish between types of polyamorous relationships, and the terms *primary* and *secondary* are used to reference partners' positioning within a hierarchical polyamorous relationship. Primary relationships typically consist of two individuals who are engaged in a long-term committed relationship, generally characterized by their sharing of a home, finances, and children if desired (Balzarini et al., 2017). Conversely, secondary partners do not typically share the same responsibilities as primary partners, nor do they hold the same amount of weight regarding decision-making within the relationship. Generally, secondary partners do not spend as much time with or receive as much attention as

primary partners and are expected to submit to the primary partners (Balzarini et al., 2017). In a nonhierarchical relationship, all partners are considered equals in all aspects of the relationship and relationship-related decision-making (Anapol, 2010).

Like many of the other terms used throughout this literature review, the definition of *consent* is contended by many, but it is a crucial distinguishing feature of CNM and must therefore be defined for the purposes of this paper. Because consent is most commonly "discussed in terms of its absence, as in rape law cases . . . there is hardly any understanding of what constitutes consent in a positive sense and how it is actually achieved" (Bauer, 2014, p. 75). In the United States, the legal definition of consent differs by state, as does the age at which an individual can legally consent (Rape, Abuse & Incest National Network [RAINN], 2020). In recognizing that laws differ by state, it is imperative that therapists perform due diligence to ensure a thorough understanding of how consent is defined in their respective state(s) and to facilitate ethical and competent client care. For the purposes of this paper and with respect to CNM specifically, the term consent was defined within the parameters of Florida law as an "intelligent, knowing, and voluntary" agreement to engage in a relationship with two or more partners, which "does not include coerced submission" by an individual who is at least 18 years of age (RAINN, 2020, Florida section). In other words, for CNM to be truly ethical and consensual, all participants within a CNM relationship configuration must engage in the relationship of their own volition and without ulterior motives such as believing that CNM is a phase, that their partner is interested in CNM in an abstract way but does not intend to actually engage in it, or that they are so in love with their partner that they agree to be in a CNM arrangement even if they are not actually interested in CNM (Taormino, 2008). Further, it is important to acknowledge that consent is an active, collaborative, and ongoing process between

all adults involved in the CNM relationship (Hardy & Easton, 2017). Consent is the way partners communicate about their willingness to fully engage in a CNM relationship and comes with veto powers as well.

In discussing biases, there are two specific terms used throughout this paper. *Heteronormativity* refers to sociocultural assumptions that individuals who are in a relationship are in a heterosexual relationship, that heterosexual relationships are superior to any other relationship type, and that heterosexual relationships are the only healthy relationship style (Hardy & Easton, 2017). Finally, *mononormativity* refers to the sociocultural assumptions that individuals who are engaged in a relationship are in a monogamous relationship, that monogamy is superior to any other relationship structure, and that CNM is unviable and unethical (Anapol, 2010). As discussed further in Chapters 3 and 4, making these assumptions can be detrimental to the mental and physical health and well-being of individuals in CNM relationships; it is time these myths be laid to rest.

Demographics

Though the CNM community was historically believed to be a homogenous group of individuals (i.e., White, middle- or upper-middle SES, and educated), empirical evidence now suggests this is not necessarily the case.

Age

The literature indicates there is no significant difference in age when comparing individuals in monogamous and CNM relationships (Balzarini et al., 2018a; Haupert et al., 2016; Rubin et al., 2014; Sheff, 2014). On average, individuals who engage in CNM tend to hover around 30 or 40 years old; however, it should be noted that a variety of individuals fall outside of this range, and in one study in particular, CNM participants' ages ranged from 18 to 84 (Rubin et

al., 2014). In comparing individuals who identify as swingers and individuals who identify as polyamorists, Jenks (2014) found a similar trend for both swingers and polyamorists who fell within the 30- to 40-year-old range. Sheff (2014) hypothesized that we typically see initial engagement in CNM around this age range because "many people follow social conventions early in life out of ingrained training, lack of power to make other choices, or sheer habit" (p. 33). Unless a state of discomfort in conforming to heteronormative and mononormative relationship structures is realized, an individual will not take steps to change their way of relating; this process "may take years to germinate and grow into taking action toward stepping outside of accepted norms and values," assuming that it occurs at all (Sheff, 2014, p. 33). Additionally, the historical lack of social visibility and consequential lack of knowledge regarding CNM is likely another factor influencing the age at which individuals first engage in CNM relationships.

Sex and Gender Identity

While some researchers have found that there is no significant difference in sex and gender identity when comparing monogamous and CNM individuals (Rubin et al., 2014), there is some evidence to suggest that individuals who identify as men are more likely to engage in CNM than those who identify as women (Fairbrother et al., 2019; Haupert et al., 2016; Moors et al., 2015). Implications of the parental investment theory—which is explored in the following chapter—suggest that men may engage in CNM relationships at a higher frequency than women because they have a bio-evolutionary tendency to seek out a greater number of sexual partners (Jonason et al., 2012). Rubin and colleagues (2014) offered an alternative hypothesis to these data; because women are more likely to be stigmatized than men for engaging in the same sexual behavior (i.e., sexual double standard; González-Marugán et al., 2021), women may underreport

their engagement in CNM relationships in an effort to thwart perceived or actual stigma and discrimination. Alternatively, as both Conley, Ziegler and colleagues (2013) and Rubin and colleagues (2014) argued, women may actually engage in CNM less frequently for fear of social repercussions or in an effort to conform to social norms. It is important to note that although the amount of research on CNM that has been conducted in recent years has exponentially increased, a dearth of research regarding transgender, nonbinary, queer-gender, and alternative gender identities' engagement in CNM continues to exist.

Sexual Orientation

One study found no significant difference in CNM engagement with respect to sexual orientation (Rubin et al., 2014); however, much of the literature indicates otherwise. Individuals who identify as lesbian, gay, or bisexual (LGB), especially bisexual women, appear to engage in CNM at a much higher frequency than heterosexual individuals (with the exception of heterosexual men, who appear to engage in monogamous and CNM relationships with similar frequency) and individuals who identify as asexual, pansexual, or use other descriptors for their sexual orientation (Balzarini et al., 2018a; Moors, Gesselman et al., 2021; Haupert et al., 2016; Séguin et al., 2017; Sheff, 2014). Some explanations for these trends include: (a) the opportunity for bisexual women, who tend to be less stigmatized than bisexual men, to engage in multiple relationships with individuals of different gender identities through CNM, and (b) the possibility that LGB individuals are more predisposed to the idea of engaging in CNM relationships because they already tend to live outside of socially-reinforced heteronormative relationship structures (Moors, Gesselman et al., 2021).

Race and Ethnicity

Sheff (2014) and Jenks (2014) both found that individuals who engage in CNM are more likely to identify as White, with Sheff suggesting, "people already laboring under the disadvantages of . . . racism . . . are less likely to be willing or able to take on additional stigma voluntarily" (p. 35). Although this argument is easy to follow, it appears that Sheff and Jenks' results may have been influenced by selection bias; in looking at studies with larger sample populations, there does not appear to be any significant difference between monogamous and CNM individuals with respect to race and ethnicity (Balzarini et al., 2018a; Haupert et al., 2016; Moors, Gesselman et al., 2021; Rubin et al., 2014).

Highest Level of Education and Income/Socioeconomic Status (SES)

A lack of consensus exists regarding the level of education in monogamous versus CNM individuals. While Balzarini and colleagues (2018a) and Moors, Gesselman and colleagues. (2021) found that monogamous individuals are more likely to have higher levels of education than individuals in CNM relationships, Haupert and colleagues (2016) found no significant differences in the level of education between the two groups and Jenks (2014) found that individuals in polyamorous and swinging relationships had higher levels of education than the general public.

Discrepancies in the literature regarding income and SES are also present. Haupert and colleagues (2016) and Moors, Gesselman and colleagues (2021) found no significant differences when comparing monogamous and CNM individuals. Alternatively, Sheff (2014) and Jenks (2014) indicated that individuals who engage in CNM, specifically those in swinging and polyamorous relationships, typically fall within the middle to upper-middle class, with Sheff (2014) noting, "people with enough money to own their own homes [and] attain the kind of

education that makes them indispensable at work or be able to be self-employed . . . have the latitude to take the risks associated with voluntary nonconformity" (p. 36). Balzarini and colleagues (2018a) found mixed results; while individuals who identified as monogamous endorsed individual (as compared to household) incomes between $40,000 to $80,000 per year and polyamorous individuals endorsed incomes less than $20,000 per year, there was no significant difference between the two groups in those making more than $80,000 per year.

Political Affiliation

Individuals in CNM relationships tend to be viewed as more liberal than those in monogamous relationships due to their willingness to challenge the heteronormative and mononormative status quos; this common belief is echoed by some of the literature (Jenks, 2014; Sheff, 2014), which found that individuals in polyamorous and swinging relationships are more likely to be Democratic/liberal. However, Haupert and colleagues (2016) and Moors, Gesselman, and colleagues (2021) found no significant difference in political affiliation when comparing monogamous and CNM individuals, and Balzarini and colleagues' (2018a) results suggested that monogamous individuals were more likely to identify as Democratic and Republican, polyamorous individuals were more likely to be Libertarian or part of the Green Party, and no significant difference between individuals who identified as independent was identified.

Religious Affiliation

While Jenks (2014) and Kolesar and Pardo (2019) found that individuals in CNM relationships reported lower degrees of religious identification than those in monogamous relationships, Haupert and colleagues (2016) and Moors, Gesselman and colleagues (2021) found no difference in religious affiliation between the two groups. Alternatively, Balzarini and colleagues (2018a) found that monogamous individuals were more likely to identify as Christian,

agonistic, or Muslim; polyamorous individuals were more likely to identify as "other" or atheist; and no significant difference between those who identified as Buddhist, Hindu, and Jewish was found.

Prevalence of CNM

Despite what is known about "poly pioneers" (Hardy & Easton, 2017) and the increased interest surrounding CNM in recent years, little is known regarding the current prevalence of CNM engagement in the United States (Haupert et al., 2016; Levine et al., 2018; Rubin et al., 2014). Unfortunately, the lack of research in this area is not new. Though Kinsey and colleagues (1948, 1953) alluded to the engagement in CNM among heterosexual couples in their seminal work, no statistics regarding actual engagement were reported. Years later, Fairbrother and colleagues (2019) found that 12% of participants in their study identified an open relationship as their ideal relationship type and Lehmiller (2020) found that over 30% of participants in his study identified sexual open relationships as their favorite sexual fantasy, with 80% of these individuals reporting that they intended to act on their fantasies.

Regarding actual engagement in CNM, Blumstein and Schwartz (1983) estimated that upwards of 15% of married couples engage in CNM; in contrast, Cole and Spaniard (1974) found that less than 2% of individuals engaged in CNM. Similarly, Haupert and colleagues (2016) and Hangen and colleagues (2019) found that over 20% and 30% of their respective samples reported engaging in CNM, but Rubin and colleagues (2014) and Levine and colleagues (2018) found that only 4% of their participants engaged in CNM. More recently, Moors, Schechinger, and colleagues (2021) found that over 10% of their participants had engaged in CNM at some point in their lives. With a current population upwards of 330 million people in the United States (U.S. Census Bureau, n.d.), a conservative estimate of 4% prevalence of CNM

translates to approximately 13 million people who currently engage in CNM. As a comparison, it is estimated that 4.5% of adults in the United States currently identify as LGB or transgender (Williams Institute, 2019).

Statement of the Problem

Despite the progress that has been made, there continues to be a profound lack of literature to guide therapists' understanding of how non-monogamous relationships work; understanding how physical and psychological health and well-being are managed in CNM relationships; what themes and unique issues may be addressed in therapy; and how therapists can appropriately manage their own personal beliefs and biases that are often rooted in heterocentrism and mononormativity (Conley, Moors et al., 2013; Girard & Brownlee, 2015). Competent clinicians must have a basic understanding of contemporary relationships, recognize personal and social biases and implications of these biases, and avoid tendencies to conceptualize clients from a heterocentric, monogamous lens (Schechinger et al., 2018). Failure to meet the above areas of competence results in marginalization and pathologization of individuals who live outside of conventional frameworks, despite the fact that non-monogamous relationships are not a new phenomenon.

Research Questions

The current literature review drew upon the existing research and sought to answer three research questions:

1. What are historical and contemporary views of the CNM community through the eyes of the media, general public, CNM individuals, healthcare professionals, and the law?
2. What does psychological and physical health look like for individuals in the CNM community?

3. What are the implications for treatment when working with individuals who are in, or are interested in, becoming a part of the CNM community?

The investigation of these research questions helps to orient readers to some of the common-identity-based characteristics of CNM individuals; to identify clinically relevant concerns specific to CNM individuals; highlights potential pitfalls and areas of competency for therapists who intend to work with CNM individuals; and serves as evidence for a proposed inclusive and CNM-sensitive structured intake interview.

Research Procedure

The data reviewed for this paper were obtained via database searches, including PsychInfo and Google Scholar, which helped to identify relevant journal articles, books, and manuals. Search terms included, but were not limited to, *monogamy, consensual non-monogamy, ethical non-monogamy, sexual minority groups, polyamory, open relationships, swinging, attachment, sexual identity development, human sexuality, impacts of stigma,* and *minority stress*. Additionally, relevant websites, forums, and blog posts were utilized to obtain supplemental and anecdotal material for review and inclusion in this literature review.

CHAPTER II: HISTORICAL AND CONTEMPORARY VIEWS OF CNM

While monogamy may currently be the most prevalent relationship style in the United States, a variety of relationship styles exist both cross-culturally and throughout the history of humanity. The following sections explore the history of monogamy, non-monogamy, and CNM from a variety of perspectives, including bio-evolutionary theories on typical human mating strategies; sexual pleasure as a fundamental and often ignored aspect of human sexuality; the advent of monogamy as a social construct; "poly pioneers" in the United States; and contemporary views of relationship structures in the United States. Finally, cultural differences are briefly explored.

Biological and Evolutionary Perspectives

The debate over typical human mating strategies has gripped the scientific community for years, without much consensus. To draw conclusions about ideal mating strategies, researchers have frequently referred to human biological traits; however, a variety of interpretations could be drawn from these observations. In looking at testes size in males, for example, researchers have identified a positive correlation between testes size and the frequency of females mating with more than one male simultaneously (Schacht & Kramer, 2019). When adjusted for body size, human testes are significantly smaller on average than those of non-human primates. This observation suggests that the expected frequency of human females simultaneously mating with more than one human male (i.e., polyandrous mating) is low and has led some researchers to conclude that humans are naturally inclined to pair-bond. When comparing human testes size to other monogamous primates, however, human testes size is larger than would be expected for a monogamous species. Thus, in considering the correlation between testes size and frequency of females simultaneously pairing with more than one male, this finding suggests that high

frequencies of polyandrous mating would be expected; however, Schacht and Kramer (2019) went on to argue that because human offspring can only result from the copulation between one male and one female, "testis size cannot discriminate between monogamy and polygyny" (i.e., one male pairing with multiple females; p. 4). In other words, the same information (e.g., observation and comparison of testes size) can be used to argue three contradicting theories of human mating strategies.

In examining evolutionary theories, there is a similar lack of consensus regarding ideal human mating strategies. The parental investment theory posits that because it is biologically "expensive" for human females to carry and nurture offspring, due to long-term pregnancies and years of nursing, females are more inclined to select one long-term partner who can provide safety and resources (Jonason et al., 2012). Thus, selecting an appropriate mate is vital to the survival of the species. Despite the fact that human males are arguably more involved in the rearing of their offspring compared to other species, their physiological obligation technically ends with copulation. As a result, males may be more inclined to mate with multiple partners in an attempt to spread their seed more liberally and increase their chances of producing viable offspring (Jonason et al., 2012). In extrapolating from these theoretical underpinnings and applying them to human mating strategies, one would expect to see a high number of females pairing with one male and a high number of males pairing with multiple females to increase the chances of species survival; in other words, one would expect to see a large number of humans in polygynous relationships.

Similarly, Darwin's theory of evolution highlights the importance of sexual selection, noting that the survival of a species is reliant on "females . . . [selecting] one out of several males" to inseminate them (Darwin, 1981, p. 259). Darwin went on to state, "the largest number

of vigorous offspring will be reared from the pairing of the strongest and best-armed males, who have conquered other males" (Darwin, 1981, p. 271). Male-male competition for "possession of the female" (Darwin, 1981, p. 259) does not end here, however; according to sperm competition theory, post-ejaculatory selection (i.e., the competition between various sperm in fertilizing the female's ova) is just as vital as pre-ejaculatory selection (Parker, 2020). If both pre- and post-ejaculatory competition occur, it could be argued that females and males would be more inclined to mate with a variety of partners to increase their chances of producing a higher number of viable offspring. Thus, the expectation would be to see a variety of non-monogamous or multi-partner mating strategies.

The Pursuit of Pleasure

Though bio-evolutionary perspectives may provide some hints about ideal mating strategies for humans, these perspectives fail to consider one of the fundamental principles of human sexuality: the pursuit of sex for pleasure. The research follows this same trend; in analyzing 300 articles published in *The Journal of Sex Research* over a five-year period, Jones (2019) found recurring themes of risk, disease, and dysfunction as they relate to sex, while the concepts of pleasure, satisfaction, and empowerment were omitted. Perspectives based solely on the potential negative consequences of sex are harmful, as they perpetuate stigma, discrimination, and sex-negative attitudes. The implications of these consequences are explored further in Chapters 3 and 4. Thus, it is imperative that human sexuality be evaluated from a holistic vantage point, rather than viewing sex as simply a mechanism of procreation.

Monogamy as a Social Construct

The concept of monogamy is relatively new; even though *homo sapiens* have walked the earth for roughly 300,000 years, evidence suggests that humans have only practiced monogamy

for the last 1,000 years or so (MacDonald, 2001). It is theorized that monogamy was created as a system to foster business and political relationships, maintain familial wealth, and reduce the spread of sexually transmitted infections (STIs). Additionally, equating monogamy with the marriage sacrament served as a control tactic, ensuring that individuals abide by the rules of Christian churches (MacDonald, 2001; Rothschild, 2018). However, in some Islamic, Jewish, and Christian traditions, polygyny is embraced as a status symbol, while women are expected to adhere strictly to monogamous relationship structures (Rothschild, 2018). In fact, it is estimated that 85% of human societies throughout history have permitted, if not encouraged, men to have more than one wife (Henrich et al., 2012). Monogamous partnerships have also been sought as a function of practical needs and economic survival, especially for women, who have historically relied on male family members or a male partner for protection and for securing assets (Hidalgo et al., 2007; Rothschild, 2018).

History of CNM in the United States

Hardy and Easton (2017) use the term *poly pioneers* to identify some of the infamous CNM *folx* (i.e., inclusive respelling of the term *folks*) in United States history. One such pioneer was John Humphrey Noyes, a Protestant preacher from Vermont, who led his congregation to establish a "free love community" in the 1840s. This community lived in a 93-bedroom mansion in Oneida, New York and became known as the Oneida Community. They communally raised their children, shared all their property, and avoided exclusive relationships, opting instead for "complex marriage . . ., where all the men and women within the community were considered to be married to each other . . . [and were encouraged] to enjoy frequent lovemaking and multiple partners" (Anapol, 2010, p. 46; Hardy & Easton, 2017). The Oneida Community eventually dissolved due to legal pressure over 30 years after it was established (Anapol, 2010; Hardy &

Easton, 2017). Brook Farm and Nashoba, another two free love communities that followed similar doctrine as the Oneida Community, were established around the same time and sadly followed the same fate as the Oneida Community (Anapol, 2010).

Another "poly pioneer" was Dr. Alfred Kinsey, who, along with his colleagues in the 1940s and 50s, collected sex histories from over 12,000 men and women (Hardy & Easton, 2017). In their historically controversial yet groundbreaking research regarding male sexuality and behavior, Kinsey and colleagues (1948) alluded to the practice of CNM in heterosexual married couples by noting that some wives "may even aid and encourage" their husbands' extra-marital intercourse (Kinsey et al., 1948, p. 592). When they published their findings on female sexuality and behavior just a few years later, Kinsey and colleagues (1953) again alluded to the practice of CNM in heterosexual married couples, asserting that some husbands "accepted or encouraged their wives' extra-marital activity" (Kinsey et al., 1953, p. 435). During this time, Kinsey and his researchers famously engaged in sexual exploration themselves, as they and their partners all engaged in EDSA with each other (Hardy & Easton, 2017).

In the 1960s, swinger parties became popular in "mainly [White], affluent heterosexual couples who lived in the suburbs," and a weekly social group for swingers that came to be known as the Lifestyles Organization was established in 1969 (Taormino, 2008, p. 33). Although swinging became popular for heterosexual individuals around this time, multiparter sex among gay men in the United States has been traced back to as early as the 1920s, and a variety of lesbian cooperative living situations began to pop up in the 1970s (Taormino, 2008). The Kerista commune, also established in the 1970s in San Francisco, serves as yet another example of a CNM community (Anapol, 2010; Sheff, 2014). The Keristans were subdivided into three group marriages called ("best friend identity clusters") and prevented pair bonding by engaging in a

"balanced rotational sleeping schedule" (Anapol, 2010, p. 57). At its peak, the community consisted of 30 members and lasted for approximately 20 years before it dissolved.

Whether or not the public is willing to accept CNM as a viable relationship configuration, one fact cannot be contradicted: non-monogamy, whether it is consensual or not, has always existed. In fact, as Barash and Lipton (2002) pointed out in their book, "the first great work of Western literature, Homer's *Iliad*," which was written around 760 BC, "recounts the consequences of adultery" (p. 2). In more contemporary times, estimates of EDSA vary from 12% to 70% of married individuals (Anderson, 2010; Negash et al., 2014), with Kinsey and colleagues (1953) reporting that about half of all married men and a quarter of all married women have engaged in EDSA.

Contemporary Views on Relationship Structure in the United States

The conventional idea of long-term monogamy is changing. Rises in divorce, infidelity, and remarriage rates suggest that our historical ideologization of monogamy must be revisited (Anapol, 2010; Cherlin, 2004; Grunt-Mejer & Campbell, 2016). Interestingly, serial monogamy, a series of monogamous relationships, has been socially normalized for quite some time; sex with multiple partners is not viewed as negative, so long as they do not overlap with each other (Hidalgo et al., 2007).

Relationship rules that were once governed by heterocentric, mononormative expectations are finally being challenged (Cherlin, 2004); the most obvious example of this occurred with the legalization of same-sex marriages in 2015 (Grunt-Mejer & Campbell, 2016). Concurrently, interest in consensual non-monogamy and seeking alternatives to "the couple" appears to have increased in the general public, with increases in internet searches for topics related to CNM, media coverage, and representation in pop culture (Moors, 2016; Schechinger et

al., 2018). This increase in social visibility is echoed in scientific literature and academia. The creation of the Society for the Psychology of Sexual Orientation and Gender Diversity (American Psychological Association [APA] Division 44) Consensual Non-Monogamy Task Force in 2018, for example, not only continues to increase the visibility of CNM in the public and academic worlds but also serves as a mechanism to generate research and provide evidence-based resources for working with CNM individuals.

Cultural Differences

It is important to note that the information in this section has not been included in this paper to argue that non-monogamy is more "natural" than monogamy or that monogamous relationships are destined to fail; there are countless examples of successful, fulfilling monogamous relationships all around us. Instead, the information in this section has been included in an attempt to highlight that although sociocultural norms, especially in the United States, may tell us otherwise, there is truly no "typical" human mating system. In fact, when examining the historical and contemporary relationship styles cross-culturally, it is evident that a variety of relationship styles exist, including monogamous, polyandrous, polygynous, and short-term relationships (Henrich et al., 2012; Schacht & Kramer, 2019).

Views of CNM: Inside and Out

The existence of heteronormative and mononormative biases has already been briefly discussed; while the impact of these biases is explored further in Chapters 3 and 4, it is also important to recognize how they can manifest in and are perpetuated by society. As such, this study explored the perceptions of CNM from five perspectives: representations in the media; opinions of the general public, the CNM community, and healthcare professionals; and CNM within the U.S. legal system.

CNM in the Media

As a result of heteronormative and mononormative societal values in the United States, folx are continually “saturated with images, role models, and stereotypes that negatively portray same-sex [and CNM] relationships” through mass media (Worthington et al., 2002, p. 508). As such, representations of CNM in the media can be difficult to find. Rambukkana (2015) argued that, even though CNM may not always be explicitly acknowledged, non-monogamous themes (e.g., adultery) have permeated television, film, and theater culture for decades, if not longer. Some TV shows such as *Big Love* (a reality show that revolves around a polygamous Fundamentalist Church of Jesus Christ of Latter-day Saints [FLDS] family; Olsen et al., 2006-2011), *Polyamory: Married and Dating* (a documentary series that follows polyamorous individuals; Berman et al., 2012-2013), and *Swingtown* (a fictional account of swinging subculture; Kelley et al., 2008), for example, provide varied depictions of different CNM relationship styles. CNM themes are also observed in mainstream films, such as Woody Allen’s (2008) *Vicky Cristina Barcelona* and John Cameron Mitchell’s (2006) *Shortbus*. Though these video media formats provide exposure to CNM, they arguably do not depict accurate portrayals of CNM.

It is not uncommon for television shows to devote single episodes to CNM themes as well. Recently, Netflix shows such as *You* (Chao et al., 2021) and *Sex/Life* (Karp & Folkson, 2021) have done just that; the main characters in both of these shows experimented with open-relationship and swinging lifestyles for a single episode. However, the problem with these specific portrayals is that CNM culture was depicted in a very negative light. In *You,* for example, the main character’s motivations for engaging in CNM are inherently problematic; when his wife approaches him about opening up their relationship, he views it as an opportunity

to disguise and act on his romantic feelings for another woman without disclosing this to his wife or gaining her consent. Similarly, in *Sex/Life*, engagement in CNM is seen as a desperate attempt to save the main characters' (a heterosexual couple) marriage. Furthermore, when this couple later decides to attend a sex party, the party's atmosphere is depicted as dark and dingy, and the other party attendees are portrayed as aggressive exhibitionists; though some swingers may enjoy exhibitionist play, this is certainly not the norm. CNM inherently requires consent, which was clearly not a focus of the sex party scene.

Rambukkana (2015) noted that themes of CNM are also observed in print media, such as investigative journalism (e.g., *The Secret Lives of Saints: Child Brides and Lost Boys in Canada's Polygamous Mormon Sect*; Bramham, 2009), non-fiction works (i.e., self-help books), and novels (e.g., *A Stranger in a Strange Land*; Heinlein, 1961). Representations of CNM in academic literature are readily observed as well. Though interest in CNM has only actively blossomed in the last 30 years or so, research on swinging and multi-partner marriages can easily be traced back to the 1960s (Sheff, 2012).

Pivec's (2018) assertion that "films [and other forms of media] . . . 'speak' to us" by providing visibility, "moral instruction . . . social observation . . . [and] political judgment" implies that consequences of inaccurate representations of CNM in the media can result in increased stigmatization, marginalization, and discrimination of CNM individuals by the general public. Experiences of internalized stigma and related distress are also more likely to occur when one finds oneself drawn to a lifestyle that departs from heteronormative and mononormative depictions of relational structures. Simultaneously, Pivec's argument serves as a plea for more accurate, and perhaps more consistent, media representations of CNM as a way to facilitate societal acceptance and destigmatization of CNM individuals.

General Public

> Aaaah yes, the open marriage. A relationship between two toxic, depressed [people], with low self love and selfsteem [*sic*].
>
> —Mineral Grey, comment on the video "A desperate man allows wife to f*** other men but her lovers start disappearing" [YouTube]

Interest in CNM among the general public appears to be increasing, as evidenced by a significant rise in Google searches for polyamory and open relationships (but not swinging relationship styles) over the years, which may at least be in part a result of increased media attention to CNM (Moors, 2016). Despite these observations, which are potentially indicative of increased interest in and desire to learn about CNM, the internet remains full of CNM-related hate speech. In a study looking at online comments regarding media representations of CNM, Cardoso and colleagues (2021) highlighted the reality of the general population's attitudes toward CNM. The use of derogatory language in referring to CNM individuals in general, such as "freak" and "abominable," was frequently observed, and CNM females specifically were referred to as "barf-worthy" and "sluts" (Cardoso et al., 2021, p. 1335). Not all of the feedback was negative; however, while neutral comments (e.g., "anyone is free to do as they please as long as no one is harmed") and criticism of detractors (e.g., "narrow-minded") were also identified, they were much less common (Cardoso et al., 2021, p. 1336). These findings are similar to another study that analyzed comments posted to three different online educational articles about polyamory. Séguin (2017) identified five overarching perceptions of polyamory, ranging from overt rejection to open acceptance: polyamory as deficient; perverse, amoral, and unappealing; unsustainable; acceptable; and valid and beneficial.

These online comments appear to reflect the general population's overall attitudes toward CNM. For starters, the presence of a sexual double standard (i.e., females perceived more negatively than males for engaging in similar sexual behaviors), regardless of relationship style, has been well documented (González-Marugán et al., 2021). This double standard appears to exist within CNM relationships as well; Carlström and Andersson (2019a) found that while CNM men were glorified (by presumably monogamous men) for having the opportunity to sleep with multiple women, these same men were encouraged to bar their female partners from doing the same. These findings appear to speak to the tendency of others to project "preconceived opinions and fantasies about what a [CNM] lifestyle means" onto CNM individuals, which often requires CNM individuals to "explain, deny, or elucidate what it means to be" in a CNM relationship (Carlström & Andersson, 2019a, p. 1326).

Compared to monogamous relationships, CNM relationships are generally viewed as less positive overall (Balzarini et al., 2018b; Conley, Moors et al., 2013; Grunt-Mejer & Campbell, 2016; Moors et al., 2017), and CNM relationship structures are perceived as being unnatural (Conley, Moors et al., 2013; Moors et al., 2017), unsustainable (Carlström & Andersson, 2019a; Séguin, 2017), less socially acceptable (Conley, Moors et al., 2013), and are associated with lower levels of trust and commitment (Conley, Moors et al., 2013; Moors et al., 2017). Individuals within CNM relationships are often viewed as: unreliable and irresponsible (Carlström & Andersson, 2019a); less moral (Anderson, 2010; Conley, Moors et al., 2013; Mogilski et al., 2020; Moors et al., 2017); more promiscuous, more likely to contract STIs (Balzarini et al., 2018b; Conley, Moors et al., 2013); and more likely to be lonely and bored with their primary relationship (if applicable; Conley, Moors et al., 2013). Furthermore, because mononormative social scripts present monogamous coupledom as the epitome of maturity and

adulthood, the sexual needs, values, and preferences of CNM individuals tend to be invalidated and minimized, and CNM individuals themselves are often perceived as indecisive and immature (Carlström & Andersson, 2019a).

In comparing perceptions of individuals in polyamorous, open, and swinging relationships, a hierarchy emerged: individuals in polyamorous relationships were consistently viewed as healthier, more moral, and more socially acceptable than those in open and swinging relationships, with swingers typically being judged the harshest (Balzarini et al., 2018b; Barker & Langdridge, 2010; Grunt-Mejer & Campbell, 2016; Moors et al., 2017). Moors and colleagues' (2017) findings may help to shed some light on this phenomenon; they found that participants in their study who endorsed the most negative attitudes toward CNM also tended to endorse higher rates of jealousy and more traditional values (e.g., religious fundamentalism, political conservatism, mononormativity). Similarly, Balzarini and colleagues (2018c) found that participants who self-identified as monogamous had the least permissive sexual attitudes, were the most erotophobic, and were the most sexually restricted among all participants. Taken together, it seems feasible that monogamous individuals may perceive polyamorous relationships as more meaningful than open or swinging relationship styles because they emphasize the importance of sex within a loving relationship rather than sex for pleasure, which aligns well with monogamists' identified sexual values (Barker & Langdridge, 2010; Moors et al., 2017).

Taking these findings one step further, though individuals in all three of these CNM relationship styles (i.e., polyamory, open relationships, and swinging) experience judgment, stigma, and discrimination from others, it is possible that those who are engage in swinging relationships may be more susceptible to negative judgments since a swinging relationship style is viewed as the least authentic and viable of the three (Balzarini et al., 2018c). In other words,

the further away one strays from mononormative standards, the more vulnerable they may be to experiences of discrimination and marginalization.

Inside the CNM Community

Interestingly, the same hierarchy of relationship styles that was observed in the general public's perceptions of CNM was also observed within the CNM community (Balzarini et al., 2018b; Conley, Moors et al., 2013). Although CNM participants tended to favor their own relationship style over other CNM styles, they consistently perceived monogamous arrangements as the most positive relationship style overall (Balzarini et al., 2018b, 2018c; Grunt-Mejer & Campbell, 2016), considering them to be of higher quality and more successful than CNM relationship styles (Conley, Moors et al., 2013). Monogamous relationships were perceived as the least sexually risky, the most sexually satisfying, more moral, more natural, and more socially acceptable than CNM. Furthermore, individuals in polyamorous and open relationships ranked swinging relationships as the least viable; promiscuity and STI stigma remained associated with swingers by everyone except swingers. Criticism within the CNM community has been observed before, with Frank and DeLamater (2009) noting that swingers and polyamorous individuals have a history of viewing each other unfavorably. Specifically, Barker and Langdridge (2010) noted that while polyamorous folx tend to look down on swingers' supposed focus on "recreational sex, and the stereotypically gendered" nature of swinging, swingers tend to condemn polyamorous folx's "conservative attitudes toward sex . . . and the idea of love bonds beyond the couple" (p. 758). These findings point to the likelihood of internalized stigma, where the (conscious or unconscious) adoption of mononormative social conventions results in the perception of monogamy as the most viable relationship style.

Implications of internalized stigma on individual and relational functioning are explored further in Chapter 3.

Healthcare Professionals

Individuals in CNM relationships are less likely to seek therapy or medical attention than monogamous individuals (Garner et al., 2019; Jenks, 2014). Fears of judgment, pathologization, and unsolicited advice often result in hesitancy to seek services; unfortunately, these fears are justified. In an effort to examine clinicians' attitudes toward CNM, Grunt-Mejer and Łyś (2019) presented 324 psychotherapists with hypothetical vignettes of monogamous, cheating, and CNM couples seeking treatment for a variety of symptoms (e.g., substance use, depressive symptoms, erectile dysfunction, marital conflicts). When the clinicians were asked to rate the couples' relationship satisfaction, morality, and competence-related abilities, monogamous individuals were consistently rated higher in each of these domains compared to the other groups. Furthermore, while the clinicians overwhelmingly attributed CNM clients' presenting problems to their lack of sexual exclusivity and suggested that these clients alter their lifestyle (i.e., stop pursuing or engaging in CNM), monogamous clients' symptoms were nearly always attributed to influences outside of the relationship. Though these findings may be surprising, they are not unique; Schechinger and colleagues (2018) found that approximately one-third of mental health clinicians are not competent to effectively work with CNM clients/patients, which they attributed to a lack of provider knowledge.

Additionally, like many systems in the United States, healthcare is underscored by heteronormative and mononormative practices, which can interfere with clinicians' ability to provide competent care. Mononormative biases in the healthcare system include presumptions of monogamy and hospitals' recognition of only one person as a partner or spouse (Kean, 2015);

failure to provide enough writing space to identify multiple partners on administrative forms and physical space for multiple partners in treatment rooms (Flicker, 2019); and failure to provide appropriate, customizable STI screenings with easily shareable results (Vaughan et al., 2018), among other examples. Healthcare providers' assumptions of monogamy with CNM individuals can lead to detrimental health outcomes in at least three ways: (a) fearing judgment from providers, patients may decide to conceal aspects of their sexual behavior or avoid requesting specific types of STI testing, which can lead to mis- or unidentified, and therefore mis- or untreated, health concerns (Carlström & Andersson, 2019a; Regula, 2021; Vaughan et al., 2018); (b) patients' may perceive judgment and stigmatization from their healthcare providers, which can lead to experiences of anger and frustration toward the provider, decreased trust in the provider, decreased adherence to treatment, and decreased willingness to return to specific providers, thereby impacting continuity of care (Vaughan et al., 2018; Zestcott et al., 2016); and (c) clinicians may make inappropriate health care decisions (e.g., inadequate medical screenings and treatment) based on heteronormative and mononormative assumptions, leading to poor health outcomes (Vaughan et al., 2018; Zestcott et al., 2016). These pathways are not independent; for instance, poor medical decision-making can negatively impact communication and patients' levels of trust in the provider and vice versa (Zestcott et al., 2016).

Furthermore, individuals in the CNM community report experiencing increased pressure to educate their providers on CNM relationship dynamics while simultaneously attempting to avoid implicit (e.g., "raised eyebrows and dirty looks," "avoidance of eye contact, and a condescending tone") and explicit ("unsolicited, unwanted advice regarding participants' relationship choices and partners") sexual stigma from these same providers (Vaughan et al., 2018, p. 46). Observed stigma-avoidance behaviors in CNM clients/patients include withholding

of pertinent health information, pre-screening of providers, asking other CNM individuals for referrals, and utilizing public health clinics for broad-based STI testing.

Consistent experiences of being questioned, invalidated, and judged by healthcare providers are likely to lead to CNM individuals' increased distrust in healthcare professionals, continued engagement in stigma-avoidance behaviors, and potentially even trauma (Carlström & Andersson, 2019a). Though these experiences are generalizable to all CNM individuals, it may be particularly important to consider the unique experiences of swingers in healthcare settings, given the previously discussed stigmas associated with the swinging relationship style. Furthermore, it is critical for healthcare providers to recognize the power that they hold. Clinicians have the capacity to inform social change by validating the experiences of CNM individuals, engaging in inclusive care practices, and working to overthrow heteronormative and mononormative systems (Grunt-Mejer & Łyś, 2019).

CNM and the Law

While LGBTQ+ advocacy movements in the United States have received increasing amounts of attention and support in the last 50 years, resulting in significant, albeit slow progress, the CNM community has not experienced the same. Moors and colleagues (2017) argued that, while marriage equality remains important for many polyamorous folx, polyamorist activists in the United States have historically avoided pursuing legal avenues for fear of detrimentally impacting same-sex marriage equality efforts by inadvertently fueling "slippery slope" arguments. Moors and colleagues also pointed out that not all individuals within the CNM community (e.g., individuals in swinging or open relationships) are necessarily interested in pursuing the legalization of multi-person marriage. In a survey of over 4,000 polyamorous individuals, ranging in age from 16 to 92, Fleckenstein and colleagues (2013) found that just

over 65% of the respondents indicated they would like to have the option to legally marry multiple partners. These findings point to notable in-group variability and serve as a reminder that each CNM relationship is underscored by unique values and expectations.

Legal rights and protections that come with marriage tend to vary by state; however, they typically include benefits in the following areas: taxes (e.g., joint filings), estate planning (e.g., inheritance, estate and gift tax exemptions), government assistance (e.g., Social Security, Medicare, veterans' and military benefits), employment (e.g., insurance through a spouse's employer), medical (e.g., making medical decisions in the event that a spouse becomes incapacitated), death (e.g., burial arrangements, consenting to after-death examinations and procedures), and housing (e.g., living in "family only" zoned neighborhoods; Guillen, n.d.). Unmarried partners and individuals in domestic partnerships or civil unions do not qualify for these benefits; they are only accessible to individuals whose partnerships culminate in federally recognized marriage, which continues to be defined as a union between "two spouses" (U.S. Marriage Laws, n.d.). Furthermore, bigamy laws—and the harsh consequences for breaking them—prevent individuals from pursuing separate and simultaneous or overlapping legal marriages (Johnson, 2013; Kean, 2015). Sheff (2011) passionately argued "public policies should facilitate the lives of those who live in a society . . . [not] further alienate already disenfranchised sexual minorities and [perpetuate] institutionalized" heteronormative and mononormative biases (p. 511). While there is still a long way to go, Somerville, Massachusetts made headlines in June 2020 when it became one of the first cities in the United States to legally recognize polyamorous relationships (McNamara, 2020); this, at least, provides some hope for the future.

Aside from the legalization of multi-partner marriage, CNM individuals face a variety of legal challenges, including state-specific criminal adultery laws, child custody concerns,

workplace discrimination, and housing and zoning laws (Johnson, 2013). CNM individuals with children, for example, may be faced with some terrifying consequences; instances in which judges have criminalized CNM individuals and declared them unfit to raise their own children are not unheard of, and there are currently no legal protections in place to protect CNM families from potentially losing custody of their children (Polyamory Legal Advocacy Coalition, n.d.). Furthermore, “there are currently no legal protections against people facing [employment] discrimination for being in a [CNM] relationship,” which inherently puts CNM individuals’ livelihoods at risk should their CNM identity be exposed (McNamara, 2020, para. 12). Furthermore, group living laws, which limit the number of unrelated adults who can live in a home, also threaten individuals in the CNM lifestyle, as they may run the risk of being evicted from their homes (Kean, 2015).

Despite all of these potential consequences, CNM individuals continue to pursue lives that they find meaningful and fulfilling while continuing to fight for equitable treatment and acceptance from others. In the next chapter, an exploration of CNM individuals’ psychological and physical health expands on the impacts of persistent heteronormative and mononormative systems and helps to debunk some common myths about CNM.

CHAPTER III: PSYCHOLOGICAL AND PHYSICAL HEALTH IN THE CNM COMMUNITY

Psychological Health

The literature lacks consensus regarding psychological well-being among CNM, compared to monogamous, individuals. While some studies have reported that the psychological well-being of monogamous and CNM individuals is comparable (Garner et al., 2019; Rubel & Bogaert, 2015), others indicate that those in CNM relationships may experience higher degrees of psychological wellness compared to monogamous individuals (Brooks et al., 2021; Cox II et al., 2021; Jenks, 2014). Specifically, one study found that CNM individuals tend to demonstrate greater life satisfaction, higher self-esteem, and lower levels of depression, anxiety, and stress (Brooks et al., 2021). Furthermore, Cox II and colleagues (2021) found that older adults in CNM relationships reported increasing levels of happiness as they aged, which is contrary to the general population's experience of decreased happiness over time.

However, a recent study with United States and Canadian college students indicated that individuals in CNM relationships are significantly more likely than monogamous individuals to endorse depressive and anxious symptoms (Borgogna et al., 2021). After adjusting for demographic variables, Borgogna and colleagues determined that depressive, but not anxious, symptomology was associated with the participants' self-identified CNM identity status. Because these findings are contradictory and the literature is sparse, the following sections continue to explore psychological health in CNM-identifying individuals related to their CNM identity development, attachment styles, and the impact of heteromononormative biases, stigma, and discrimination. Protective factors are also discussed, including group identification and relationship satisfaction levels.

Sexual Identity Development

Identity development theories have been explored for decades, with prominent psychologists such as Erik Erikson (1968, 1980) and James Marcia (1966, 1980) largely paving the way. According to these early theories, identity development is a complex process by which an individual comes to develop their sense of self (i.e., self-concept), including identification of their unique beliefs, values, and worldview. Sexual identity development is similar to general identity development; however, it is specific to one's experience of sexual orientation, sexual attraction, and partnering behavior (Hanley et al., 2015). While sexual identity development is an essential part of the general human experience, it is particularly salient for the LGB+ and CNM populations since these identities inherently contradict heteronormative and mononormative sociocultural expectations.

Fixed or Fluid. The fixed versus fluid debate regarding sexual identity has long existed, with some theorists arguing that sexuality is innate and unchanging (i.e., an essentialist point of view; take Freud as a prime example) and others contending that sexuality is an ongoing process, influenced by societal norms and culture, in addition to a variety of other factors (i.e., a constructionist point of view; Evans et al., 2010).

Empirical evidence supports the theory that at least one component of sexual identity, sexual orientation, is biologically influenced (Bogaert & Skorska, 2020). Differences in size, number of neurons, and activation levels in specific regions of the brain (e.g., the third interstitial nucleus of the anterior hypothalamus and the anterior hypothalamus), for example, have been identified in heterosexual, as compared to homosexual, males. Genes, including distinct patterns of methylation (i.e., activation or inactivation) on the X chromosomes and specific autosomes, may also play a role in sexual orientation development, specifically in gay males. There is also

evidence to suggest that a correlation between handedness and sexual orientation exists, which is influenced by genes. Both males and females with same-sex attraction have a higher rate of left-handedness than heterosexual individuals; however, the effect sizes of these findings are more significant in females than males. Prenatal hormones are also suspected to impact sexual orientation development. In reviewing a number of studies, Bogaert and Skorska also found consensus that gay—as compared to heterosexual—males were prenatally exposed to a lower amount of androgen, while lesbian—as compared to heterosexual—females were prenatally exposed to a greater amount of androgen; again, these findings appear to be more significant in female individuals compared to males.

The fraternal birth order effect (FBOE), defined as "the phenomenon of [males] with same-sex attraction having a greater number of older brothers (but not sisters) than heterosexual [males]" also suggests that biological influences are at play in the process of sexual orientation development (Bogaert & Skorska, 2020, p. 3). In support of the biological component, research indicates that mothers who are pregnant with male-designated fetuses produce "antibodies to proteins specific to male brain development," which "increase in concentration with each gestation" of a male-designated fetus; higher levels of prenatal exposure to these antibodies are associated with differences in areas of the brain that are correlated with sexual attraction development (Bogaert & Skorska, 2020, p. 3). While prenatal influences are evident, Balthazart (2017) suggested that FBOE likely cannot be attributed to biology alone. Although previous theories relating sexual orientation development to maternal/paternal age and social interactions between multiple male fraternal or stepsiblings have been largely rejected, sexual orientation is likely a function of both biological prenatal influences and the postnatal environment.

In identifying common milestones of sexual orientation identity development through a meta-analysis of over 3,200 peer-reviewed articles, Hall and colleagues (2021) found that Millennials in the United States achieve the 5 most common milestones (i.e., same-sex or queer attraction, self-identity, first experience of sexual activity, coming out to others, and first experience of engaging in a same-sex or queer romantic relationship) earlier and in the shortest amount of time, compared to previous generations. These findings support the theory that environmental factors, specifically the shifts in societal views like more accepting attitudes toward LGB+ people and sex-positive parenting, may facilitate the sexual development process of LGB+ youth. Biological perspectives regarding the observance of earlier milestone achievement suggest that the earlier onset of puberty, particularly among female adolescents, is correlated with these earlier achievements; however, this too is theorized to be environmentally mediated. Oehme and colleagues (2020, p. 3) argued that although genetics undoubtedly play a part in the earlier onset of puberty, "lifestyle factors such as nutrition, general health, psychosocial stress, perinatal factors, body composition, and environmental factors such as endocrine disruptors" account for much of the variation as well.

Despite the ongoing nature versus nurture debate regarding sexual orientation, the fluidity of sexuality as a whole, which is conceptualized as shifts in sexual identity (i.e., sexual orientation, attraction, and partnering behavior) (Hanley et al., 2015), has been well documented for decades. In their seminal work, Kinsey and colleagues (1948) argued that humans are the only living beings who "[invent] categories and force facts into separated pigeon-holes" (p. 639); instead, they asserted "the living world is a continuum in each and every one of its aspects" and encouraged their readers to recognize that sexual behavior also exists along a spectrum. Kinsey and his colleagues famously created a "heterosexual-homosexual rating scale" (colloquially

known as the "Kinsey scale") to reflect the variability of human sexuality observed in their research. Although their scale includes only seven categories, ranging from exclusively heterosexual to exclusively homosexual, Kinsey and colleagues specifically noted that "individuals in the population [occupy] not only the seven categories which are recognized [on the scale] but every gradation between each of the categories as well" (p. 639). Furthermore, Kinsey and others argued that individuals might be assigned to different positions on the scale across time and relationships.

In 2008, Peter Benson applied Kinsey's scale of human sexuality to relational styles; he posited that similar to sexual orientation, monogamy and CNM exist on a spectrum. He further speculated that one's self-identified position on this spectrum is likely to change across the lifetime and with respect to different relationships. Rubin and colleagues' (2014) findings regarding the fluidity or stability of a CNM identity were inconclusive; however, the potential fluidity of CNM partnering styles remains an area of interest, and in 2019, Thorne and colleagues again theorized, "if sexual identity is not always static, and sexual desire and romantic love are independent systems, people may, as a consequence, experience different types of love in their lifetime" (p. 251).

Regarding the fluidity of sexual orientation across the lifespan, Kinsey and colleagues' (1948) theory was recently supported by Hanley and colleagues' (2015) work. In comparing the self-reported sexual identity of monogamous and polyamorous participants at two points in time (i.e., seven months apart), Hanley and colleagues found that although relational and sexual identity (i.e., how one defines their relationship and how one defines their sexual orientation, respectively) remained relatively stable, shifts in sexual attraction were identified. These shifts in

sexual attraction were most commonly observed among participants with gender-nonexclusive (e.g., bisexual) attractions, especially among polyamorous females.

Because these females identified as polyamorous, it is important to consider the rules of their existing relationship(s) and implications for the pursuit of additional ones. It is possible that the negotiated boundaries of their current relationship(s) may prevent them from acting on any changes in sexual attraction (i.e., engaging with additional partner[s] romantically or sexually) without first consulting and gaining consent from their current partner(s). Alternatively, it is possible that approval is not necessary or has already been obtained by the polyamorous unit, but an additional partner has not yet been identified, thereby eliminating the need to redefine the relationship. Furthermore, a gender-nonexclusive sexual orientation may already account for shifts in sexual attraction; Robinson (2013) commented on the experience of sexual fluidity among bisexual women, noting that conceptualizing CNM, specifically polyamory and monogamy as “strategic identities,” accommodates the identity shifts that typically occur within this subset of the CNM population. Additionally, it is possible that these females did not act on their shifting sexual attraction due to the demands of psychosocial factors (e.g., life stressors related to family, employment, health), which impeded them from seeking out additional partner(s), despite a shift in sexual attraction.

Sizemore and Olmstead (2017) also found that, compared to males, females reported more active sexual identity exploration across the lifespan, which was associated with increased willingness to engage in sexual experimentation. As proposed by Rubin and colleagues (2014), participation in sexual exploration may in and of itself influence an individual’s understanding of their sexual identity. Differences in the reported sexual fluidity of males and females may be explained by slightly higher rates of internalized stigma among gay and bisexual men, which

may prevent them from reporting, accepting, or acting on changes in sexual attraction (Hall et al., 2021). Alternatively, it may be true that females experience more variation in sexual attraction than males.

Instead of continuing to engage in the circuitous debate regarding the fixed or fluid nature of sexual identity, perhaps it is more fruitful to accept a middle ground, as proposed by Evans and colleagues (2010): it is likely that "people experience and make meaning of their sexual [identity] in a variety of ways," with some individuals "experiencing it as a central, stable, and fundamental part of who they are and others experiencing more fluid identities" (p. 307). While individuals who view their sexuality as innate and unchanging would argue that their sexual orientation, attraction, and partnering behaviors are predetermined, those who view their sexuality as fluid readily accept that they have the freedom to explore and redefine their sexuality over their lifetime (Barker, 2005). Furthermore, how one perceives their sexual identity is inherently influenced by the social norms of the culture in which they exist; because cultures vary across time and place, we must recognize "human sexuality [is] as much a social construction as any other aspect of human functioning" (Worthington et al., 2002, p. 506). In other words, it is likely impossible to determine with absolute certainty whether sexual identity is truly a fixed or fluid phenomenon.

Models of Sexual Identity Development. Currently, no identity development model specific to CNM individuals appears to exist. As such, the following discussion is based on historical and current literature regarding models of development for sexual orientation and kink identity; these identity development models were chosen because research suggests that, although the relative incidences remain up for debate, both heterosexual and LGB+ individuals engage in CNM relationships (Balzarini et al., 2018a; Haupert et al., 2016; Moors, Schechinger

et al., 2021; Rubin et al., 2014; Sheff, 2014) and significant overlap between the CNM and kink communities has been identified (Carlström & Andersson, 2019b; Vilkin & Sprott, 2021). The hope is that by looking at established models of development related to some of the intersecting identities of CNM individuals, readers may be able to gain a more global understanding of CNM sexual identity formation. A more thorough discussion on intersecting identities follows.

Cass's Gay and Lesbian Identity Development Model. Vivienne Cass (1979, 1996) developed one of the earliest and most renowned models of sexual orientation development for gay men and lesbians. In her model, Cass outlined six stages of "homosexual" identity development: identity confusion, identity comparison, identity tolerance, identity acceptance, identity pride, and identity synthesis. In this model, it is assumed that each individual begins at stage one (i.e., identity confusion), when an incongruence between a heterosexual self-perception and internal lesbian/gay (LG) thoughts and feelings is first identified; the individual then progresses through the next five steps, but only if they are actively engaging in the identity development process. Following initial acknowledgment of the incongruence in actual versus ideal self-perception, Cass posited that LG individuals move into a stage of identity comparison, where they begin to accept the possibility that they may identify as LG. This stage is expected to result in the experience of alienation, which can only be overcome by a growing sense of tolerance and eventual, potentially begrudged, acceptance of an LG identity (i.e., stages three and four). Stage five (i.e., identity pride) is supposed to be colored by devaluation of heterosexual individuals and a growing "us versus them" mindset; rejection of heteronormative values; anger "born of frustration and alienation"; and "purposeful confrontation with the establishment" (i.e., society; Cass, 1979, p. 233). In the final stage (i.e., identity synthesis), the individual is expected to continue to experience anger and pride, but with less intensity than in the previous stage. It is

assumed that, in having moved through all six steps, the individual's "personal and public sexual identities [would] become synthesized" as they come out to their interpersonal environment (Cass, 1979, p. 234).

Comments on Cass's Model. To her credit, Cass (1979) acknowledged that her six-stage model of sexual orientation identity development would not "be true in all respects for all people" and asserted "over time, changes in societal attitudes and expectations" would be expected, requiring the model to be updated (p. 235). She was right; in analyzing her original model through a present-day lens, various weaknesses exist. Perhaps most obvious is the lack of generalizability to bisexual and Black, Indigenous, or people of color (BIPOC) individuals, in addition to adults in the United States, since the original and subsequent data were normed on gay men and lesbians in Australia (Cass, 1979, 1996). Her model, along with other gay identity models of that era, is whitewashed and offers a biased perspective of development. The assumption that individuals will fall into identity foreclosure, where they will remain frozen in a stage of development if they do not actively engage in the identity development process, is also problematic. It is now known that sexual orientation is at least partially mediated by genetics, and to insinuate that individuals will only learn to identify as LG if they have intentionally moved through Cass's six proposed steps would be ludicrous. Additionally, Cass's model is linear and does not allow for deviations from the stepwise progression; recent evidence suggests an endless number of ways to achieve a healthy understanding and acceptance of one's LG identity (Evans et al., 2010).

Cass's assumptions that individuals in stages one and two experience confusion and alienation have also been disproved. As Hall and colleagues (2015) pointed out, not all LGB+ children and adolescents experience a sense of confusion, uncertainty, or feeling different from

others; again, this is likely a byproduct of greater social and parental acceptance of LGB+ identities. Cass's model also assumes that for an individual to achieve identity synthesis, they must pass through a stage of activism and eventually publicly come out as LG (Cass, 1979). These assumptions have also been rejected, as it does not consider sociopolitical influences or cultural variations (Evans et al., 2010).

The impact of social stigma and discrimination associated with multiple intersecting minority identities—which is explored further in the following section—on sexual orientation development has also been omitted from Cass's original model. It is now widely understood that the process of sexual identity development can be experienced as more difficult for members of minority groups who already experience stigma and discrimination, such as individuals who are BIPOC (Evans et al., 2010). Relatedly, Cass's model does not account for cultural differences in "social constructions of sexual orientation, cultural values about sexuality, and institutional policies and practices about sexual orientation" (Hall et al., 2021, pp. 3-4).

One of the most important lessons we can learn from Cass's model is that social norms, which are determined according to the values of the majority group, greatly impact society's view of minority groups, leading to marginalization and pathologization of typical human processes, including those related to sexual identity development. The assumptions that all LG individuals move through stages of confusion, anger, and activism as they develop their sexual orientation identity are reflective of social and political forces of the 1970s and serve as prime examples of this phenomenon (Evans et al., 2010). Furthermore, because social norms are culturally dependent and invariably change from one generation to another as shifts in power and visibility occur, it is important to recognize that our understanding of the CNM population, including the identity development process, will likely need to be revised over time.

Fassinger's Model of Gay and Lesbian Identity Development. Recognizing the weaknesses in previous models of sexual orientation identity development, McCarn and Fassinger (1996) created a more inclusive and culturally aware model of lesbian identity formation. The model was later expanded to encompass the identity development process of gay men and bisexual individuals as well (Fassinger, 1998; Fassinger & Miller, 1996). Fassinger's model comprises two parallel processes (i.e., individual sexual identity and group membership identity) that are each broken down into four phases. These processes are "reciprocal and mutually catalytic," and although they may occur simultaneously, it is possible for an individual to be in two different phases related to the two processes (Fassinger & Miller, 1996; McCarn & Fassinger, 1996, p. 526). Additionally, McCarn and Fassinger specifically noted that progress through these phases is "continuous and circular," noting that an individual may move through the same phase multiple times over their lifetime as they engage in new relationships and exist within different social contexts (p. 522).

The first phase of Fassinger's model is awareness (Fassinger & Miller, 1996; McCarn & Fassinger, 1996). Regarding individual sexual identity, this phase is typically defined by the internal experience of being different from others; in terms of group identity, individuals in this phase become aware that a variety of sexual orientations exist in the world. The second phase is exploration, which encompasses the individual's experience of becoming aware of strong emotional or erotic feelings toward a member of the same sex; alternatively, the group experience is defined by an exploration of personal attitudes regarding the LG community and assessment regarding personal identification with the community. In phase three (i.e., deepening/commitment), the individual begins to identify as LG as they achieve a higher level of self-awareness and internalization of their sexual identity. The deepening/commitment phase of

group identity development is defined by increased awareness of the oppression of the LG community, identification with the LG community, and a unique combination of affective experiences ranging from "excitement, pride, rage, and internal conflict," among others (Fassinger & Miller, 1996, p. 525). Finally, the individual approaches the fourth phase: internalization/synthesis. In this phase, the individual's LG identification becomes synthesized with their overall identity, and they may or may not choose to share their sexual orientation with others. Within the group identity process, individuals in this final phase begin to identify with the LG community, which is presumed to result in feelings of "fulfillment, security, and an ability to maintain" their LG identity across contexts (Fassinger & Miller, 1996, p. 525).

Comments on Fassinger's Model. Fassinger's model has many strengths, including the achievement of empirical evidence to support the application of her model not only to lesbians but to gay men and bisexual individuals as well (Fassinger, 1998; Fassinger & Miller, 1996; McCarn & Fassinger, 1996). Fassinger's intentional decision to use the term phase instead of stage to describe each period of development also served as a strength; in doing so, Fassinger not only allowed for but also validated the normalcy in a nonlinear process of sexual self-identification. Additionally, Fassinger's emphasis on the dual processes of individual and group identification moved away from previous models' tendency to focus too frequently on either: (a) the internal experience of increased self-awareness and eventual acceptance of an LG identity or (b) community influences on the self-identification process, including social norms, experiences of stigma and discrimination, and coming out (Evans et al., 2010). Perhaps most importantly, Fassinger acknowledged "disclosure behaviors [do not necessarily serve] as evidence of developmental advancement" and recognized that coming out in an oppressive environment could subject the individual to undue harm (McCarn & Fassinger, 1996, p. 522).

Fassinger achieved her primary goal of addressing and amending a variety of weaknesses in previous models and developed a model that was objectively more inclusive than those previous models; however, her model of sexual identity development also fell short in acknowledging the potential impact of specific intersecting identities, which could have a significant impact on the self-identification process (e.g., religion, social class, disabilities). Additionally, Fassinger's first phase assumes that LGB individuals encounter a state of confusion and see themselves as different from others; again, this notion has been refuted in recent works, which indicate that not all LGB individuals experience feelings of differentness (Hall et al., 2021). Last, although it is not explicitly stated, it appears that Fassinger also conceptualized the self-identification and self-actualization processes as active ones; this assumption has since been refuted, as contemporary literature supports the notion that individuals can move consciously or unconsciously through phases of identity development based on social, cognitive, and behavioral learning experiences (Evans et al., 2010).

Fassinger's model (Fassinger, 1998; Fassinger & Miller, 1996; McCarn & Fassinger, 1996) highlights the importance of acknowledging that individuals with more than one intersecting identity that departs from the status quo are likely to experience radically different and increasingly complex, processes of identity development compared to individuals who conform to heteronormative and mononormative social norms. Additionally, despite Fassinger's concerted efforts to make her model as inclusive as possible, we can recognize that it continues to fall short. This is a valuable lesson in humility but also serves as a reminder that cultural competency is an active, lifelong process; it is not something anyone can fully achieve. Fassinger's recognition of the fluid and perhaps circular nature of identity development also helps to validate the lived experience of individuals who experiment with their sexuality over the

lifespan. In relating these takeaways to the CNM population in particular, it is imperative that clinicians—and society in general—remain curious and open-minded to the lived experiences of CNM individuals. Additionally, in normalizing the fluid and sometimes circular processes of sexual exploration and self-identification related to sexual attraction, orientation, and partnering styles, we may be able to help increase awareness of these natural human processes and reduce the impact and experience of internalized shame in minority group individuals.

Identity Development Milestones Meta-Analysis. Through a systematic review of over 3,200 peer-reviewed articles and a subsequent meta-analysis, Hall and colleagues (2021) identified a variety of milestones in sexual identity development. In this brief discussion, the five most common milestones were explored: (a) same-sex or queer attraction, (b) self-identification as LGB+, (c) first sexual experience with a same-sex or queer individual, (d) coming out to others, and (e) engagement in a same-sex or queer romantic relationship. In contrast to earlier developmental models suggesting that LGB+ individuals move through fixed stages or continuous and circular phases of identity development, Hall and colleagues suggested a cascade model of development, "in which early sexual experiences serve as bases for and influence future sexual experiences in the life course" (Hall et al., 2021, p. 11). In other words, the aforementioned milestones are not expected to occur in any specific sequence; however, some milestones appear to be foundational (e.g., attraction). Self-identification as LGB+ and sexual activity with a same-sex or queer individual, for example, are not likely to occur without an individual first experiencing attraction to same-sex or queer individuals.

Though these milestones may be achieved in any order, some dominant sequences emerged (Hall et al., 2021). For example, awareness of same-sex attraction typically occurs during early adolescence and may or may not be accompanied by confusion or questioning of

their sexual orientation. Additionally, males generally reached the attraction and self-identification milestones prior to females; however, these differences were less noticeable among Millennials, which may be attributed to increased acceptance and visibility of LGB+ identities in the United States in recent years. Self-identification as LGB+ and first sexual experience with a same-sex or queer individual typically follow, occurring in late adolescence. Again, sex differences were noted, with males typically engaging in sexual activities before females. Hall and colleagues suggested that these observed differences may result from societal values in the United States, which praise the pursuit of sexual encounters in males and simultaneously demand that females suppress their sexuality. Entering into a same-sex or queer romantic relationship and coming out to others tend to occur next during the period of emerging adulthood; however, as Hall and colleagues noted, the coming out process typically occurs over the lifetime with various people and across a variety of settings. Alternatively, an LGB+ individual may choose not to come out at all or may selectively come out to specific individuals in their lives. Overall, LG individuals tended to achieve these five milestones before bisexual individuals. Hall and colleagues postulated that individuals with an emerging bisexual identity might experience higher levels of confusion or uncertainty regarding their sexual orientation, which can result in delayed arrival at each of these milestones. The minimization and questioning of a bisexual identity as valid, and higher levels of stigma toward bisexual males, may also play a part in this phenomenon.

Meta-Analysis Comments. Hall and colleagues' (2021) identification of the five most common milestones, among many others, which have not been included in this paper for the sake of brevity, can help mental health clinicians to facilitate the process of sexual identity development not only in LGB+ clients/patients but in CNM individuals as well. If, for instance, a

client/patient presents to therapy in search of support around their sexual identity exploration, their clinician can provide psychoeducation around these common milestones of sexual identity development, which may help to normalize their experience. Additionally, Hall and colleagues' recognition that a variety of identity development pathways exist helps to de-pathologize individuals who deviate from a specified course and can encourage individuals to more readily explore their unique path to self-identification.

Multidimensional Model of Heterosexual Identity Development. One of the more comprehensive models of sexual identity development is Worthington and colleagues' model (2002). Like Fassinger (Fassinger, 1998; Fassinger & Miller, 1996), Worthington and colleagues proposed that heterosexual individuals move through two parallel, reciprocal processes (i.e., individual sexual identity and social sexual identity) as a part of their sexual identity development. Five identity development statuses that apply to both the individual and social domains of development were identified: (a) unexplored commitment, (b) active exploration, (c) diffusion, (d) deepening and commitment, and (e) synthesis. While most people are likely to begin in the unexplored commitment status, Worthington and colleagues emphasized that the statuses are fluid and can be revisited multiple times throughout the lifetime. Additionally, the statuses may be achieved consciously or unconsciously, through behavioral and/or cognitive experimentation (Evans et al., 2010).

In the unexplored commitment status, most individuals are aware of and operate within socially normed gender roles and sexual behavior; conversely, the active exploration status is defined as a period of purposeful, goal-directed evaluation of one's sexual needs, values, and preferences for sexual activities, regardless of whether they conform to or deviate from social norms (Worthington et al., 2002). Active exploration may be behavioral (i.e., engaging in sexual

acts) or cognitive (i.e., discussions with self or others) and typically results in self-identification as part of the dominant heterosexual group. This group identity may "result in: (a) questioning the justice of a privileged status or (b) more consistently asserting the privileges of majority status" (Worthington et al., 2002, p. 517). Deepening of and commitment to one's heterosexual identity allows the individual to move toward their identified needs, values, and preferences for activities, resulting in crystallization of their heterosexual group identity. Synthesis is described as a stage of enlightenment, where the individual's "individual sexual identity, group membership identity, and attitudes toward sexual minorities merge" (Worthington et al., 2002, p. 519). The diffusion status can be entered into at any time in the sexual identity development process and is usually a result of crisis and is characterized by an individual's rejection of social or cultural values without goal-directed evaluation or intentionality.

Further expanding on their model, Worthington and colleagues (2002) emphasized the importance of biopsychosocial influences on an individual's progression through both their individual and social identity development processes; these influences include: (a) biology, (b) microsocial context, (c) gender norms and socialization, (d) culture, (e) religious orientation, and (f) systemic homonegativity, sexual prejudice, and privilege. Some biological influences (i.e., genetic, hormonal [prenatal], and pubertal/maturational) of sexual identity development were briefly discussed at the start of this chapter. Worthington and colleagues also highlighted that "sexual development is a multistep and multi-gated process leading to substantial variation in anatomy, psychology, and behavior" (p. 503). According to this model, one's sexual identity development is also influenced by both the micro- and macrosocial contexts in which they exist; while the microsocial environment is limited to immediate relationships (e.g., family, peers, neighbors, coworkers), the macrosocial environment encompasses the attitudes, beliefs, and

values held by one's culture. Gender norms and socialization, which are also defined by one's culture, dictate the approved characteristics, roles, and sexual behaviors of each gender. Worthington and colleagues argued that gender-specific expectations are internalized "through language and discourse about gender" (p. 504) and are based in heteronormativity in the United States, which results in homonegative prejudice and heterosexual privilege. Last, Worthington and colleagues recognized the impact of religious orientation on sexual identity development, noting that sexual behavior and specific values regarding sexuality are largely regulated by religious beliefs.

Comments on Heterosexual Identity Model. Worthington and colleagues' (2002) model of heterosexual identity development has many strengths, including their recognition of simultaneous individual and group identity processes, their understanding of the sexual identity development process as ongoing and potentially nonlinear, and their acknowledgment of a variety of influences on the identity development process. Their emphasis on sociocultural influences (specifically, their explicit recognition of the impact of systemic homonegativity, sexual prejudice, and privilege on sexual identity development and identification) is particularly salient to this research paper. Discussions surrounding the implications of heteronormativity and mononormativity can be found later in this chapter and in Chapter 4.

Hughes's Model of Kink Identity Development. Because CNM is not a sexual orientation but rather an intentional partnering style, it would be beneficial to explore the development of another intentional sexuality-based identity as a comparison: kink. Similar to CNM, *kink* is an umbrella term; it encompasses a variety of behaviors (e.g., bondage and discipline, dominance and submission, sadism and masochism [BDSM]; fetishism; role-playing) that may or may not be explicitly sexual in nature (Aaron, 2018; Vilkin & Sprott, 2021).

As proposed by Hughes (2018), kink identity development occurs in five stages, starting in early childhood: early encounters, exploration with self, evaluation, finding others, and exploration with others. Hughes found that many of the individuals in his studies who self-identified as “kinky” and would consider themselves to be in the BDSM lifestyle experienced kink-related attractions early on in life, such as a child desiring to be captured by an opponent during a game of tag. Hughes posited that kinky individuals go on to fantasize about kink play, sometimes seeking out erotic media (i.e., porn) before entering into a self-evaluative phase, where they may grapple with feeling different from their peers, internalized stigma, and exploring what their kink interests mean for them. Beyond the evaluation phase, kinky individuals discover that other kinky individuals exist, which can facilitate the process of developing a positive kink-related identity. Kinky individuals may then begin to engage in sexual experimentation involving kink interests with others.

Comments on Hughes’s Model. CNM individuals likely experience a similar developmental process as kink-oriented individuals. According to Barker (2005), the CNM identity is constructed through “negotiating potentially conflicting discourses around difference and sameness, identity and behavior, [and] nature and choice,” which parallels the proposed model for kink identity development (p. 86). In addition to their shared experience of transgressing from heteronormative and mononormative relational structures, the kink and CNM communities both rely on shared values for responsible play, including consent, clear negotiations and explicit agreements, safety, and a culture of acceptance and open-mindedness (Carlström & Andersson, 2019b). Additionally, the lived experience of both kinky and CNM individuals is largely silenced in U.S. culture (Aaron, 2018). This phenomenon is evident in the exclusion of kink and CNM practices in sex education programs and diversity courses, along

with the demonization of these practices in religious teachings, politics and law, and media representations. It is likely that as a result of these exclusionary practices, individuals who identify with either (or both) of these communities consequently feel ostracized from the general public, which may result in experiences of internalized stigma and shame. Hughes's model of kink identity development combats these negative experiences by normalizing a variety of sexual fantasies and desires that deviate from the status quo, which are experiences many, if not all, CNM individuals experience as well.

Finding the 'Right' Language

Despite their differences, one common theme throughout all of the aforementioned models of identity development is self-identification, which inherently requires the establishment of vocabulary. Language is important for a variety of reasons, many of which are beyond the scope of this paper; however, what is important to note in the context of this discussion is that language allows us to share our thoughts, feelings, and values with others, which helps to create meaningful interpersonal connections and allows us to better relate to and understand ourselves. In other words, our ability to self-identify is reliant on the language that is available to us (Ritchie & Barker, 2006).

In instances where language used to describe a lived experience does not exist, alternative languages must be developed, or existing terms must be redefined and reclaimed. To this effect, the production of vocabulary provides power. With the emergence of the term *gay* in the 1970s, for example, many homosexual men were able to establish "a clear social identity, which offered a previously unavailable sense of security and community," and eventually led to significant political policy changes (Ritchie & Barker, 2006, p. 585). Similarly, in an effort to claim power in their sexual practices, the kink community developed the terms *kink* and *kinky* to replace

fetishism and *sadomasochism*, terms previously imposed on them by the medical and scientific communities (Hammack et al., 2018). It is important to note that the adoption of labels is not desired by all; in fact, instead of experiencing a sense of empowerment, some may view labels as restricting, and it is important to respect individual preferences regarding labels.

In a review of the literature regarding language development and reclamation, Ritchie and Barker (2006) identified three distinct reasons for which CNM individuals construct new languages: "to claim identity, [to] define relationships, and [to] describe feelings" (p. 585). As was previously mentioned, language allows for self-identification, something noted in many of the models of identity development and typically facilitates the process of group identification. The literature regarding the benefits of group identification is robust and will not be fully explored here. In brief, group membership is associated with higher self-esteem and more positive mood (Knowles & Gardner, 2008), a reduction in depressive symptoms and experiences of loneliness (Cruwys et al., 2013), and can help to "bond people together . . . [and] enable political action on behalf of the group" (Robinson, 2013, p. 23).

Conventional language used to describe relationships in the United States, such as the ultimate dream of finding "the one," is based in heteronormativity and mononormativity and therefore revolves around the idealized concept of a monogamous, heterosexual couple. Because CNM relationships inherently involve more than two people and often deviate from heteronormativity, this conventional language is inadequate to describe the complexities of the relationships between all those involved. The term *metamour*, for example, was established by the polyamorous community to describe a partner's partner, a phenomenon that is not considered to be a part of monogamous relationships. Complex feelings unique to CNM relationships also deserve their own terminology. One such example is experiencing joy about a partner(s)'

happiness related to their relationships and experiences with other partners; this feeling has been labeled *compersion* (Ritchie & Barker, 2006).

Intersecting Identities

In 1996, Pamela Hays developed a model of nine “complex and overlapping” (see abstract) domains of identity, which she organized into the acronym ADDRESSING. The nine domains of identity as defined by Hays’s model are: (a) age and generational influences, (b) disability, developmental or acquired later in life, (c) religion, (d) ethnicity, (e) social status, (f) sexual orientation, (g) Indigenous heritage, (h) national origin, and (i) gender. Although her model is far from comprehensive, it provides an invaluable structure of identity factors that are important for clinicians to consider in their work with clients/patients, especially when working with individuals who are actively marginalized, such as the CNM population.

Hays (1996) outlined at least three ways that clinicians can use her model in their work: (a) to identify and challenge their own biases, which is discussed in Chapter 4; (b) to achieve greater awareness regarding the impact of oppression (e.g., racism, heterocentrism) on client/patient functioning, which is discussed later in this chapter and in Chapter 4; and (c) to consider how client/patient identity factors impact their self-identity development process and related health, which is the focus of the present discussion.

Each of the ADDRESSING domains exists along a continuum acknowledging that majority groups possess social and political power over minority groups; majority group power is perpetuated through overt or covert discrimination, marginalization, and oppression of minority groups (Hays, 1996). Let us look at sexual orientation, for instance. In this case, sexual minorities (LGB+ individuals) are stripped of power by pervasive heterosexism, which stereotypes and discriminates against them based on their sexual orientation. In a landmark

decision in June 2020, the U.S. Supreme Court ruled that employment discrimination based on an individual's identified sexual orientation violates their civil rights (Legualt et al., 2020). Though the ruling was a wonderful, albeit desperately overdue, step toward actualizing gender equality, discrimination based on sexual orientation and gender identity continues to persist in other areas, such as adoption and fostering (Movement Advancement Project, 2022). As Thorne et al. (2019) cautioned, it is important to "remain vigilant against a modern prejudiced attitude that might assume that because equality has been achieved in law [to some extent], heterosexism and heteronormativity are no longer cautions of concern" (p. 249).

Simultaneously navigating multiple minority identities can be extremely difficult, as it may result in facing oppression on multiple levels. In a study examining college-aged African American men who have sex with other men (AAMSM), many participants reported experiencing discrimination and stereotyping related to both their race and their sexual orientation (Goode-Cross & Good, 2009). As an aside, this study provides one example of why individuals may reject labels; many of the men in this study expressed negative views of gay and bisexual men, which they largely attributed to African American cultural values and norms, and instead referred to themselves as AAMSM or same-gender-loving men. Their rejection of the gay label may also indicate internalized experiences of stigma and shame, which likely contributed to reported distress related to fear of perceived or actual rejection from others. Specifically, many of the AAMSM feared if they disclosed their sexual orientation to other members of the African American community, they would be ostracized from a community that provided them a refuge from experiences of racism; however, they also found it difficult to align themselves with a predominantly White LGB+ community. In other words, because they felt

they did not fully fit into either the African American or LGB+ communities, these men viewed themselves as living on the fringes of both.

Another study investigated the experiences of lesbian, bisexual, queer, and pansexual women and nonbinary individuals of Latinx and/or African American descent (Cerezo et al., 2020). In this study, experiences paralleling the previously mentioned AAMSMs emerged. The participants reported experiences of pressure from families of origin to conform to typical gender norms; struggles to find the freedom to explore their identity; engagement in constant internal negotiations related to prior experiences of being "othered" but continuing to feel like an outsider; and eventually finding self-acceptance and synthesizing all of their identities into one. As was noted in the paper, "arriving to an integrated identity that was inclusive of their lived experiences was achieved in the face of repeated, ongoing experiences of marginalization and exclusion" (p. 77).

Taken together, it is imperative for clinicians to understand the implications of multiple minority identities on the identity formation process. Regarding the CNM population, in particular, demographic data alone suggest a variety of identity-based intersections (e.g., age, race and ethnicity, sexual orientation, sex and gender identity) that should be explored. Some additional identity-related domains that may be important to consider when working with the CNM population include gender expression, sex assigned at birth, body size, and perhaps most importantly, the nuances of their relationship style.

Minority Stress

The minority stress model, originally proposed by Ilan Meyer (2003), asserts that disproportionate experiences of negative mental health outcomes in individuals belonging to stigmatized minority groups (compared to the general public) are a product of stressful and

rejecting social environments. While Meyer's work focused on gender and sexual minority groups, the intersection of multiple minority identities within the CNM community suggests that the tenets of minority stress theory can be extrapolated to CNM individuals as well.

Meyer (2003) argued that minority stress is: (a) unique (i.e., additional to stressors that are experienced by the general public), (b) chronic (i.e., related to social structures), and (c) socially based (i.e., related to both individual experiences and systemic processes of heteronormativity and mononormativity).

In assessing experiences of identity-based discrimination specifically for polyamorous folx, Fleckenstein and colleagues (2013) found that while a small portion (5.5%) of the general population endorsed experiences of discrimination in the previous 10 years, over 28% of the polyamorous participants reported experiences of identity-based discrimination. Experiences of discrimination were particularly common among polyamorous women, further bolstering the aforementioned sexual double standard theory. Additional research indicates, compared to monogamous individuals, CNM folx are also more likely to endorse experiences of emotional abuse, physical abuse, and sexual assault in the past 12 months (Borgogna et al., 2021). Though experiences of emotional and physical abuse did not appear to be directly related to the participants' CNM identities, experiences of sexual assault tended to be identity-based.

Furthermore, the "additive effects of multiple minority identities" likely result in unique experiences of stress in CNM individuals, as they must learn to navigate each of the identities while existing in oppressive sociocultural environments (Borgogna et al., 2021, p. 3). Specific to the CNM community, it is likely that heteronormative and mononormative sociocultural pressures negatively impact CNM individuals' overall happiness and satisfaction (Killeen, 2022). Taken together, individuals who experience identity-based rejection and discrimination are

subject to greater overall stress and are required to engage in greater adaptation efforts than others who are not stigmatized.

Internalized Stigma

Heteronormative, mononormative, and other biases related to minority identities are implicitly and explicitly perpetuated throughout U.S. society on a variety of levels (e.g., family, peers, media, politics, religion). Through consistent interactions with these social systems, the heteronormative and mononormative beliefs and values (e.g., being heterosexual and monogamous is normal) are learned by the individuals of that society, and when an individual's developed self-identity departs from heteronormative and mononormative expectations, biased sociocultural judgments may be turned inward (Lin et al., 2019). This phenomenon can result in identity-based shame and is often referred to as internalized stigma (Meyer & Frost, 2012). Internalized stigma is associated with deleterious effects on interpersonal functioning, relationship quality, and overall well-being, and the effects of internalized stigma may be compounded by fears of judgment and/or rejection by others (Meyer & Frost, 2012; Moors, Schechinger et al., 2021). Furthermore, the experience of internalized stigma is also associated with negative psychological health outcomes, such as low self-esteem, low self-efficacy, and greater psychological distress (Drapalski et al., 2013). Physical health correlates are discussed below.

Moors, Schechinger, and colleagues (2021) identified three distinct ways that internalized CNM negativity might materialize: (a) personal discomfort, (b) social discomfort, and (c) public identification. An individual who experiences internalized stigma as personal discomfort may wish to change their relationship style or may endorse CNM as unnatural. Someone who experiences internalized stigma as social discomfort may notice heightened levels of distress

when surrounded by CNM individuals or in CNM-friendly communities. Those who experience internalized stigma related to public identification may avoid or attempt to avoid being seen in public spaces with other CNM individuals for fear of being noticed. Thus, these forms of internalized stigma can interfere with sexual self-identity, group identification, and healthy interpersonal functioning—all of which are important for overall well-being. Of these three manifestations, personal discomfort appears to be the most detrimental, as it tends to be associated with “lower satisfaction with romantic and sexual relationship agreements, global relational satisfaction, and commitment” (Moors, Schechinger et al., 2021, abstract).

Rejection Identification

Increased experiences of anxiety, vigilance, and internalized stigma in minority group members are associated with fears of rejection and ostracization by dominant social groups (Meyer, 2003); however, actual or perceived rejection from the dominant group can also lead to increased levels of in-group identification and identity centrality (i.e., identity salience; Branscombe et al., 1999; Hinton et al., 2022; Ramos et al., 2012). The rejection identification model (RIM; Branscombe et al., 1999) suggests that increased group identification can buffer stigmatized individuals from the negative effects of discrimination and can help marginalized individuals to build more meaningful, positive self-concepts. In other words, by developing a sense of pride in their identity, stigmatized individuals can more readily question the nature of a stigma’s existence rather than incorporating negative pieces of the marginalized identity into their self-concept. RIM’s proposed directional effect was validated by Ramos et al. (2012), who found that perceptions of discrimination led to greater minority group identification and identity centrality rather than the other way around.

RIM additionally suggests that while group identification can serve as an effective defense against stigma and discrimination, it can also serve as a bonding, celebratory function and can prompt collective efforts toward social and political reform (Branscombe et al., 1999). Increased group identification has also been associated with lower rates of depression and psychological distress (Ramos et al., 2012), as well as lower rates of identity concealment, less identity uncertainty, less internalized stigma, and greater outness (Hinton et al., 2022). Though all of these outcomes point to increases in global well-being, it is important to note that identity centrality is also related to increased experiences of prejudice and greater stigma sensitivity; thus, although group membership can have positive psychological effects, it does not mitigate all of the negative impacts of stigma and discrimination. Furthermore, group identity and identity centrality may not be important to all minority individuals. For instance, Hinton and colleagues found that bisexual individuals tended to endorse lower levels of identity centrality, noting that it did not feel important for them. These findings suggest that individuals who are sexually attracted to more than one gender may find the bisexual identity label insufficient or inaccurate; this serves as another example of individual preferences regarding labels. Alternatively, Hinton and colleagues theorized that because bisexual individuals tend to experience prejudice from gay, lesbian, and heterosexual communities, they may experience a decreased sense of belonging or increased internalized stigma related to their sexual orientation identity.

Attachment and CNM

Attachment theory has become the gold standard in understanding interpersonal functioning, as it helps to conceptualize the establishment and maintenance of interpersonal relationships. Attachment styles are also related to an individual's understanding of self (e.g., self-concept) and others (Ainsworth et al., 1978/2014; Bowlby, 1969, 1973, 1980; Bretherton,

1992; Shaver & Mikulincer, 2009), and studies have demonstrated that attachment behaviors correlated with specific interpersonal problems as well (Shaver & Mikulincer, 2009). Thus, an exploration of attachment in CNM individuals can offer insight regarding the psychological well-being of CNM individuals.

Attachment Theory. Following the end of World War II, John Bowlby was commissioned by the World Health Organization to explore the impact of parental (specifically, maternal) separation and deprivation on homeless children across Europe in response to mass casualties of the war (Ainsworth & Bowlby, 1991; Bretherton, 1992). Bowlby, a psychiatrist formally trained in psychoanalysis, teamed up with researchers across the globe to explore the influence of mother-child separation on personality development. Commonly recognized as the father of attachment theory, John Bowlby theorized that to grow up mentally healthy, the "infant and young child should experience a warm, intimate, and continuous relationship with [their] mother (or permanent mother-substitute) in which both find satisfaction and enjoyment" (Bowlby, 1952, p. 11). He went on to argue that in the absence of a consistent attachment figure, children would experience an inability to form secure, meaningful relationships with others later in life (Bowlby, 1952; Bretherton, 1992).

Mary Salter Ainsworth, a psychologist and researcher whose interests were primarily rooted in security theory, was also interested in exploring the relationship between an infant's bond with their caregivers and personality development (Ainsworth & Bowlby, 1991; Bretherton, 1992). Specifically, Ainsworth intended to achieve a greater understanding of attachment security, or lack thereof, in infant-caregiver relationships. Ainsworth joined Bowlby's research lab in 1950 and conducted a series of observational studies, which arguably influenced Bowlby's work over the next few decades (Ainsworth & Bowlby, 1991). One of

Ainsworth's most influential studies is commonly known as the Strange Situation, which provided a foundational understanding of attachment styles in infants (Ainsworth & Bell, 1970; Ainsworth & Bowlby, 1991; Ainsworth et al., 1978/2014; Bretherton, 1992). In the Strange Situation, Ainsworth and her colleague, Silvia Bell, observed the interaction between 23 one-year-old infants and their mothers, as mother and child were introduced to a stranger, separated, and reunited in a series of 8 "episodes." Through their observations, Ainsworth and Bell noticed that the infants engaged in three distinct behavioral reactions, which were then classified as three attachment styles: (a) secure, (b) insecure-avoidant, and (c) insecure-ambivalent/resistant (Ainsworth & Bell, 1970; Ainsworth et al., 1978/2014; Berghaus, 2011; Shaver & Mikulincer, 2009); Main and Solomon (1986) later went on to identify a fourth attachment style: insecure-disorganized/disoriented.

While infants with a secure attachment style may or may not have experienced distress upon separation from their mother, those who did become distressed recovered quickly upon reunification with their mother and were observed to re-engage in exploration of the environment (Ainsworth & Bell, 1970; Ainsworth et al., 1978/2014; Shaver & Mikulincer, 2009). Alternatively, insecure-avoidant infants exhibited no distress upon separation and ignored, actively turned away from, or pushed their mothers away upon her return. Meanwhile, insecure-ambivalent infants engaged in proximity-seeking and contact-maintaining behaviors even before, and especially after, separation from their mother and her subsequent return, as evidenced by their angry protesting (e.g., crying), search behavior, and refusal to re-engage in exploration; these reactions were intensified upon re-separation, and the infants seemingly found little comfort in their mother's return (Ainsworth & Bell, 1970; Ainsworth et al., 1978/2014; Shaver & Mikulincer, 2009). Infants who were classified as insecure-disorganized/disoriented engaged

in contradictory behaviors (e.g., moving toward their mother while also averting their gaze), disordered sequences of behaviors (e.g., active avoidance of the mother, followed by proximity-seeking behaviors), "behavioral stilling" (e.g., freezing of movement, dazed expressions), "incomplete or undirected movements and expressions, including stereotypies (e.g., undirected expressions of fear or distress, stereotypic rocking)," and "direct indices of confusion and apprehension (e.g., hand-to-mouth gestures immediately upon parent's entrance)" (Main & Solomon, 1986, p. 97).

Ainsworth's findings, combined with Bowlby's earlier research, were synthesized to formulate the basis of what we know now as attachment theory, one of the most highly regarded, extensively researched, and continually evolving psychological theories to date (Ainsworth & Bowlby, 1991; Ainsworth et al., 1978/2014; Berghaus, 2011; Bowlby, 1969, 1973, 1980; Bretherton, 1992; Shaver & Mikulincer, 2009). Attachment theory posits that humans are born with an innate *attachment behavioral system*, or a set of *attachment behaviors* (e.g., proximity-seeking and contact-maintaining behaviors), the sole purpose of which is to assure dependable access to *attachment figures* (Berghaus, 2011; Bowlby, 1969, 1973, 1980; Shaver & Mikulincer, 2009). Attachment figures are specific individuals in the infant/child's life whose role is threefold: (a) to provide physical and psychological safety and support, especially when the child is faced with a perceived or actual threat; (b) to encourage safe, healthy exploration of the environment; and (c) to assist the child in learning how to effectively regulate their emotions (Bowlby, 1969; Shaver & Mikulincer, 2009).

When an infant/child experiences an actual or perceived threat, their attachment system will become activated, and the infant/child engages in behaviors designed to achieve proximity to their attachment figure to reestablish safety; these bids continue until their sense of security is

restored, and their attachment system is consequentially deactivated (Ainsworth et al., 1978/2014; Bowlby, 1969; Shaver & Mikulincer, 2009). If an infant finds that a specific behavioral strategy is successful in achieving their goal, that behavior is reinforced; however, if the attachment behavior "results in punishment or caregiver withdrawal, that behavior will become weaker and less visible," and other behavioral strategies take its place (Shaver & Mikulincer, 2009, p. 22). For example, if an infant/child's bids for connection are dismissed or ignored, the infant/child may engage in one or both of the following: (a) hyperactivated attachment behavior strategies or intense and persistent bids for connection, in which the goal is to gain support from an unreliable attachment figure or (b) deactivating attachment behavior strategies. Deactivating strategies are typically observed as avoidance of the attachment figure; this allows the infant/child to "minimize the pain and frustration caused by unavailable, unsympathetic, or unresponsive attachment figures" (Shaver & Mikulincer, 2009, p. 23).

As infants/children navigate the world and gain experience with their attachment figures, they develop and refine working models of themselves and others; these working models serve as schemas through which the infant/child views the world and is able to make predictions about future relationships (Ainsworth et al., 1978/2014; Bowlby, 1969, 1973, 1980; Bretherton, 1992; Shaver & Mikulincer, 2009). One's internal working models are also correlated with specific attachment styles: those with a secure attachment style have a positive view of themselves (i.e., see themselves as worthy and lovable) and others (i.e., see others as generally accepting and responsive); those with an insecure-ambivalent/resistant attachment style have a negative view of themselves (i.e., see themselves as unlovable, unworthy) and a positive view of others; those with an insecure-avoidant attachment style have a positive view of themselves and a negative view of others (i.e., see others as untrustworthy and rejecting); and those with an insecure-

disorganized/disoriented attachment style have a negative view of both themselves and others (Bartholomew & Horowitz, 1991).

While working models are likely maintained through social feedback (e.g., how attachment figures respond to bids for proximity and safety), it seems they can also be modified as a result of significant interpersonal experiences that are inconsistent with existing working models (Bartholomew & Horowitz, 1991). Internal working models may also be refined as a result of major life transitions (e.g., losing a loved one, moving out of the primary caregivers' home), which can force us to reorganize the way in which we relate to the world.

Adult Attachment. Although many of the interpersonal behaviors adults engage in can arguably be traced back to the relationships developed with their caregivers as infants/children, Bowlby (1969) theorized that the attachment system included the refinement of internal working models is active across the lifespan. This refinement happens as people continually establish and terminate relationships with friends, peers, and romantic partners. Bowlby's theory was echoed by Bartholomew and Horowitz's (1991) findings in that many of their participants' attachment behaviors and attachment styles fluctuated across time and within relationships.

Paralleling the four infant attachment styles previously mentioned, four adult attachment styles have also been identified: secure, dismissing, preoccupied, and fearful (Bartholomew & Horowitz, 1991; Shaver & Hazan, 1988; Shaver & Mikulincer, 2011). Adult attachment styles are:

> thought to vary along two dimensions . . . [creating four quadrants defined by levels of] anxiety (insecurity about a partner's availability) and avoidance (discomfort with closeness to a partner), which reflects the differences in sensitivity to relationship threats

> and the behavioral strategies employed to regulate attachment relationships. (Moors et al., 2019, p. 103)

These four quadrants correspond well with Bartholomew and Horowitz' (1991) proposed conceptualization of attachment in that individuals with more positive views of themselves experience lower levels of anxiety with regard to interpersonal relationships, and those with negative views of themselves experience higher levels of anxiety; similarly, those with more negative views of others experience higher levels of avoidance and those with more positive views of others experience lower levels of avoidance.

Taken together, individuals with a secure adult attachment style experience low levels of both anxiety and avoidance, similar to securely attached infants; individuals with a dismissing adult attachment style correspond with insecure-avoidant infants and demonstrate low levels of anxiety and high levels of avoidance; individuals with a preoccupied adult attachment style correspond with insecure-ambivalent/resistant infants, and have high levels of anxiety and low levels of avoidance; and individuals with a fearful adult attachment style correspond with insecure-disorganized/disoriented infants, who experience a high degree of both anxiety and avoidance (Moors et al., 2019).

Adult attachment behaviors also mirror the behaviors of their infant counterparts. For securely attached adults, we would expect to see them rely on—and be comforted by—their romantic partner(s) in times of distress and to use their partner(s) as a secure base from which to explore the world (Bartholomew & Horowitz, 1991; Shaver & Mikulincer, 2009). Alternatively, adults with a dismissing attachment style typically express discomfort with closeness and dependence on others and engage in behaviors that ensure the maintenance of emotional distance between themselves and their romantic partner(s) to protect themselves from eventual

disappointment by others. Meanwhile, adults with a preoccupied attachment style typically experience a strong desire for closeness, which may result in persistent engagement in proximity-seeking behaviors or requests for reassurance from their partner(s); these individuals may be perceived as having a dominant interpersonal style as they desperately attempt to fulfill their dependence needs (Bartholomew & Horowitz, 1991). Last, adults with a fearful attachment style avoid close relationships in an attempt to protect themselves from rejection by others; however, they are also likely to engage in proximity-seeking behaviors because their sense of self-worth is reliant on acceptance from others. Fearfully-attached adults are likely to experience social insecurity and lack assertiveness, as they put others' needs ahead of their own in an attempt to secure interpersonal relationships.

Regarding sexuality, Shaver and Hazan's (1988) findings suggest that those with secure attachment styles are more likely to strive for mutual pleasure and intimacy. More recent research has expanded on this idea, indicating that a secure base within a romantic relationship allows for sexual exploration (*sexploration*) and empowers individuals to more readily explore the "cognitive, behavioral, and identity-based" aspects of their sexuality (Selterman et al., 2019, p. 20). Conversely, individuals high in avoidance (i.e., dismissing- or fearfully-attached) are more likely to be promiscuous, as they experience difficulty trusting others to meet their needs and strive to maintain emotional distance through casual or non-intimate sexual relations (Shaver & Hazan, 1988). Those who experience high levels of anxiety (i.e., preoccupied- or fearfully-attached individuals) may also "have an unusually high number of sexual partners" as they attempt to meet their intense desire for security through their sexual partner(s); however, unlike avoidant individuals, anxious individuals actively seek intimacy, often fluctuating between

"being needy and demanding" and "being compulsive caregivers . . . [who] resent their own self-sacrifice" (Shaver & Hazan, 1988, p. 488).

Attachment in CNM Individuals. Securely attached individuals seem to engage in monogamous and CNM relationships, specifically polyamorous relationship styles, at similar rates (Moors et al., 2017, 2019; Morrison et al., 2011). Alternatively, those who experience higher levels of avoidance (i.e., dismissing or fearful individuals) are less likely to engage in CNM relationships compared to monogamous relationships, despite endorsing more positive attitudes toward CNM and a greater willingness to engage in CNM (Moors et al., 2015). It is possible that CNM relationships are perceived as encouraging or allowing for more intimate distance between partners than monogamous relationships, which would be a palatable option, in an abstract sense, for avoidant individuals; however, CNM relationships very often require open, vulnerable, and consistent communication between all partners to ensure mutual satisfaction, which would deter avoidant individuals from actually engaging in CNM.

Individuals with higher levels of anxiety (i.e., preoccupied or fearful) demonstrate negative attitudes toward CNM; however, data suggest they are equally likely to engage in CNM and monogamous relationships (Moors et al., 2015). It is possible that their attitude toward and actual engagement in CNM is reflective of their experienced ambivalence toward intimacy and closeness, while more partners can theoretically offer more affection and having a greater number of partners also means there is a greater threat of being abandoned by those partners. Furthermore, anxious individuals tend to experience heightened romantic jealousy, which is likely a function of their fear of abandonment and may also contribute to their negative views of CNM, as intense jealousy can often feel like an unacceptable emotion.

As was previously mentioned, the types of CNM relationships explored in this paper are limited to polyamory, open relationships, and swinging; however, a great deal of variety exists within each of these types of CNM relationships. For example, the negotiated expectations of partners in one polyamorous relationship may look significantly different from the agreed-upon boundaries of another polyamorous relationship; the same holds true for open and swinging relationship styles. With this in mind, it is important to consider one's motivations for engaging in CNM and how it may relate to their attachment style (Moors et al., 2019). Polyamorous relationships, for example, which are typically defined by deep, intimate connections between relationship partners, may be more attractive to individuals with lower levels of avoidance (i.e., secure or preoccupied individuals), as higher levels of openness and vulnerability are typically expected within these relationship configurations. Research with securely attached CNM individuals suggests that polyamory is a highly attractive relationship style; however, more research in this area is certainly warranted. Conversely, an individual with an avoidant attachment style (i.e., dismissing or fearful individuals) may find greater satisfaction and success within an open or swinging relationship dynamic, in which the partners may expect or encourage emotional distance outside of sexual interactions.

In specifically looking at polyamorous individuals, Moors and colleagues (2019) found that adult romantic attachments are formed independently of each other; instead of relating to every romantic partner in the same way, attachment styles and engagement in related attachment behaviors are based on the intricacies of each distinct relationship. These findings contradict the assumption that engagement in more than one concurrent romantic relationship dilutes the strength of the primary relationship and indicates that it is possible for individuals to be securely

attached, in a romantic context, to more than one person without negatively influencing relationship satisfaction across partners.

Moreover, it appears that adult attachment bonds are not only independent of each other but are also reciprocal. Each partner can serve as a secure base for their respective partner(s), which allows for more personal exploration, sexual or otherwise, and greater satisfaction within the relationship as long as the needs of all partners are met (Selterman et al., 2019). Conversely, a secure individual may experience heightened and unfamiliar anxiety when in a relationship with a dismissing individual or may act in an avoidant manner when in a relationship with a preoccupied individual (Hazan & Shaver, 1987). Despite all that we know about attachment theory, we must also acknowledge that relationships are wildly "complex, powerful phenomena with causal effects beyond those predictable from personality variables alone" (Hazan & Shaver, 1987, p. 522). It is likely that an individual's satisfaction within each respective relationship is dependent not only on attachment style but also on their sexual identity development journey, intersecting identities, and the impact of various psychosocial influences.

Attachment Styles: Clinically Relevant Correlations. As was previously mentioned, CNM individuals, especially those in polyamorous relationships, demonstrate patterns of secure attachment (i.e., high levels of trust, intimacy, relationship satisfaction; low levels of jealousy) just as frequently as their monogamous counterparts (Moors et al., 2015, 2019). Furthermore, CNM individuals are equally likely to experience attachment-related anxiety compared to monogamous individuals and are less likely to experience higher levels of attachment-related avoidance than monogamous individuals (Moors et al., 2015, 2017; Morrison et al., 2011).

Attachment-related behaviors were explored in the previous section; however, research also suggests that attachment styles are correlated with specific psychological and interpersonal

problems, which contribute to overall adjustment and psychological well-being. For example, the experience of high anxiety that corresponds to preoccupied and fearful attachment styles has been linked to "global distress, [clinical] depression [and] anxiety, eating disorders, substance abuse, conduct disorder, and severe personality disorders" (Shaver & Mikulincer, 2009, pp. 35-36). Similarly, high avoidance that often corresponds to dismissing and fearful attachment styles is correlated with "depression characterized by perfectionism, self-punishment, and self-criticism; somatic complaints; substance abuse and conduct disorder; and schizoid and avoidant personality disorders" (Shaver & Mikulincer, 2009, p. 36).

Conversely, securely attached individuals are more likely to have higher levels of self-esteem (e.g., perceive themselves as valuable, worthy of love), self-efficacy, and overall well-being. They also typically have more positive views of others (e.g., the beliefs that their partner[s] are good-natured, reliable), have the capacity to practice compassion more readily with themselves and others, and are more willing to engage in exploration of new experiences or phenomena. Secure attachment is also negatively correlated with depression and anxiety, indicating that secure attachment may serve as a protective factor regarding psychopathology (Shaver & Mikulincer, 2009); however, it is important to remember that while secure attachment styles have been identified in CNM individuals, this finding has thus far been limited to polyamorous folx (Moors et al., 2015, 2019). CNM relationship styles that fall outside of polyamory (i.e., open and swinging relationships, among others) may not benefit from these same protective factors and likely experience their own unique benefits and challenges (Borgogna et al., 2021).

Relationship Satisfaction

Much of the existing research on CNM individuals' relationship health and satisfaction is problematic in that monogamous individuals are almost always used as a comparison group; by doing so, researchers continue to perpetuate mononormative biases. Additionally, most scales and assessment tools were designed for and normed on monogamous individuals; thus, it is possible that accurate assessments of relationship satisfaction in CNM individuals is not yet possible (Conley et al., 2017). Furthermore, to use monogamous populations as comparison groups is to assume that monogamous populations represent the gold standard of relational functioning; this is baffling, considering the fact that divorce rates among presumably monogamous couples in the United States continue to rise (Abdel-Sater, 2022). Nevertheless, the data that follow reflect the current understanding of relationship health in CNM populations in the United States.

Love and Emotional Intimacy. Love is difficult to operationalize; in fact, it is a feeling, a thought, a behavior, and a chemical reaction all at once. It is also a central component of many relationships and is exalted in United States society as the defining feature of successful and presumably monogamous relationships. In comparing CNM and monogamous individuals, those in CNM relationships tend to report higher levels of intimacy and passionate love than their monogamous counterparts (Brooks et al., 2021; Moors et al., 2015). Brooks and colleagues hypothesized that these findings might be a function of CNM individuals' tendencies to demonstrate "more flexibility and responsiveness to the romantic needs of their partners" (p. 11), which is likely facilitated by open, effective communication and access to multiple romantic and/or sexual partners.

Furthermore, while passionate love has been observed to sometimes decline rapidly over the course of long-term, monogamous relationships (Conley & Moors, 2014), this does not appear to be the case in CNM relationships. In a study comparing CNM and monogamous adults aged 55 and older, Fleckenstein and Cox II (2015) found that CNM adults reported greater relationship satisfaction and overall happiness, which appeared to be closely related to their respective sexual frequencies and number of sexual partners.

Sexual Satisfaction and Frequency. One study found that CNM and monogamous individuals reported similar levels of sexual satisfaction (Lecuona et al., 2021), while others found that CNM individuals experienced higher levels of sexual satisfaction than monogamous individuals (Conley et al., 2018; Fleckenstein & Cox II, 2015). It is important to note that the monogamous participants did not report sexual dissatisfaction; they simply reported lower levels of sexual satisfaction than their CNM counterparts (Conley et al., 2018). Regardless of relationship style, individuals reported greater sexual satisfaction when they knew they were meeting the sexual needs of their partner(s), even if their partner(s)' desires were different from their own, as long as their own sexual needs were also met (Selterman et al., 2019). A positive correlation between sexual satisfaction and sexual frequency was also observed, particularly among multi-partnered and female CNM individuals (Cox II et al., 2021). Meanwhile, the sexual frequencies of monogamous individuals typically fell below those of CNM individuals, which correlated with lower reported sexual satisfaction. Moreover, evidence suggests that sexual activity over the lifespan is associated with better physical health and greater overall happiness (Fleckenstein & Cox II, 2015; Muise et al., 2018).

Discrepancies in sexual frequency between monogamous and CNM individuals may result from a variety of factors, including the possibilities that: (a) CNM individuals may devote

more time and effort to their sexual relationships than monogamous individuals, (b) increased numbers of sexual partners may allow for CNM individuals to experiment with and practice skills that result in increased sexual satisfaction, thereby increasing the probability that they will continue to achieve sexual pleasure in the future, or (c) individuals in CNM relationships may be less susceptible to "normal habituation processes that occur in the sexual relationships of monogamous" individuals (Conley et al., 2018, p. 527).

Commitment. Relationship commitment, as defined by Brooks and colleagues (2021), reflects "how much a partner is willing to persist in a relationship over a period of time" (p. 4). The same study found that CNM individuals tended to demonstrate higher levels of commitment than monogamous individuals. In an effort to more thoroughly assess CNM relationship commitment levels, Hangen and colleagues (2019) developed their triple-C model of commitment, which outlines three critical dimensions of relationship commitment: consent (i.e., explicit agreement by all partners about their relationship configuration), communication (i.e., clear, ongoing negotiations regarding the relationship's boundaries and expectations, particularly concerning EDSA), and comfort (i.e., satisfaction with the agreed-upon relationship structure).

While the triple-C model was created to conceptualize CNM relationships, Hangen and colleagues acknowledged that these criteria equally apply to monogamous and CNM relationships; evaluation of relationships on each of these domains can help to identify areas of growth, which can ultimately strengthen the relationship dynamic and increase overall relationship satisfaction. They also identified five distinct relationship styles in their study, including two distinct monogamous groups (differing in recent EDSA engagement and communication about the EDSA), one CNM group, a partially open group, and a one-sided EDSA group (i.e., non-consensual non-monogamy). Of all the groups, the CNM group

demonstrated the highest levels of mutual consent, communication, and comfort, closely followed by the monogamous groups. These findings indicate that individuals in both monogamous and CNM relationships demonstrate a high degree of commitment to their romantic partner(s).

Trust. With regard to a relationship, trust is defined as a subjective sense of safety and comfort when in the presence of one's partner (Conley et al., 2017). Higher levels of trust in one's relationship help to facilitate stronger, more meaningful connections between partners. In comparing levels of trust in monogamous and CNM individuals, one study found that CNM individuals demonstrate higher levels of trust than monogamous individuals (Conley et al., 2017) and results from another study suggested the exact opposite (Brooks et al., 2021). Regardless of which group actually experiences higher levels of trust, what is most important to note is that, in both studies, monogamous and CNM individuals all endorsed high levels of trust in their partner(s). Furthermore, both groups also demonstrated similar perceptions of deceptive behaviors (i.e., infidelity), which inherently challenges or perhaps even decreases the level of trust one may have in their partner(s) (Rodrigues et al., 2016). These findings suggest that, although monogamous and CNM relationship styles may allow for differing levels of EDSA, trust and deception are experienced similarly; individuals from both groups expect their partner(s) to uphold the agreed-upon boundaries of the relationship.

Jealousy. Assessing levels of jealousy within a relationship is important because high levels of jealousy in a relationship are generally associated with negative relationship functioning, such as increases in relationship conflicts, distrust, and—in some cases—intimate partner violence (Conley et al., 2017). Perhaps somewhat surprisingly, low levels of jealousy within a relationship are positively associated with relationship longevity; the presence of some

jealousy in a relationship, therefore, can be indicative of a healthy relationship. Aumer and colleagues (2014) explored three distinct types of jealousy, which are discussed here: cognitive jealousy (i.e., preoccupations or suspicion of a partner's infidelity), behavioral jealousy (i.e., jealousy-based actions, such as checking a partner's phone or pockets), and emotional jealousy (i.e., experiencing hurt or feelings of rejection as a result of suspected infidelity).

For monogamists, higher degrees of emotional jealousy conferred greater relationship satisfaction; however, among CNM individuals, there were higher degrees of behavioral jealousy, which was more likely to be experienced by CNM women and translated to lower relationship satisfaction (Aumer et al., 2014). Conley and colleagues (2017) also explored different experiences of jealousy. In their study, cognitive jealousy was found to be lower in CNM individuals than in monogamous individuals, and behavioral jealousy was decidedly low in both CNM and monogamous groups; overall, CNM individuals endorsed lower experiences of jealousy. Looking at jealousy in general, Moors and colleagues (2014) also found that CNM individuals experienced lower levels of jealousy, while Lecuona and colleagues (2021) found jealousy to be equally present in CNM and monogamous relationships.

Despite potentially differing experiences of specific forms of jealousy, these studies suggest neither group is exempt from this natural human emotion, and both CNM and monogamous individuals experience some degree of jealousy within their relationships. However, differences in jealousy management may have significant implications for overall relationship functioning. Both Conley and colleagues (2017) and Lecuona and colleagues (2021) suggested while the experience of jealousy in CNM relationships may not significantly differ from monogamous relationships, CNM individuals may be more prepared to identify and respond to jealousy when it occurs due to CNM community values of increasing self-awareness

of possessive attitudes toward one's partner(s) and engaging in self-regulation processes when jealousy is identified. Furthermore, the CNM community has embraced the concept of compersion, which is essentially the opposite of jealousy. Instead of experiencing distress related to a partner's sexual or romantic engagement with another person, someone who experiences compersion feels happiness or joy for their partner or partners (Aumer et al., 2014). Higher degrees of compersion in CNM individuals are associated with greater relationship satisfaction; however, compersion had no effect on monogamous relationship satisfaction levels.

Conflict Resolution Styles. In addition to assessing a variety of other relationship satisfaction measures, Brooks and colleagues (2021) also examined conflict resolution styles in monogamous and CNM individuals, including conflict engagement (e.g., personal attacks on one's partner, flooding), positive problem-solving (e.g., engagement in compromise and negotiation), withdrawal (e.g., avoidance behaviors, such as stonewalling), and compliance (e.g., submissive behaviors). Monogamous participants were more likely to demonstrate avoidance and withdrawal from interpersonal conflict, which was associated with lower relationship satisfaction overall. Conversely, CNM participants were observed to approach interpersonal conflict with positive problem-solving tactics. Brooks and colleagues also posited that CNM individuals' tendency to approach rather than avoid conflict could be demonstrative of more advanced communication skills, which could be attributed to the "nature of CNM relationships relying on a more complex level of interpersonal negotiating" (p. 11).

Variability Between CNM Relationship Styles. Again, it is important to recognize that each CNM relationship is unique. This paper uses the term CNM to encompass a variety of relationship styles (i.e., polyamorous, open, and swinging relationship styles) due to a significant shortage of research on CNM, despite the humble acknowledgment that doing so may erase

some of the unique experiences of individuals who identify with specific forms of CNM. Fortunately, at least one study has intentionally separated polyamorous, open, and swinging groups from each other and compared them to monogamous individuals on global relationship satisfaction, trust, jealousy, passionate love, and commitment across (Conley et al., 2017).

In comparing monogamous and swinging participants, Conley and colleagues (2017) noted that swingers tended to experience fewer jealous cognitions but did not otherwise differ from their monogamous counterparts. Alternatively, participants in open relationships demonstrated marked differences overall; they were significantly less satisfied, less committed, and demonstrated lower levels of passionate love than monogamous individuals. Individuals in open relationships also endorsed lower levels of cognitive and behavioral jealousy compared to monogamous individuals. Last, in comparing polyamorous and monogamous individuals, polyamorous folx were significantly more satisfied, more committed, more trusting, demonstrated higher degrees of passionate love, and endorsed lower levels of cognitive and behavioral jealousy. The significant differences between the three CNM groups indicate that different styles of CNM may carry unique implications for relational functioning with them.

Overall Relationship Satisfaction. Despite differences between CNM groups, it appears that relationship structure is not a powerful predictor of relationship satisfaction and global well-being overall (Rubel & Bogaert, 2015). Although it is true that some evidence suggests that CNM individuals have greater overall relationship satisfaction than monogamous individuals (Brooks et al., 2021), the vast majority of studies comparing CNM and monogamous individuals indicate that monogamous and CNM individuals demonstrate similar, and high, levels of relationship satisfaction and individual functioning (Conley et al., 2017; Garner et al., 2019; Hangen et al., 2019; Lecuona et al., 2021; Rubel & Bogaert, 2015; Séguin et al., 2017). Some of

the largest effect sizes regarding overall relationship satisfaction were tied to sexual frequency Fleckenstein & Cox II, 2015; Muise et al., 2018) and adherence to relationship agreements (Rodrigues et al., 2016).

In comparing CNM individuals to the general population, Cox II and colleagues (2021) found that CNM individuals were significantly happier than the general population when they had two or more sexual partners available; however, if their relationship was sexless or if they had only engaged with one sexual partner in the past year, their overall happiness and relationship satisfaction fell well below that of the general population's. Regarding adherence to agreed-upon boundaries, Rubel and Bogaert (2015) found that individuals in CNM and monogamous relationships reported lower levels of happiness and relationship satisfaction when relationship agreements had been violated.

Physical Health in CNM Individuals

As previously mentioned, CNM individuals who identify as swingers are often stigmatized by the general public as promiscuous and more likely to contract and spread STIs (Balzarini et al., 2018b); however, research regarding STI incidences suggests this is not the case. In a study comparing self-identified CNM and monogamous individuals, lifetime STI rates were comparable between both groups (Lehmiller, 2015). While CNM individuals did report a higher number of lifetime sexual partners than monogamous individuals, they were also more likely to use condoms with their primary partner, if applicable, along with any additional sexual partners. CNM individuals were also more likely to engage in frequent, broad-based STI testing, and their partners were more likely to be aware of specific instances of EDSA. Alternatively, monogamous individuals were less likely to use condoms with their primary partner, were less likely to engage in frequent STI testing, and in instances of infidelity (which were reported in

approximately one-quarter of monogamous relationships) were less likely to inform their partner of the EDSA. These results suggest that those in the CNM community are much more conscientious of sexual health and the potential risks of having multiple sexual partners than monogamous individuals.

Sexual frequency was previously explored concerning sexual and relationship satisfaction; however, studies indicate that sexual frequency is also associated with better physical health, particularly among individuals in the CNM population (Cox II et al., 2021; Fleckenstein & Cox II, 2015). Much of the dialogue surrounding sexual behaviors in the United States revolves around abstinence, the use of barriers (e.g., condoms), and limiting the number of sexual partners one engages with (i.e., risk aversion); however, based on Cox II and colleagues' and Fleckenstein and Cox II's findings, it seems more appropriate to shift the dialogue from a risk-focused perspective to a sex-positive one, where the promotion of sexual health is emphasized.

Minority stress is another significant factor correlated with health outcomes in CNM individuals. Research on the impact of minority stress on physical health suggests that for HIV-positive males who conceal their sexual orientation from medical providers, minority stress is correlated with increased HIV symptoms, more rapid HIV progression, poorer lab results, increased side effects to treatment, and higher AIDS mortality (Flentje et al., 2020; Meyer & Frost, 2012). Experiences of minority stress have also been linked to increased incidences of respiratory infections and cancer, changes in cardiovascular function, higher BMI (particularly in lesbians), increased likelihood of risky sexual behavior (i.e., condomless sex, particularly in gay men), higher levels of cortisol in the bloodstream, and increased incidences of smoking (particularly in lesbians; Flentje et al., 2020; Meyer & Frost, 2012). As was previously discussed,

the experience of minority stress is theoretically compounded with each additional minority identity that an individual holds, and the impact of minority stress on CNM individuals is likely exacerbated when CNM individuals interact with systems based in heteronormative and mononormativity, such as the healthcare system.

CHAPTER IV: BARRIERS TO CARE, DETRIMENTAL PRACTICES, AND SUGGESTED PRACTICES

Again, the purpose of this paper was not to compare CNM and monogamy, nor is it to argue that one relational style is superior to the other. In fact, CNM and monogamous relationships have both unique and shared benefits, many of which have been explored throughout this paper. Furthermore, as previously discussed, levels of psychological well-being, relationship satisfaction, and physical health among CNM and monogamous individuals have all been found to be comparable.

Ultimately, while there is "evidence [to suggest] that non-monogamy increases relationship satisfaction for some individuals . . . there is little compelling evidence that all monogamists would be happier exploring non-monogamy" (Killeen, 2022, abstract). In other words, it can be reasonably concluded that CNM and monogamous relationships are equally viable, valid, healthy, and fulfilling options for romantic and sexual partnering. Regardless of one's relationship style, or if partnering preferences change over the lifetime, individuals should purposefully reflect and evaluate what boundaries and desires are important and think about goals in every relationship they enter into (Moors et al., 2014). Rather than defaulting to monogamy or adopting preconceived ideas of what a CNM relationship might look like, relationship dynamics should be intentionally chosen and designed to fit the individual needs of those in the relationship.

Despite these conclusions, people in sexual and gender minorities continue to experience disparities in healthcare which are largely grounded in heteronormative and mononormative biases. In fact, in 2016, sexual and gender minority communities were officially recognized as a health disparity population by the National Institutes of Health (Flentje et al., 2020). Though this

acknowledgment helps to facilitate a significant and necessary shift in standard healthcare practices—and the population identified inherently includes some CNM individuals due to the significant overlap in LGB+ and CNM communities—it is not specific to the CNM community and therefore neglects to raise awareness of health discrepancies unique to the CNM population. As such, additional studies focusing on the healthcare needs of the CNM community are desperately needed. The following sections aim to highlight some of the barriers to care CNM individuals face, in addition to identifying harmful practices that clinicians engage in. An exploration of inclusive practices and steps that have already been taken toward inclusive care follow.

Barriers to Care

A variety of factors can impact access to care and contribute to healthcare disparities; as identified by the Institute of Medicine, these factors fall into three categories: patient-level, provider-level, and system-level (Allen et al., 2017). Patient-level barriers to care include financial restraints, family and work responsibilities, time constraints, language barriers, and lack of transportation. Mental health stigma, which may be particularly salient within certain cultures and for male-identifying individuals, and geographic limitations can also contribute to one's difficulty in accessing appropriate mental health care. Alternatively, barriers at the provider level tend to include problems with discrimination, stigma, and lack of knowledge regarding certain areas of practice. At the system level, cost of services, lack of insurance coverage or confusion about coverage, poor experiences with the healthcare system, lack of education surrounding mental health care services, long wait times for scheduling appointments, and limited office hours all play a role in limiting access to care.

While these factors can all serve as obstacles to care for anyone in the general public, for minority groups like the CNM population, these general barriers are compounded by a significant shortage of competent clinicians who are able to provide inclusive (i.e., non-stigmatizing, validating) care (Schechinger et al., 2018). While studies suggest that CNM individuals are less likely than non-CNM individuals to pursue mental health treatment (Jenks, 2014), those who do decide to attend therapy likely spend time and effort pre-screening for providers who specialize in CNM populations, thereby unjustly placing the onus of obtaining competent care on already marginalized individuals (Vaughan et al., 2018). Furthermore, when CNM individuals do engage in treatment, assumptions of monogamy and unacknowledged or unchecked implicit and explicit biases on the therapist's part also serve as barriers to care, as these presumptions have the potential to exacerbate minority stress that many CNM individuals carry with them, resulting in more harm than good (Schechinger et al., 2018). Heteronormative practices, including sexual stigma and CNM discrimination, can also complicate the relationship between clinician and client/patient, as these behaviors have been linked to an increase in therapy-interfering stigma reactions on the part of the client/patient (Flicker, 2019; Vaughan et al., 2018). Furthermore, the lack of inclusive forms, which include administrative and intake forms, can also serve as barriers to care. It is important to acknowledge that most clients/patients who walk into their clinician's office have already overcome various obstacles to get there. In the office environment, cues such as magazines in the waiting room, art on the walls, and books on the shelf can communicate affirmation to potential clients/patients. Clinicians should be aware of how their office environments communicate to their prospective clients, as they have an ethical obligation to ensure they do not perpetuate heteronormative and mononormative stigmas or serve as additional barriers to care.

Common Therapist Mistakes

Even the most well-meaning clinicians may inadvertently engage in harmful practices; however, clinicians can endeavor to avoid making mistakes in their work with clients/patients by increasing their knowledge of problematic practices, identifying them in their own practice, and working to rectify their errors. Specifically, regarding the CNM population, some of the most common therapist blunders include: assuming monogamy and lacking basic knowledge regarding CNM issues (Moors & Schechinger, 2014); perpetuating heteronormativity or mononormativity through language (Kean, 2015); demonstrating unwillingness or refusal to learn about CNM (Schechinger et al., 2018); using monogamous relationships as a benchmark for relational functioning in CNM relationships or prioritizing one type of CNM relationship style over others (Moors et al., 2017); dismissing, holding judgmental attitudes about, or pathologizing CNM (Schechinger et al., 2018); viewing a client's CNM relationship as a significant factor contributing to their psychological distress (Grunt-Mejer & Łyś, 2019; Moors & Schechinger, 2014; Schechinger et al., 2018); or pressuring a client to abandon their CNM lifestyle (Grunt-Mejer & Łyś, 2019; Moors & Schechinger, 2014). Though this list is certainly not comprehensive, it offers at least a basic foundation for identifying areas of growth in clinical practice.

As has been previously discussed, clinician engagement in these practices can lead to exacerbation of minority stress and internalized stigma, which are associated with negative psychological and physical health outcomes (Flentje et al., 2020). Furthermore, experiences of consistent invalidation and judgment from healthcare professionals can lead a client/patient to experience increased levels of distrust of clinicians, increased engagement in therapy-interfering stigma-avoidance behaviors, decreased treatment compliance, and increased likelihood of

terminating therapy early (Carlström & Andersson, 2019a; Vaughan et al., 2018). A clinician's bias toward CNM may also lead them to attribute a client/patient's presenting problems to their partnering styles (Grunt-Mejer & Łyś, 2019). As such, these practices can also lead to inappropriate treatment planning and poor treatment outcomes.

Suggestions for Clinical Practice

There are an endless number of ways that clinicians can increase their level of competence for working with CNM individuals. Some of the most frequently identified CNM-inclusive strategies to incorporate into clinical practice include: using inclusive language and demonstrating respect for diverse relationship styles (Vaughan et al., 2018); avoiding assumptions of monogamy and equating sexual exclusivity with healthy relational functioning (Moors & Schechinger, 2014); practicing open-mindedness, holding affirming attitudes toward, and avoiding pathologization of CNM clients/patients (Borgogna et al., 2021; Schechinger et al., 2018; Vaughan et al., 2018); appreciating the uniqueness of CNM, including unique benefits that individuals in CNM relationships experience (Moors et al., 2017); considering the impact of stigma and discrimination on CNM individuals, especially regarding identity formation, minority stress, and internalized stigma (Schechinger et al., 2018; Vilkin & Sprott, 2021); and promoting safe sex practices instead of discouraging CNM or encouraging monogamy (Flicker, 2019).

In cases of infidelity (which can happen in both monogamous and CNM relationships), clinicians should be careful not to pathologize non-monogamous desires while simultaneously highlighting that deceitful behavior is inappropriate and hurtful because "stigmatizing the desire for sexual and/or romantic novelty . . . discourages honesty and sets the stage for deceptive patterns to repeat" (Moors & Schechinger, 2014, p. 480). Ultimately, clinicians should aim to

help their clients/patients embrace their CNM identity, whatever it looks like for them, and collaboratively work with them toward identified goals for treatment (Schechinger et al., 2018).

Practically, clinicians can also create inclusive spaces for their CNM clients by using inclusive language on intake and other administrative forms and identifying multiple emergency contacts, if applicable (Vaughan et al., 2018); ensuring that there is ample space in the therapy room for multiple partners to engage in treatment (Flicker, 2019); intentionally including overt messages or symbols to communicate CNM affirmation on websites or in office spaces (Flicker, 2019; Schechinger et al., 2018); identifying themselves as CNM-affirmative therapists on therapist locator websites, personal websites, bio pages of organization websites, and the like (Schechinger et al., 2018); and providing sexual health resources (Flicker, 2019).

Additionally, clinicians should be sure to: prioritize their commitment to continued education regarding CNM practices and common CNM issues (Schechinger et al., 2018); identify, monitor, and challenge biases based in heteromononormativity (Vaughan et al., 2018); understand and appreciate the uniqueness of CNM rather than comparing it to monogamy (Moors et al., 2017); remain up to date on best practices for working on LGBTQ+ clients and kink-oriented clients, since there is a significant overlap in sexual minority and CNM communities (Borgogna et al., 2021; Vilkin & Sprott, 2021); and assess CNM clients'/patients' experiences with mental health systems (Schechinger et al., 2018).

Vaughan and colleagues (2018) specifically suggested that clinicians actively practice cultural humility, noting that a variety of studies have identified positive correlations between "collaborative, patient-centered communication . . . , patient satisfaction with care, and health outcomes" (p. 49). Clinicians who approach their clinical work from a cultural humility perspective "explicitly [value] the patients' expertise, [acknowledge] the power imbalance

between provider and patient, and [cultivate] a commitment to lifelong self-reflection and self-critique" (Vaughan et al., 2018, p. 49). Because the practice of cultural humility inherently centers on transparency, unconditional positive regard, and collaboration between clinician and client/patient, it may be especially useful in establishing and maintaining trust with CNM clients, who may have previously developed distrust for or skepticism toward healthcare providers due to experiences of stigma and discrimination.

Suggestions for Systems

Of the three previously mentioned types of barriers to care, research suggests that the most detrimental are system-level barriers (Allen et al., 2017); a proposed brief training regarding the significance of CNM-inclusive intake assessments can be found in Appendix B. Healthcare organizations may be able to mitigate some of the existing barriers to care by requiring employees or clinicians who interact with clients/patients to provide clear, comprehensive information regarding insurance coverage to clients/patients at various points of contact and throughout treatment. Additionally, including search terms for CNM-affirming clinicians on healthcare organization websites can help clients/patients to identify and request to work with those who can provide them with the most competent care (Flicker, 2019).

Furthermore, although continuing education is an ethical imperative for clinicians, the responsibility to produce competent clinicians also falls on the shoulders of graduate schools, training programs, medical schools, and healthcare organizations. As such, these systems should work to address the lack of current training (Flicker, 2019). At both the training and patient-care levels, mental health systems should incorporate CNM into periodic diversity training to ensure that clinicians establish and maintain competency as the worlds of relational and sexual health continue to evolve. Without adequate training, clinicians may inadvertently continue to

perpetuate harmful heteromononormative stigmas (Flicker, 2019; Haupert et al., 2016; Moors & Schechinger, 2014; Schechinger et al., 2018; Zestcott et al., 2016). Bias awareness and mitigation training should include bias-awareness strategies, control strategies (i.e., seeking counter-stereotypic and common-identity information), and perspective-taking strategies, among others (Zestcott et al., 2016).

CHAPTER V: CLINICAL IMPLICATIONS AND A PROPOSED INTAKE ASSESSMENT TOOL

It is undeniable that, at least in the United States, monogamy is the most practiced relationship format and is considered the norm for romantic and sexual relationships. In exploring the history of monogamy, non-monogamy, and CNM, however, it is evident that alternatives to monogamy have always existed, both across time and cross-culturally. Further exploration of the psychological well-being, physical health, and levels of relationship satisfaction among CNM individuals suggests that CNM relationships are a valid, viable relationship style.

Despite these findings, stigma and discrimination based in heteronormative and mononormative biases occur across a variety of settings, including in the media, in the general public, with healthcare professionals, and in the U.S. legal system. Experiences of bias and discrimination that often accompany a CNM identity, in addition to the variety of additional minority identities that intersect with CNM (e.g., LGB+, TGNC, older adults, racial and ethnic minority groups), can lead CNM individuals to bring some level of minority stress with them into the therapy room (Meyer, 2003; Moors, Schechinger et al., 2021; Schechinger et al., 2018). Stigma and discrimination have also been identified within the CNM community, indicating that CNM individuals likely experience internalized stigma, which can contribute to experiences of psychological distress as well.

Many existing administrative forms perpetuate heteronormative and mononormative biases, which may be a contributing factor (if not the cause) of a client/patient's distress and reasons for seeking therapy in the first place (Haupert et al., 2016). Practices that erase or invalidate their minority identities (i.e., non-inclusive intake or patient history forms) can

exacerbate the impact of minority stress and/or internalized stigma, often resulting in poor mental and physical health outcomes, increased levels of distrust in healthcare providers, and decreased treatment and compliance, and increased likelihood of early termination of therapy (Carlström & Andersson, 2019a; Vaughan et al., 2018). The intake assessment is often the first point of contact for a client/patient, sometimes being provided to the client/patient even before meeting the clinician in person. Thus, ensuring that the intake assessment is inclusive and validates all of the client/patient's identities is imperative.

Intake Assessment

The use of inclusive language and providing ample space to list multiple partners and emergency contacts are two small, significant changes that should be made to existing intake assessment forms (Flicker, 2019). In the following sections, each of the domains of a standard intake is explored through a CNM-inclusive lens; an example intake assessment incorporating the following suggestions can be found in Appendix A. It is proposed that the first two pages of the intake assessment be provided to the client/patient for them to fill out before, or during, the initial appointment. The remainder of the intake tool can serve as a semi-structured interview for the clinician to utilize during the client's initial assessment.

Additionally, training regarding the significance of CNM-inclusive intake forms for use in systems (i.e., graduate schools, training programs, medical schools, and healthcare organizations) is also proposed (see Appendix B). Within the suggested training slides, specific questions from the proposed intake regarding CNM inclusivity are highlighted in yellow.

Identifying Information

Asking for a client/patient's "preferred name" and "preferred pronouns" is inherently pathologizing and invalidating; instead, asking for the client/patient's "name" and "pronouns"

signifies respect for the client/patient's identity and their autonomy. For clients/patients using insurance to pay for services, clinicians and/or organizations may need to document the client/patient's name and sex assigned at birth; in these instances, clinicians can ask the client/patient for their legal documentation in a validating, inclusive manner. For example, the clinician may begin by asking the client/patient for their name and pronouns before recognizing that their name, sex, and pronouns may differ on legal and insurance identification. The clinician can then request the information that the client/patient's insurance company has on file, explicitly noting that that information will be used for billing purposes only.

A client/patient's gender identity and sexual orientation are also important pieces of information to explicitly assess for, since one's gender and sexual identities relate to the way they see themselves in the world and may provide some insight into how others view them as well. In assessing for these identity factors, it is important to remember that these identities are socially mediated; therefore, the client/patient's gender and sexual identities may be fluid in nature (Barker, 2005; Evans et al., 2010; Worthington et al., 2002). Typical intakes tend to include boxes for "male," "female," and "other" genders; however, using an "other" gender specifier can further marginalize gender minority clients who may already experience identity-based discrimination and bias. Instead, it may be beneficial to include a wide variety of gender identities (e.g., female, genderqueer/gender fluid, intersex, male, nonbinary, transgender female/transgender woman, transgender male/transgender man, two-spirit) while also acknowledging that the list is not comprehensive. Furthermore, organizing the options in alphabetical order may also assist in destigmatizing and legitimizing traditionally "othered" identities while also ensuring that prioritization of one relationship style over another is not inadvertently communicated. Providing a space where the client/patient can self-define another

gender identity, if none of the ones listed fit the client/patient's identity, can also serve as validation for the client/patient. Similarly, a variety of sexual orientations (e.g., asexual, bisexual, gay, heterosexual, lesbian, queer, questioning), followed by a space to self-define another sexual orientation, can also provide validation for the client/patient's sexual identity label. Alternatively, the intake form could simply provide a space for the client to self-identify their gender identity and sexual orientation without providing any specific options. One benefit of including a variety of gender identity and sexual orientation options is that it demonstrates overt acceptance of the spectrum of gender and sexual identities and validates the wide variety of ways in which one person may identify (Moors & Schechinger, 2014). On the other hand, providing a space for the client to self-identify reduces the chances of perpetuating harmful biases but does not explicitly convey acceptance of gender minorities.

Similar to gender and sexual identities, a clinician can decide to include a variety of options for a client/patient to choose from (e.g., consensually/ethically non-monogamous, divorced, domestic partnership/living with partner(s), married, partnered [not living together], single [never married], widowed), followed by a space where the client/patient can self-identify their relationship status, or the clinician may decide to allow the client/patient to self-identify their relationship status without providing any options to choose from. Again, one benefit of including a variety of relationship styles on the intake form is an explicit demonstration of respect for relationship styles that deviate from monogamy, in addition to heightened visibility of alternatives to monogamy (Moors & Schechinger, 2014).

Typical intake forms tend to include spaces for a client's age, race, and ethnicity; each of these sections is also included in the proposed intake. Because ideal relational styles can differ by culture, which is inherently tied to race and ethnicity, it is important for the clinician to obtain

information from each of these domains; doing so can provide insight to help build the clinician's conceptualization of the client.

Presenting Concerns

Typical intake forms include questions regarding referral sources, reasons for seeking treatment, history of current symptoms (including onset, duration, intensity, and frequency), precipitating factors or current stressors, and level of subjective distress caused by the presenting problem. In addition to these domains, assessing for any barriers to care (past or present) in CNM-identifying clients may also be beneficial (Allen et al., 2017; Schechinger et al., 2018; Vaughan et al., 2018). Doing so can give the client/patient a greater sense of control over their treatment and can help to establish the therapeutic relationship as a safe space to air grievances, work on problem-solving, and/or can help to identify any potential resources the client may benefit from.

Psychiatric History

Inquiring about any client/patient's past experiences with mental health treatment can help to identify interventions that have been previously helpful and unhelpful, gives the client a space to discuss any previous progress made and frustrations encountered and can give the clinician insight into the client/patient's expectations for therapy. Furthermore, asking about a client/patient's history in treatment can prompt the client/patient to disclose any past experiences of stigma and discrimination; identity-based experiences of stigma and discrimination are explicitly assessed in the brief trauma assessment section.

Assessing a client/patient's personal and familial psychiatric history is a standard part of most intakes. Personal psychiatric history can provide clinicians with more data regarding a potential mental health diagnosis and may help to identify patterns in a client/patient's

experience of mental health symptoms or episodes. Familial psychiatric history is also clinically significant since a variety of mental disorders have biological bases. It should be noted that, for clients/patients who are adopted, information on their biological family's psychiatric history may not be available. Furthermore, clinicians should always be considerate of the fact that familial trauma, especially identity-based trauma, may be present when working with individuals who deviate from heteronormative and mononormative standards.

Risk Assessment

Conducting a thorough risk assessment is a typical and ethical part of every intake. It is important to ask clients past and present experiences about non-suicidal self-injury, past and present suicidal ideation (including any previous attempts; past and present plans, means, and intent), and past and present homicidal ideation (including any previous attempts; past and present plans, means, and intent). The questions included in the proposed intake assessment (see Appendix A) were adapted from the Colombia-Suicide Severity Rating Scale (C-SSRS).

Brief Trauma Assessment

As noted by Borgogna and colleagues (2021), CNM individuals have been shown to endorse a higher incidence rate of identity-based trauma experiences (specifically, sexual assault) than their monogamous counterparts. With each additional minority identity, this incidence rate, along with any minority stress the client may experience, likely increases (Balzarini et al., 2018c; Fassinger, 1998; Fassinger & Miller, 1996; McCarn & Fassinger, 1996; Meyer, 2003). Care should be taken in assessing any history of trauma, especially for those clients/patients who carry multiple minority identities with them and whose identities may differ from the clinician's, since their experiences of trauma may be ongoing and/or systematic in nature (Meyer, 2003).

Furthermore, explicitly assessing for experiences in identity-based discrimination and bias within the healthcare system is also clinically significant (Allen et al., 2017; Schechinger et al., 2018; Vaughan et al., 2018). Obtaining information regarding any negative experiences can help the clinician in formulating their conceptualization of the client, can facilitate the building of a strong alliance between the client/patient and clinician, and can help the client/patient and clinician to collaboratively determine an appropriate treatment plan.

Psychosocial History

In asking about a CNM client/patient's family of origin and the relationship(s) they have with their family members, clinicians should be mindful of any potential experiences of family-based discrimination and bias of CNM-identifying clients/patients, including familial rejection. Additionally, for CNM individuals who have either been rejected by their family of origin or have actively made the decision to remove their family of origin from their lives, a "chosen" or "found" family may be identified. Regardless of whether the client/patient's identified family is their family of origin or their chosen/found family, it is important for clinicians to assess for and respect the significance of the client/patient's relationship with each of the identified individuals.

In addition to asking about the client/patient's relationship with their family of origin, it may also be beneficial to inquire about the culture and values of the client/patient's family of origin. Calling attention to the messages that an individual received while growing up can help to conceptualize how they relate to themselves, other significant people in their life (e.g., identify attachment styles and related behaviors), and can provide some insight with respect to their worldview. Additionally, exploring the client/patient's family of origin's values can also help to shed light on internal dialogues that may contribute to internalized stigma (Schechinger et al., 2018; Vilkin & Sprott, 2021). Furthermore, asking whether a client/patient has children or

grandchildren in their legal care is also clinically relevant. As was previously mentioned, U.S. law does not currently have any protections in place for CNM families and may penalize them from engaging in CNM; in some cases, mononormative biases in the court have devastatingly resulted in children being removed from their parent(s)' home (Polyamory Legal Advocacy Coalition, n.d.). As such, identifying as CNM and having children comes with its own unique stressors, which may contribute to the psychological distress of a CNM client/patient.

Regarding the assessment of intimate, sexual, and/or romantic relationships, clinicians must be mindful of avoiding heteronormative and mononormative assumptions (Moors & Schechinger, 2014). In addition to inquiring about the number of partners and the nature of each partnership, it may also be helpful to understand where the client/patient is in their CNM identity formation by inquiring about how long they have been in a CNM relationship. Exploring this area can help identify whether the client/patient considers themselves to be a part of the CNM community and can help facilitate discussions surrounding their CNM identity formation if it is clinically significant or related to the client/patient's presenting problem. Furthermore, inquiring about the CNM individual's positioning within the CNM relationship and level of satisfaction can provide information regarding any relational concerns. Asking CNM individuals whether they feel supported in their relationship and whether they have ever felt unsafe with their partner(s) also facilitates discussions regarding consent and serves as a method of assessing for any potential coercive behaviors. Regarding sexual activity, Vaughan et al. (2018) suggested the use of explicit, open-ended questions regarding sexual behaviors in addition to number and gender(s) of sexual partners. Assessment of a client/patient's sexual behaviors is included in the physical health section.

Aside from romantic and sexual partners, clinicians should be sure to assess for friendships and any other significant relationships in the client/patient's life, as social support and in-group identification can be a protective factor against the negative impacts of minority stress and internalized stigma (Branscombe et al., 1999; Hinton et al., 2022; Ramos et al., 2012). Educational and employment history can also provide valuable information to incorporate into the conceptualization of a client. CNM individuals who also belong to gender or sexual minority groups may have had adverse experiences in school (e.g., bullying, discrimination) and/or in employment settings. Additionally, because U.S. law still does not protect CNM individuals from employment-based discrimination, bias, harassment, and any potential fears the client may have about being outed in the workplace are important to assess, as these stressors may contribute to the client/patient's overall distress and/or presenting problem (Johnson, 2013; McNamara, 2020). Assessing for any financial concerns is also clinically significant since financial barriers to treatment can impact the client/patient's ability or willingness to regularly attend sessions (Allen et al., 2017). Relatedly, the client/patient's housing status should also be assessed; again, U.S. law does not provide protection for CNM individuals, and fears of facing retaliation in the form of eviction or housing discrimination are legitimate concerns (Johnson, 2013; Kean, 2015).

Assessing for a client/patient's religious and spiritual beliefs can also provide the clinician with important information related to the client/patient's values. As was previously mentioned, religious organizations have played a significant part in the normalization of monogamy and the simultaneous demonization of CNM (MacDonald, 2001; Rothschild, 2018). Exploring a client/patient's religious and/or spiritual affiliation, and the messages they have received through associating with specific religious or spiritual practices, can highlight

experiences of identity-based religious trauma and may contribute to a client/patient's experience of internalized stigma. Finally, in assessing for any legal concerns, clinicians should be sure to inquire about any experience of identity-based crimes and concerns regarding maintaining custody of children/grandchildren.

Physical Health

With any client, conducting an assessment regarding physical health is important because it can help identify stressors in the client/patient's life and/or can highlight symptomology that may be attributed to a mental health diagnosis (e.g., appetite and sleep disturbances related to depression and anxiety). In addition to inquiring about general health concerns, medications, and disabilities, it is also important for clinicians to ask clients about safe sex practices and STIs, especially if the client/patient is sexually active, and even more so if they are sexually active with a variety of partners. As was previously mentioned, the use of explicit language around sexual behavior (e.g., oral sex on a vagina, anus, penis; vaginal or anal penetration; sex without penetration) and safe sex practices can facilitate discussion surrounding safe sex practices and can give clinicians an understanding of resources that may be potentially useful for clients/patients to have (Vaughan et al., 2018).

Substance Use

Assessment of past and present substance use is also part of a typical intake assessment. Asking a client/patient about their substance use habits (including frequency, amount used, and circumstances of use) can help to shed light on dangerous substance use and/or risky behaviors related to substance use (e.g., sharing needles, condomless sex). Furthermore, asking the client about the circumstances in which they typically use substances can provide the clinician with insight related to the client/patient's coping strategies.

Resources

Assessing for resources clients/patients are currently using and inquiring about whether there are any specific resources that would be beneficial for clients/patients to gain access can be a valuable part of the intake process, as it can highlight the collaborative nature of therapy and can allow the clinician to demonstrate their allyship with the client/patient. Specifically regarding CNM clients/patients, clinicians may want to provide resources on any relevant therapy, social, and/or advocacy groups.

Considerations for Additional Assessments

As a supplement to the clinical intake interview, it may be helpful to include objective assessments at the time of intake to establish clinical baselines, collaboratively determine measurable treatment goals, and to facilitate the ongoing evaluation of treatment effectiveness. Because CNM individuals may be subject to bias and discrimination in the healthcare system (Grunt-Mejer & Łyś), and because prior experiences of discrimination and bias may interfere with a client/patient's trust in their clinician or commitment to therapy (Vaughan et al., 2018; Zestcott et al., 2016), it is suggested that an assessment related to patient experiences in healthcare (e.g., Multidimensional Trust in Health Care Systems Scale) be administered to CNM-identifying individuals. A screener for experiences of internalized stigma may also be beneficial if the client/patient's presenting problem is related to their carrying a minority identity (e.g., CNM), as doing so can shed light on potential sources of the client/patient's subjective levels of psychological distress. Additionally, per Borgogna et al.'s (2021) findings, CNM individuals may be more likely than monogamous individuals to have experienced discrimination or trauma (specifically, sexual assault) as a result of identity-based bias. Thus,

administering a trauma assessment (e.g., global psychotrauma screen) may also be clinically relevant at intake for those who identify as CNM.

In addition to the above assessments, clinicians might also consider administering assessments related to relationship satisfaction and attachment, but only if they are relevant to the client/patient's presenting problem(s). In their study, Borgogna and colleagues (2021) found that the CNM individuals endorsed more depressive symptoms than their monogamous counterparts; as such, it may be helpful to administer a screener for depressive symptoms as well (e.g., Beck Depression Inventory Second Edition). Additionally, for clients/patients who present with relationship difficulties, the Relationship Assessment Scale can help provide insight regarding the client/patients' perception of relationship strengths and areas of growth. Similarly, the Revised Adult Attachment Scale or adult attachment interview can help to identify the client/patient's attachment style to their romantic and/or sexual partner(s), thereby assisting in the identification of adaptive and maladaptive attachment behaviors that contribute to interpersonal functioning.

In instances where the client/patient identifies relational issues as a presenting problem and has multiple concurrent sexual or romantic partners, it is important for the client/patient and clinician to collaborate in determining which relationship(s), if any, it would be beneficial to assess objectively. For instance, an individual in a polyamorous relationship may identify two or more significant romantic and/or sexual partners with whom they regularly interact; it may therefore be beneficial to administer attachment and relational functioning objective assessments to each identified partner. Alternatively, an individual in an open relationship may only indicate one partner with whom they share a significant emotional attachment, even if they are sexually

nonexclusive; in this case, it would likely only be clinically relevant to assess the client/patient's interpersonal functioning with their primary partner.

It should be explicitly noted that with each additional assessment, the client/patient would be required to expend more resources (e.g., time, money, energy); therefore, assessments should only be administered if clinically indicated (e.g., relevant to the client's presenting problem[s], relevant to the client's goals for treatment, aligns with APA's Ethics Code Principle A [beneficence and nonmaleficence]). As always, clinicians should be intentional and self-aware of the potential influences of any biases in their decision to administer (an) assessment(s) and should familiarize themselves with the pros and cons of each of them. Clinicians should also be intentional in interpreting assessment results from a multicultural, inclusive perspective not to pathologize CNM itself but rather to identify any clinically relevant symptoms that may interfere with the client's ability to maintain a healthy CNM identity or CNM relationship.

Steps Toward Inclusive Care

As relational dynamics continue to evolve along with client needs, the field of psychology must also continue to expand and grow. Though there is still a long way to go, progress toward CNM-inclusive care has already begun. In January 2018, the APA's Division 44 established a task force dedicated to CNM; in 2021, this task force's proposal to become a permanent committee was approved. Furthermore, some popular therapist locator websites have started to include indicators and filters for CNM-affirming therapists; APA Psychologist Locator incorporated this change in June 2019 and *Psychology Today* incorporated the update in February 2021. Additionally, APA's recently revised *Guidelines for Psychological Practice with Sexual Minority People* (American Psychological Association, 2021) explicitly recognizes the

impact of stigma on CNM individuals and affirms the significance of developing and maintaining knowledge around CNM-related issues.

The hope is that by exploring heteronormative and mononormative biases, their impact on the CNM community, and CNM psychological and physical health, the reader can achieve a more comprehensive and unbiased view of CNM. The production of the proposed intake tool (see Appendix A) serves as an example for clinicians to implement into their own practice; the objective of this tool is to help clinicians assess CNM clients in a way that is non-pathologizing, affirming, and comprehensive. Additionally, the proposed training regarding the significance of CNM-inclusive intake forms serves as an example of a brief training that can be used in systemic settings (e.g., training programs, medical schools, healthcare systems). It is anticipated that as gender, sexual, relational, and other identities continue to shift, the proposed intake and training materials will be modified to remain relevant and inclusive of all individuals in all relational styles.

Future Directions

The importance of continued advocacy for legal rights and protections of CNM-identifying folx cannot be understated. While the impact of stigma and discrimination are well-acknowledged, legal concerns and lack of legal protection (e.g., housing, employment, custody of children) based on a CNM identity can also be causes of significant psychological distress in CNM individuals (Johnson, 2013; Kean, 2015; McNamara, 2020; Polyamory Legal Advocacy Coalition, n.d.).

As noted at various points throughout this paper, the existing research on CNM relationship styles is scarce. Specifically, research focusing on differences across CNM relationship styles regarding attachment styles, experiences of stigma and discrimination and

related subjective distress, experiences of internalized stigma and related subjective distress, and the psychological well-being and physical health of CNM individuals requires more exploration. Additionally, as was previously noted, continuing to use monogamous individuals as a control or comparison group for CNM individuals continues to perpetuate heteronormative and mononormative biases. Thus, it is suggested that future research on CNM individuals focus on CNM in general or specific styles of CNM (e.g., polyamory, open relationships, swinging) without using monogamous relationships as a benchmark.

Continued exploration regarding the development of a CNM identity is also clinically significant, as the self-identity process may be accompanied by psychological distress. Some literature suggests that while individuals in open and swinging relationships view CNM as a behavior they engage in, polyamorous individuals may view CNM as part of who they are (Barker, 2005). Thus, examining the identity development process across CNM groups could offer additional clinical insight.

Management of discrimination, minority stress, and internalized stigma specific to the CNM population also warrants additional research, as exploring these areas may help to uncover specific clinical interventions that can be used to help CNM individuals navigate these challenging experiences. Furthermore, continuing to explore the relationship between group identification and psychological well-being within the CNM community is also suggested, as group identification is associated with positive psychological health outcomes (Branscombe et al., 1999; Hinton et al., 2022; Ramos et al., 2012).

While CNM itself is not pathological, higher incidence rates of abuse and sexual assault in CNM individuals (compared to monogamous individuals) warrant continued exploration (Borgogna et al., 2021). Correlations between trauma history and CNM engagement may be

similar to those seen in the kink community. Research in this area suggests that using BDSM can help kinky individuals cope with and transform past experiences of trauma (Cascalheira et al., 2021). Thus, research in this area may provide insight regarding some of the motivations for engaging in CNM relationships and/or may uncover ways in which CNM serves to manage previous experiences of trauma. Exploring the relationship between motivations for CNM engagement as they relate to relationship satisfaction can also be fruitful, as research in this area may help to provide insight regarding additional assessment strategies and/or interventions specific to the CNM population. Furthermore, the development of CNM-specific or CNM-inclusive objective assessments is needed since objective assessments can help to guide treatment planning, facilitate collaborative determination of measurable treatment goals, and can enable ongoing evaluation of treatment effectiveness (Conley et al., 2017).

Last, an exploration of the cross-cultural experiences of CNM is needed, as much of the existing CNM literature is whitewashed and based on the experiences of CNM individuals in the United States. Examining the lived experiences of CNM individuals across the globe can shed light on the intensity of psychological distress related to stigma, discrimination, and internalized stigma in CNM individuals and may provide insight regarding resilience and protective factors for managing these experiences.

References

Aaron, M. (2018, May 30). *Growing up kinky: Research shows how kink identity is formed*. Psychology Today. https://www.psychologytoday.com/us/blog/standard-deviations/201805/growing-kinky-research-shows-how-kink-identity-is-formed

Abdel-Sater, R. (2022). Marriage dissolution in the United States: A survival analysis approach. *Journal of Divorce and Remarriage, 63*(4), 235-261. https://doi.org/10.1080/10502556.2022.2042788

Ainsworth, M. D. S., & Bell, S. M. (1970). Attachment, exploration, and separation: Illustrated by the behavior of one-year-olds in a strange situation. *Child Development, 41*(1), 49-67. https://www.jstor.org/stable/1127388

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (2014). *Patterns of attachment: A psychological study of the strange situation*. Psychology Press. (Original work published 1978).

Ainsworth, M. D. S., & Bowlby, J. (1991). An ethological approach to personality development. *American Psychologist, 46*(4), 333-341. http://www.psychology.sunysb.edu/attachment/online/ainsworth_bowlby_1991.pdf

Allen, E. M., Call, K. T., Beebe, T. J., McAlpine, D. D., & Johnson, P. J. (2017). Barriers to care and healthcare utilization among the publicly insured. *Medical Care, 55*(3), 207-214/ https://doi.org/10.1097/MLR.0000000000000644

Allen, W. (2008). *Vicky Cristina Barcelona* [Film]. The Weinstein Company; Mediapro; Gravier Productions; Antena 3 Films; Antena 3 TV; Televisió de Catalunya.

American Psychological Association, APA TaskForce on Psychological Practice with Minority Persons. (2021). *Guidelines for psychological practice with sexual minority persons.* www.apa.org/about/policy/psychological-practice-sexual- minority-persons.pdf

Anapol, D. (2010). *Polyamory in the twenty-first century: Love and intimacy with multiple partners.* Rowman & Littlefield Publishers.

Anderson, E. (2010). "At least with cheating there is an attempt at monogamy": Cheating and monogamism among undergraduate heterosexual men. *Journal of Social and Personal Relationships, 27*(7), 851-872. https://doi.org/10.1177/0265407510373908

Aumer, K., Bellew, W., Ito, B., Hatfied, E., & Heck, R. (2014). The happy green-eyed monogamist: Role of jealousy and compersion in monogamous and non-traditional relationships. *Electronic Journal of Human Sexuality, 17*.

Balthazart, J. (2017). Fraternal birth order on sexual orientation explained. *Biological Sciences, 115*(2), 234-236. https://doi.org/10.1073/pnas.11719534115

Balzarini, R. N., Campbell, L., Kohut, T., Holmes, B. M., Lehmiller, J. J., Harman, J. J., & Atkins, N. (2017). Perceptions of primary and secondary relationships in polyamory. *PLoS ONE, 12*(5), e0177841. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0177841

Balzarini, R. N., Dharma, C., Kohut, T., Holmes, B. M., Campbell, L., Lehmiller, J. J., & Harman, J. J. (2018a). Demographic comparison of American individuals in polyamorous and monogamous relationships. *The Journal of Sex Research*, *56*(6), 681-694. https://doi.org/10.1080/00224499.2018.1474333

Balzarini, R. N., Shumlich, E. J., Kohut, T., & Campbell, L. (2018b). Dimming the "halo" around monogamy: Reassessing stigma surrounding consensually non-monogamous romantic relationships as a function of personal relationship orientation. *Frontiers in Psychology, 9*, Article 894. https://doi.org/10.31219/osf.io/7fa3m

Balzarini, R. N., Shumlich, E. J., Kohut, T., & Campbell, L. (2018c). Sexual attitudes, erotophobia, and sociosexual orientation differ based on relationship orientation. *The Journal of Sex Research, 57*(4), 458-469. https://doi.org/10.1080/00224499.2018.1523360

Barash, D. P., & Lipton, J. E. (2002). *The myth of monogamy: Fidelity and infidelity in animals and people.* Henry Holt and Company.

Barker, M. (2005). This is my partner, and this is my . . . partner's partner: Constructing a polyamorous identity in a monogamous world. *Journal of Constructivist Psychology, 18*, 75-88. https://doi.org/10.1080/10720530590523107

Barker, M.-J., & Langdridge, D. (2010). Whatever happened to non-monogamies? Critical reflections on recent research and theory. *Sexualities, 13*(6), 748-772. https://doi.org/10.1177/1363460710384645

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 61*(2), 226–244. https://doi.org/10.1037/0022-3514.61.2.226

Bauer, R. (2014). *Queer BDSM intimacies: Critical consent and pushing boundaries.* Macmillan Publishers Limited; St Martin's Press.

Benson, P. (2008). *The polyamory handbook: A user's guide.* AuthorHouse.

Berghaus, B. J. (2011). A new look at attachment theory and adult “attachment” behavior. *Behaviorology Today, 14*(2), 3-10. https://www.behaviorology.org/oldsite/pdf/AttachmentTheoryBeh.pdf

Berman, G., Braun, L., Garcia, N., Stango, J., Stein, G., & Cowan, C. (Executive producers). (2012-2013). *Polyamory: Married and dating* [TV series]. BermanBraun.

Blumstein, P., & Schwartz, P. (1983). *American couples: Money, work, sex.* William Morrow & Company.

Bogaert, A. F., & Skorska, M. N. (2020). A short review of biological research on the development of sexual orientation. *Hormones and Behavior, 119*, 104659. https://doi.org/10.1016/j.yhbeh.2019.104659

Borgogna, N. C., Aita, S. L., & Aita, L. J. (2021). Minority stress in consensually non-monogamous individuals: Mental health implications. *Sexual and Relationship Therapy.* https://doi.org/10.1080/14681994.2021.1959545

Bowlby, J. (1952). *Maternal care and mental health.* World Health Organization. https://apps.who.int/iris/handle/10665/40724

Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. Basic Books.

Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation anxiety and anger.* Basic Books.

Bowlby, J. (1980). *Attachment and loss: Vol. 3. Loss—sadness and depression.* Basic Books.

Bramham, D. (2009). *The secret lives of saints: Child brides and lost boys in Canada’s polygamous Mormon sect.* Vintage Canada.

Branscombe, N. R., Schmitt, M. T., & Harvey, R. D. (1999). Perceiving pervasive discrimination among African Americans: Implications for group identification and well-being. *Journal of Personality and Social Psychology, 77*(1), 135-149. https://doi.org/10.1037/0022-3514.77.1.135

Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental Psychology, 28*(5), 759-775. https://doi.org/10.1037/0012-1649.28.5.759

Brooks, T. R., Shaw, J., Reysen, S., & Henley, T. B. (2021). The vices and virtues of consensual non-monogamy: A relational dimension investigation. *Psychology & Sexuality*. https://doi.org/10.1080/19419899.2021.1897034

Cardoso, D., Rosa, A., & da Silva, M. T. (2021). (De)politicizing polyamory: Social media comments on media representations of consensually non-monogamies. *Archives of Sexual Behavior, 50*(4), 1325-1340. https://doi.org/10.1007/s10508-020-01887-5

Carlström, C., & Andersson, C. (2019a). Living outside protocol: Polyamorous orientations, bodies, and queer temporalities. *Sexuality & Culture, 23*, 1315-1331. https://doi.org/10.1007/s12119-019-09621-7

Carlström, C., & Andersson, C. (2019b). The queer spaces of BDSM and non-monogamy. *Journal of Positive Sexuality, 5*(1), 14-19. https://doi.org/10.51681/1.513

Cascalheira, C. J., Ijebor, E. E., Salkowitz, Y., Hitter, T. L., & Boyce, A. (2021). Curative kink: Survivors of early abuse transform trauma through BDSM. *Sexual and Relationship Therapy*. https://doi.org/10.1080/14681994.2021.1937599

Cass, V. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality, 4*(3), 219-235. https://doi.org/10.1300/J082v04n03_01

Cass, V. (1996). Sexual orientation identity formation: A Western phenomenon. In R. P. Cabaj & T. S. Stein (Eds.), *Textbook of homosexuality and mental health* (pp. 227-251). American Psychiatric Association.

Cerezo, A., Cummings, M., Holmes, M., & Williams, C. (2020). Identity as resistance: Identity formation at the intersection of race, gender identity, and sexual orientation. *Psychology of Women Quarterly, 44*(1), 67-83. https://doi.org/10.1177/0361684319875977

Chao, A. B. (Writer), & Cohen, D. (Writer), & Chatmon, P. (Director). (2021, October 15). Swing and a miss (Season 3, Episode 8) [TV series episode]. In M. Foley, S. Gamble, J. W. Lo, D. Madden, & S. Tree (Executive producers), *You.* A+E Studios; Alloy Entertainment; Berlanti Productions; Man Sewing Dinosaur; Warner Horizon Television.

Cherlin, A. J. (2004). The deinstitutionalization of American marriage. *Journal of Marriage and Family, 66*, 848-861. https://www.commackschools.org/Downloads/Reading%2053%20CHERLIN.pdf

Cole, C. L., & Spaniard, G. B. (1974). Comarital mate-sharing and family stability. *Journal of Sex Research, 10*(1), 21-31. https://doi.org/10.2307/3811743

Conley, T. D., Matsick, J. L., Moors, A. C., & Ziegler, A. (2017). Investigation of consensually non-monogamous relationships: Theories, methods, and new directions. *Perspectives on Psychological Science, 12*(2), 205-232. https://doi.org/10.1177/1745691616667925

Conley, T. D., & Moors, A. C. (2014). More oxygen please!: How polyamorous relationship strategies might oxygenate marriage. *Psychological Inquiry: An International Journal for the Advancement of Psychological Theory, 25*(1), 56-63. https://doi.org/10.1080/1047840X.2014.876908

Conley, T. D., Moors, A. C., Matsick, J. L., & Ziegler, A. (2013). The fewer, the merrier?: Assessing stigma surrounding consensually non-monogamous romantic relationships. *Analysis of Social Issues and Public Policy, 13*(1), 1-30. https://doi.org/10.1111/j.1530-2415.2012.01286.x

Conley, T. D., Piemonte, J. L., Gusakova, S., & Rubin, J. D. (2018). Sexual satisfaction among individuals in monogamous and consensually non-monogamous relationships. *Journal of Social and Personal Relationships, 35*(4), 509-531. https://doi.org/10.1177/0265407517743078

Conley, T. D., Ziegler, A., & Moors, A. C. (2013). Backlash from the bedroom: Stigma mediates gender differences in acceptance of casual sex offers. *Psychology of Women Quarterly, 37*(3), 392-407. https://doi.org/10.1177/0361684312467169

Cox, D. W. II, Fleckenstein, J. R., & Sims-Cox, L. R. (2021). Comparing the self-reported health, happiness, and marital happiness of a multinational sample of consensually non-monogamous adults with those of the U.S. general population: Additional comparisons by gender, number of sexual partners, frequency of sex, and marital status. *Archives of Sexual Behavior, 50*(4), 1287-1309. https://doi.org/10.1007/s10508-021-01973-2

Cruwys, T., Dingle, G. A., Haslam, C., Haslam, S. A., Jetten, J., & Morton, T. A. (2013). Social group memberships protect against future depression, alleviate depression symptoms, and prevent depression relapse. *Social Science & Medicine*, *98*, 179-186. https://doi.org/10.1016/j.socscimed.2013.09.013

Darwin, C. (1981). *The descent of man and selection in relation to sex.* Princeton University Press.

Drapalski, A. L., Lucksted, A., Perrin, P. B., Aakre, J. M., Brown, C. H., DeForge, B. R., & Boyd, J. E. (2013). A model of internalized stigma and its effects on people with mental illness. *Psychiatric Services, 64*(3), 264-269. https://doi.org/10.1176/appi.ps.001322012

Erikson, E. H. (1968). *Identity: Youth and crisis.* W. W. Norton & Co.

Erikson, E. H. (1980). *Identity and the life cycle.* W. W. Norton & Co.

Evans, N. J., Forney, D. S., Guido, F. M., Patton, L. D., & Renn, K. A. (2010). *Student development in college: Theory, research, and practice* (2nd ed.). Jossey-Bass.

Fairbrother, N., Hart, T. A., & Fairbrother, M. (2019). Open relationship prevalence, characteristics, and correlates in a nationally representative sample of Canadian adults. *The Journal of Sex Research, 56*(6), 695-704. https://doi.org/10.1080/00224499.2019.1580667

Fassinger, R. E. (1998). Lesbian, gay, and bisexual identity and student development theory. In R. L. Sanlo (Ed.), *Working with lesbian, gay, bisexual, and transgender college students: A handbook for faculty and administrators* (pp. 13-22). Greenwood Press.

Fassinger, R. E., & Miller, B. A. (1996). Validation of an inclusive model of sexual minority identity formation on a sample of gay men. *Journal of Homosexuality*, *32*(2), 53-78. https://doi.org/10.1300/j082v32n02_04

Fleckenstein, J., Bergstrand, C. R., & Cox II, D. W. (2013). *What do polys want?: An overview of the 2012 Loving More survey.* Loving More Magazine. http://www.lovemore.com/polyamory-articles/2012-lovingmore-polyamory-survey/

Fleckenstein, J. R., & Cox, D. W. II. (2015). The association of an open relationship orientation with health and happiness in a sample of older U.S. adults. *Sexual and Relationship Therapy, 30*(1), 94-116. https://doi.org/10.1080/14681994.2014.976997

Flentje, A., Heck, N. C., Brennan, J. M., & Meyer, I. H. (2020). The relationship between minority stress and biological outcomes: A systemic review. *Journal of Behavioral Medicine, 43*(5), 673-694. https://doi.org/10.1007/s10865-019-00120-6

Flicker, S. M. (2019). Reducing barriers to care for patients who practise consensual nonmonogamy. *Canadian Medical Association Journal, 191*(41), 1118-1119. https://doi.org/10.1503/cmaj.191246

Frank, K., & DeLamater, J. (2009). Deconstructing monogamy: Boundaries, identities, and fluidities across relationships. In M. Barker & D. Langdridge (Eds.), *Understanding Non-monogamies* (pp. 9-20). Routledge.

Garner, C., Person, M., Goddard, C., Patridge, A., & Bixby, T. (2019). Satisfaction in consensual nonmonogamy. *The Family Journal: Counseling and Therapy for Couples and Families, 27*(2), 115-121. https://doi.org/10.1177/1066480719833411

Girard, A., & Brownlee, A. (2015). Assessment guidelines and clinical implications for therapists working with couples in sexually open marriages. *Sexual and Relationship Therapy, 30*(4), 462-474. https://doi.org/10.1080/14681994.2015.1028352

González-Marugán, E. M., Castaño, M. E. F., de Miguelsanz, M. M., & Antón, L. J. M. (2021). Are women still judged by their sexual behavior? Prevalence and problems linked to sexual double standard amongst university students. *Sexuality & Culture, 25*(6), 1927-1945. https://doi.org/10.1007/s12119-021-09857-2

Goode-Cross, D. T., & Good, G. E. (2009). Managing multiple-minority identities: African American men who have sex with men at predominantly White universities. *Journal of Diversity in Higher Education, 2*(2), 103-112. https://doi.org/10.1037/a0015780

Grey, M. (2022, June 22). *Aaaah yes, the open marriage. A relationship between two toxic, depressed, with low self love and selfsteem.* [Comment on the video "A desperate man allows wife to f*** other men but her lovers start disappearing"]. YouTube. https://www.youtube.com/watch?app=desktop&v=MfBrgxO5rnA

Grunt-Mejer, K., & Campbell, C. (2016). Around consensual non-monogamies: Assessing attitudes toward nonexclusive relationships. *Journal of Sex Research, 53*(1), 45-53. https://doi.org/10.1080.00224499.2015.1010193

Grunt-Mejer, K., & Łyś, A. (2019). They must be sick: Consensual nonmonogamy through the eyes of psychotherapists. *Sexual and Relationship Therapy.* https://doi.org/10.1080/14681994.2019.1670787

Guillen, L. (n.d.). *Marriage rights and benefits.* Nolo. https://www.nolo.com/legal-encyclopedia/marriage-rights-benefits-30190.html#:~:text=Receiving%20Social%20Security%2C%20Medicare%2C%20and,Receiving%20public%20assistance%20benefits

Hall, W. J., Dawes, H. C., & Plocek, N. (2021). Sexual orientation identity development milestones among lesbian, gay, bisexual, and queer people: A systematic review and meta-analysis. *Frontiers in Psychology, 12,* 753954. https://doi.org/10.3389/fpsyg.2021.753954

Hammack, P. L., Frost, D. M., & Hughes, S. D. (2018). Queer intimacies: A new paradigm for the study of relationship diversity. *The Journal of Sex Research, 56*(4-5), 556-592. https://doi.org/10.1080/00224499.2018.1531281

Hangen, F., Crasta, D., & Rogge, R. D. (2019). Delineating the boundaries between nonmonogamy and infidelity: Bringing consent back into definitions of consensual nonmonogamy with latent profile analysis. *The Journal of Sex Research, 57*(4), 438-457. https://doi.org/10.1080/00224499.2019.1669133

Hanley, M. H., Diamond, L. M., & van Anders, S. M. (2015). Polyamory, monoamory, and sexual fluidity: A longitudinal study of identity and sexual trajectories. *Psychology of Sexual Orientation and Gender Diversity, 2*(2), 168-180. https://doi.org/10.1037/sgd0000098

Hardy, J. W., & Easton, D. (2017). *The ethical slut*. Ten Speed Press.

Haupert, M. L., Gesselman, A. N., Moors, A. C., Fisher, H. E., & Garcia, J. R. (2016). Prevalence with experiences of consensual nonmonogamous relationships: Findings from two national samples of single Americans. *Journal of Sex & Marital Therapy, 43*(5), 424-440. https://doi.org/10.1080/0092623X.2016.1178675

Hays, P. (1996). Addressing the complexities of culture and gender in counseling. *Journal of Counseling & Development, 74*(4), 332-338. https://doi.org/10.1002/j.1556-6676.1996.tb01876.x

Hazan, C., & Shaver, P. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology, 52*(3), 511-524. https://adultattachmentlab.human.cornell.edu/HazanShaver1987.pdf

Heinlein, R. A. (1961). *A stranger in a strange land.* Ace Books.

Henrich, J., Boyd, R., & Richerson, P. J. (2012). The puzzle of monogamous marriage. *Philosophical Transactions of the Royal Society B*, 367(1589), 657-669. https://doi.org/10.1098/rstb.2011.0290

Hidalgo, D. A., Barber, K., & Hunter, E. (2007). The dyadic imaginary: Troubling the perception of love as dyadic. *Journal of Bisexuality, 7*(3-4), 171-189. https://doi.org/10.1080/15299710802170797

Hinton, J. D. X., de la Piedad Garcia, X., Kaufmann, L. M., Koc, Y., & Anderson, J. R. (2022). A systemic and meta-analytic review of identity centrality among LGBTQ groups: An assessment of psychological correlates. *The Journal of Sex Research, 59*(5), 568-586. https://doi.org/10.1080/00224499.2021.1967849

Hughes, S. (2018). *"I'm not alone and not a freak": The 5 states of kink identity development* [Webinar]. Kink Knowledgeable. https://kinkknowledgeable.com/kk-webinar-september-2018/

Jenks, R. J. (2014). An online survey comparing swingers and polyamorists. *Electronic Journal of Human Sexuality,* Article 17.

Johnson, A. L. (2013). Counseling the polyamorous client: Implications for competent practice. *VISTAS Online,* Article 50.

Jonason, P. K., Valentine, K. A., & Li, N. P. (2012). Human mating. In V. S. Ramachandran (Ed.) *The encyclopedia of human behavior* (2nd ed., pp. 371-377). Oxford University Press.

Jones, A. (2019). Sex is not a problem: The erasure of pleasure in sexual science research. *Sexualities, 22*(4), 643-668. https://doi.org/10.1177/1363460718760210

Karp, K. (Writer), & Folkson, S. (Director). (2021, June 25). Small town Saturday night (Season 1, Episode 7) [TV series episode]. In J. Borsiczky, J. Hawley, & S. Rukeyser (Executive producers), *Sex/life*. Demilo Films; Demilo Productions.

Kean, J. (2015). A stunning plurality: Unraveling hetero- and mononormativities through HBO's *Big Love. Sexualities, 18*(5-6), 698-713. https://doi.org/10.1177/1363460714561718

Kelley, M., Poul, A., & Barbee, C. (Executive producers). (2008). *Swingtown* [TV series]. Mike Kelley/Alan Poul Productions; CBS Paramount Network Television.

Killeen, E. (2022). Consensual non-monogamy and relationship satisfaction. *Canadian Journal of Family and Youth, 14*(2), 92-102. https://doi.org/10.29173/cjfy29825

Kinsey, A. C., Pomeroy, W. B., & Martin, C. E. (1948). *Sexual behavior in the human male*. W. B. Saunders Company.

Kinsey, A. C., Pomeroy, W. B., Martin, C. E., & Gebhaard, P. H. (1953). *Sexual behavior in the human female*. W. B. Saunders Company.

Knowles, M. L., & Gardner, W. L. (2008). Benefits of membership: The activation and amplification of group identities in response to social rejection. *Personality & Social Psychology Bulletin*, *34*(9), 1200-1213. https://doi.org/10.1177/0146167208320062

Kolesar, A. E. A., & Pardo, S. T. (2019). The religious and philosophical characteristics in a consensually nonmonogamous sample. *International Journal of Transpersonal Studies, 38*(1), 99-117. https://doi.org/10.24972/ijts.2019.38.1.99

Lecuona, O., Suero, M., Wingen, T., & de Rivas, S. (2021). Does "open" rhyme with "special"? Comparing personality, sexual satisfaction, dominance, and jealousy of monogamous and non-monogamous practitioners. *Archives of Sexual Behavior, 50*, 1537-1549. https://doi.org/10.1007/s10508-020-01865-x

Legualt, M., Pasternak, D., Lawless, L., & Clark, L. (2020). *Landmark U.S. Supreme Court ruling prohibits sexual orientation and gender identity-based discrimination in employment.* Employment Law Worldview. https://www.employmentlawworldview.com/landmark-u-s-supreme-court-ruling-prohibits-sexual-orientation-and-gender-identity-based-discrimination-in-employment-us/

Lehmiller, J. J. (2015). A comparison of sexual health history and practices among monogamous and consensually non-monogamous sexual partners. *The Journal of Sexual Medicine, 12*(10), 2022-2028. doi:10.1111/jsm.12987

Lehmiller, J. J. (2020). Fantasies about consensual nonmonogamy among persons in monogamous romantic relationships. *Archives of Sexual Behavior, 49*(8), 2799-2812. https://doi.org/10.1007/s10508-020-01788-7

Levine, E. C., Herbenick, D., Martinez, O., Fu, T.-C., & Dodge, B. (2018). Open relationships, nonconsensual nonmonogamy, and monogamy among U.S. adults: Findings from the 2012 national survey of sexual health and behavior. *Archives of Sexual Behavior, 47*(5), 1439-1450. https://doi.org/10.1007/s10508-018-1178-7

Lin, Y.-J., Israel, T., & Ryan, W. S. (2019). Releasing internalized stigma for empowerment: Development of theory-driven interventions for sexual and gender minorities. *Journal of LGBT Issues in Counseling, 13*(4), 276-292. https://doi.org/10.1080/15538605.2019.1662358

MacDonald, K. (2001). Theoretical pluralism and historical complexity in the development and maintenance of socially imposed monogamy: A comment on Kanazawa and Still. *Social Forces*, *80*(1), 343-347. https://doi.org/10.1353/sof.2001.0080

Main, M., & Solomon, J. (1986). Discovery of an insecure-disorganized/disoriented attachment pattern. In Brazelton, T. B. & Yogman, M. W. (Eds.), *Affective development in infancy* (pp. 95-124). Ablex Publishing.

Marcia, J. E. (1966). Development and validation of ego-identity status. *Journal of Personality and Social Psychology, 3*(5), 551-558. https://doi.org/10.1037/h0023281

Marcia, J. E. (1980). Identity in adolescence. In J. Adelson (Ed.), *Handbook of adolescent psychology*. Wiley.

McCarn, S. R., & Fassinger, R. E. (1996). Revisioning sexual minority identity formation: A new model of lesbian identity and its implications for counseling and research. *The Counseling Psychologist*, *24*(3), 508-534. https://doi.org/10.1177/0011000096243011

McNamara, A. (2020, July 3). *Massachusetts city officially recognizes polyamorous relationships.* CBS News. https://www.cbsnews.com/news/somerville-massachusetts-recognizes-polyamorous-relationships/

Merriam-Webster. (n.d.). *Merriam-Webster.com dictionary*. https://www.merriam-webster.com/

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychology Bulletin, 129*(5), 674-697. https://doi.org.10.1037/0033-2909.129.5.674

Meyer, I. H., & Frost, D. M. (2012). Minority stress and the health of sexual minorities. In C. J. Patterson & A. R. D'Augelli (Eds.), *Handbook of psychology and sexual orientation* (pp. 252-266). https://doi.org/10.1093/acprof:oso/9780199765218.001.0001

Mitchell, J. C. (2006). *Shortbus* [Film]. THINKFilm; Fortissimo Films; Q Television; Process Media.

Mogilski, J. K., Mitchell, V. E., Reeve, S. D., Donaldson, S. H., Nicolas, S., & Welling, L. (2020). Life history and multi-partner mating: A novel explanation for moral stigma against consensual non-monogamy. *Frontiers in Psychology, 10*, 3033. https://doi.org/10.3389/fpsyg.2019.03033

Moors, A. C. (2016). Has the American public's interest in information related to relationships beyond "the couple" increased over time? *The Journal of Sex Research, 54*(6), 677-684. https://doi.org/10.1080/00224499.2016.1178208

Moors, A. C., Chopik, W., Edelstein, R., & Conley, T. (2014). Consensual non-monogamy: Table for more than two, please. *In Mind Magazine,* 6(21). https://www.in-mind.org/article/consensual-non-monogamy-table-for-more-than-two-please

Moors, A. C., Conley, T. D., Edelstein, R. S., & Chopik, W. J. (2015). Attached to monogamy? Avoidance predicts willingness to engage (but not actual engagement in) consensual non-monogamy. *Journal of Social and Personal Relationships, 32*(2), 222-240. https://doi.org/10.1177/0265407515429065

Moors, A. C., Gesselman, A. N., & Garcia, J. R. (2021). Desire, familiarity, and engagement in polyamory: Results from a national sample of single adults in the United States. *Frontiers in Psychology, 23*(12), 619-640. https://doi.org/10.3389/fpsyg.2021.619640

Moors, A. C., Matsick, J. L., & Schechinger, H. A. (2017). Unique and shared relationship benefits of consensually non-monogamous and monogamous relationships: A review and insights for moving forward. *European Psychologist, 22*(1), 55-71. https://doi.org/10.1027/1016-9040/a000278

Moors, A. C., Ryan, W., & Chopik, W. J. (2019). Multiple loves: The effects of attachment with multiple concurrent romantic partners on relational functioning. *Psychology and Individual Differences, 147*, 102-110. https://doi.org/10.1016/j.paid.2019.04.023

Moors, A. C., & Schechinger, H. A. (2014). Understanding sexuality: Implications of Rubin for relationship research and clinical practice. *Sexual and Relationship Therapy*, *29*(4), 476-482.

Moors, A. C., Schechinger, H. A., Balzarini, R., & Flicker, S. (2021). Internalized consensual non-monogamy negativity and relationship quality among people engaged in polyamory, swinging, and open relationships. *Archives of Sexual Behavior, 50*(1), 1389-1400. https://doi.org/10.1007/s10508-020-01885-7

Morrison, T. G., Beaulieu, D., Brockman, M., & Beaglaoich, C. Ó. (2011). A comparison of polyamorous and monoamorous persons: Are there differences of relationship well-being and sociosexuality? *Psychology & Sexuality, 4*(1), 75-91. https://doi.org/10.1080/19419899.2011.631571

Movement Advancement Project. (2022). *Equality maps: Foster and adoption laws.* https://www.lgbtmap.org/equality-maps/foster_and_adoption_laws

Muise, A., Laughton, A. K., Moors, A., & Impett, E. A. (2018). Sexual need fulfillment and satisfaction in consensually nonmonogamous relationships. *Journal of Social and Personal Relationships, 36*(7), 1917-1938. https://doi.org/10.1177/0265407518774638

Negash, S., Bui, M., Fincham, F. D., & Pasley, K. (2014). Extradyadic involvement and relationship dissolution in heterosexual women university students. *Archives of Sexual Behavior, 43*(3), 531-539. https://doi.org/10.1007/s10508-013-0213-y

Oehme, N., Bruserud, I. S., Madsen, A., & Júlíusson, O. (2020). Starter puberteten tidligere enn før? [Is puberty starting earlier than before?]. *Tidsskrift for den Norske Laegeforening, 140*(12), 1-5. https://doi.org/10.4045/tidsskr.20.0043

Olsen, M. V., Sheffer, W., Knoller, D., Goetzman, G., Hanks, T., & Caulfield, B. (Executive Producers). (2006-2011). *Big love* [TV series]. Anima Sola Productions; Playtone.

Parker, G. A. (2020). Conceptual developments in sperm competition: A very brief synopsis. *Philosophical Transitions of the Royal Society B, 375*(1813). https://doi.org/10.1098/rstb.2020.0061

Pivec, N. (2018). "Three (is not a crowd)": An analysis of *Tom Tykwer's* polyamorous film *Three*. *Graduate Journal of Social Science, 14*(1), 79-99.

Polyamory Legal Advocacy Coalition. (n.d.). *Frequently asked questions (FAQ).* https://polyamorylegal.org/faqs

Rambukkana, N. (2015). *Fraught intimacies: Non/monogamy in the public sphere*. UBC Press.

Ramos, M. R., Cassidy, C., Reicher, S., & Haslam, S. A. (2012). A longitudinal investigation of the rejection-identification hypothesis. *British Journal of Social Psychology, 51*, 642-660. https://doi.org/10.1111/j.2044-8309.2011.02029.x

Rape, Abuse & Incest National Network (RAINN). (2020, March). Consent Laws.

Regula, L. (2021). Times and terms: Teaching anatomy that is inclusive and respectful of LGBTQ patients. *Academia Letters,* Article 2940. doi:10.20935/AL2940

Ritchie, A., & Barker, M. (2006). "There aren't words for what we do or how we feel so we have to make the up": Constructing polyamorous languages in a culture of compulsory monogamy. *Sexualities, 9*(5), 584-601. https://doi.org/10.1177/1363460706069987

Robinson, M. (2013). Polyamory and monogamy as strategic identities. *Journal of Bisexuality, 13*(1), 21-38. https://doi.org/10.1080/15299716.2013.755731

Rodrigues, D., Lopes, D., & Pereira, M. (2016). "We agree and now everything goes my way": Consensual sexual nonmonogamy, extradyadic sex, and relationship satisfaction. *Cyberpsychology, Behavior, and Social Networking, 19*(6), 373-379. https://doi.org/10.1089/cyber.2016.0114

Rothschild, L. (2018). Compulsory monogamy and polyamorous existence. *Graduate Journal of Social Science, 14*(1), 28-56. http://gjss.org/sites/default/files/issues/chapters/papers/GjSS%20Vol%2014-1%20Rothschild.pdf

Rubel, A. N., & Bogaert, A. F. (2015). Consensual nonmonogamy: Psychological well-being and relationship quality correlates. *Journal of Sex Research, 52*(9), 961-982. https://doi.org/10.1080/00224499.2014.942722

Rubin, J. D., Moors, A. C., Matsick, J. L., Ziegler, A., & Conley, T. D. (2014). On the margins: Considering diversity among consensually non-monogamous relationships. *Journal für Psychologie, 22*(1), 19-37. https://digitalcommons.chapman.edu/psychology_articles/133/

Schacht, R., & Kramer, K. L. (2019). Are we monogamous? A review of the evolution of pair-bonding in humans and its contemporary variation cross-culturally. *Frontiers in Ecological Evolution, 7.* https://doi.org/10.3389/fevo.2019.00230

Schechinger, H. A., Sakaluk, J. K., & Moors, A. C. (2018). Harmful and helpful therapy practices with consensually non-monogamous clients: Toward an inclusive framework. *Journal of Consulting and Clinical Psychology 86*(11), 879-891. https://doi.org/10.1037/ccp0000349

Séguin, L. J. (2017). The good, the bad, and the ugly: Lay attitudes and perceptions of polyamory. *Sexualities, 22*(4), 669-690. https://doi.org/10.1177/1363460717713382

Séguin, L. J., Blais, M., Goyer, M.-F., Adam, B. D., Lavoi, F., Rodrigue, C., & Magontier, C. (2017). Examining relationship quality across three types of relationship agreements. *Sexualities, 20*(1-2), 86-104. https://doi.org/10.1177/1363460716649337

Selterman, D., Gesselman, A. N., & Moors, A. C. (2019). Sexuality through the lens of secure base dynamics: Individual differences in sexploration. *Personality and Individual Differences, 147,* 229-236. https://doi.org/10.31234/osf.io/zsg3x

Shaver, P. R., & Hazan, C. (1988). A biased overview of the study of love. *Journal of Social and Personality Relationships, 5,* 473-501. https://www.academia.edu/20456630/A_Biased_Overview_of_the_Study_of_Love

Shaver, P. R., & Mikulincer, M. (2009). An overview of adult attachment theory. In J. H. Obegi & E. Berant (Eds.), *Attachment theory and research in clinical work with adults* (pp. 17-45). The Guilford Press.

Sheff, E. (2011). Polyamorous families, same-sex marriage, and the slippery slope. *Journal of Contemporary Ethnography, 40*(5), 487-520. https://doi.org/10.1177/0891241611413578

Sheff, E. (2012, October 23). *Three waves of non-monogamy: A select history of polyamory in the United States*. Sheff Consulting. https://elisabethsheff.com/2012/09/09/three-waves-of-polyamory-a-select-history-of-non-monogamy/

Sheff, E. (2014). *The polyamorists next door: Inside multiple-partner relationships and families.* Rowman & Littlefield Publishers.

Sizemore, K. M., & Olmstead, S. B. (2017). Willingness to engage in consensual nonmonogamy among emerging adults: A structural equation analysis of sexual identity, casual sex attitudes, and gender. *The Journal of Sex Research, 54*(9), 1106-1117. https://doi.org/10.1080/00224499.2016.1243200

Taormino, T. (2008). *Opening up: A guide to creating and sustaining open relationships.* Cleis Press.

Thorne, S. R., Hegarty, P., & Hepper, E. G. (2019). Equality in theory: From a heteronormative to an inclusive psychology of romantic love. *Theory & Psychology, 29*(2), 240-257. https://doi.org/10.1177/0959354319826725

U.S. Census Bureau. (n.d.). *U.S. and world population clock.* https://www.census.gov/popclock/

U.S. Marriage Laws. (n.d.). *United States marriage laws.* https://www.usmarriagelaws.com/

Vaughan, M. D., Jones, P., Taylor, A., & Roush, J. (2018). Healthcare experiences and needs of consensually non-monogamous people: Results from a focus group study. *The Journal of Sexual Medicine, 16*(1), 42-51. https://doi.org/10.1016/j.jsxm.2018.11.006

Vilkin, E., & Sprott, R. (2021). Consensual non-monogamy among kink-identified adults: Characteristics, relationship experiences, and unique motivations for polyamory and open relationships. *Archives of Sexual Behavior, 50*, 1521-1536. https://doi.org/10.1007/s10508-021-02004-w

Williams Institute. (2019, January). *LGBT demographic data interactive*. https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT#about-the-data

Worthington, R. L., Savoy, H. B., Dillon, F. R., & Vernaglia, E. R. (2002). Heterosexual identity development: A multidimensional model of individual and social identity. *The Counseling Psychologist, 30*(4), 496-531. https://doi.org/10.1177/00100002030004002

Zestcott, C. A., Bair, I. V., & Stone, J. (2016). Examining the presence, consequences, and reduction of implicit bias in health care: A narrative review. *Group Process Intergroup Relations, 19*(4), 528-542. https://doi.org/10.1177/1368430216642029

Appendix A

CNM-Affirming Semi-Structured Intake Assessment

Identifying Information:

Name: ______________________________________

Age: ______________________________________

Pronouns: ______________________________________
Alternatively, you may choose from the following options (please select all that apply):

☐ Ae/aer
☐ He/him
☐ She/her
☐ They/them
☐ Ze/zir
☐ Decline to answer

Gender identity: ______________________________________
Alternatively, you may choose from the following options (please select all that apply):

☐ Female
☐ Genderqueer / gender fluid
☐ Intersex
☐ Male
☐ Nonbinary
☐ Transgender female / transgender woman
☐ Transgender male / transgender man
☐ Two-spirit
☐ Decline to answer

Sexual orientation: ______________________________________
Alternatively, you may choose from the following options (please select all that apply):

☐ Asexual
☐ Bisexual
☐ Gay
☐ Heterosexual
☐ Lesbian
☐ Queer
☐ Questioning
☐ Decline to answer

Relationship status: ____________________________________
Alternatively, you may choose from the following options (please select all that apply):

- ☐ Consensually/ethically non-monogamous
  Please specify your relationship style, or choose from the following (select all that apply): ____
  - ☐ Monogamish
  - ☐ Open relationship
  - ☐ Polyamorous
  - ☐ Relationship anarchist
  - ☐ Swinging relationship
- ☐ Divorced
- ☐ Domestic partnership / living with partner(s)
- ☐ Married
- ☐ Partnered, not living together
- ☐ Single, never married
- ☐ Widowed
- ☐ Decline to answer

Race: _____________________________________

Ethnicity: _____________________________________

Emergency Contacts:

	Name	Relationship	Contact Information (phone number, email address)
1			
2			
3			
4			
5			
6			

[For insurance purposes only]

Name on insurance card: _____________________________________

Sex assigned at birth: _____________________________________

Presenting Concern(s):

1. Referral source:
   ____
   ____
2. Reasons for seeking treatment:
   ____
   ____
3. History of current symptoms:
   a. Onset
      ____
      ____
      i. Precipitating factors
         ____
         ____
   b. Duration
      ____
      ____
   c. Intensity
      ____
      ____
      i. Level of subjective distress
         ____
         ____
   d. Frequency
      ____
      ____
4. Barriers to care:
   a. Have you experienced any difficulty (past or present) accessing services?
      ____
      ____
      i. Patient-level:
         1. Financial constraints:
            ____
            ____
         2. Time constraints:
            ____
            ____
         3. Transportation concerns:
            ____
            ____
         4. Language barrier:
            ____
            ____

ii. Provider-level:
   1. Lack of provider knowledge regarding your presenting concerns:
      ____
      ____
   2. Discrimination concerns / history of discrimination in the healthcare system:
      ____
      ____

iii. System-level:
   1. Lack of insurance coverage:
      ____
      ____
   2. Long wait times for scheduling appointments:
      ____
      ____
   3. Limited office hours:
      ____
      ____

iv. Other identified barriers to care:
   ____
   ____

Psychiatric History:

1. Have you ever been in therapy before?
   a. If no:
      i. Have you ever considered engaging in therapy before now?
         ____
         ____
         1. *If no, skip to Question 2 (History of Diagnosis/es).*
         2. If yes, what stopped you from going at that time?
            ____
            ____
   b. If yes:
      i. What was your experience like?
         ____
         ____
      ii. How did your therapeutic relationship end?
         ____
         ____
      iii. What felt helpful?
         ____
         ____
      iv. What did not feel helpful?
         ____
         ____

2. Have you ever been diagnosed with a psychiatric disorder, or have you ever suspected that you had a psychiatric disorder?
    a. *If no, skip to Item C (Medications).*
    b. If yes, which one(s)?

        ____

        ____

    c. Are you currently prescribed any psychotropic medication(s)?
        i. If no:
            1. Have you ever been prescribed psychotropic medications in the past?
                a. *If no, skip to Question 3 (Hospitalization).*
                b. If yes:
                    i. Which medications?

                        ____

                        ____

                    ii. What was/were the medication(s) prescribed for?

                        ____

                        ____

                    iii. How long were you prescribed the medication(s) for?

                        ____

                        ____

                    iv. Did you take them as prescribed?
                        1. If no, what got in the way?

                            ____

                            ____

        ii. If yes:
            1. What medication(s)?

                ____

                ____

            2. What is/are your medication(s) prescribed for?

                ____

                ____

            3. Do you take your medication as prescribed?

                ____

                ____

                a. If no, what gets in the way of doing so?

                    ____

                    ____

            4. How happy are you with your current medication(s)?

                ____

                ____

3. Have you ever been voluntarily/involuntarily hospitalized?
    a. *If no, skip to Question 4 (Familial Psychiatric History).*
    b. If yes, what was the reason?
    ____
    ____
4. Does anyone in your family of origin (birth family) have a history of mental illness?
    a. *If no, skip to Question 5 (Other Psychiatric History).*
    b. If yes, who?
    ____
    ____
5. Does any other significant person in your life (chosen family, partner(s), friends) have a history of mental illness?
    a. *If no, skip to Risk Assessment section.*
    b. If yes, who?
    ____
    ____

Risk Assessment:

1. Non-suicidal self-injury:
    a. Have you ever cut, scratched, or burned yourself when you were upset?
    ____
    ____
    b. Have you ever intentionally caused harm to yourself?
    ____
    ____
        i. *If no, skip to Question 2 (Suicidal Ideation).*
        ii. What did you do?
        ____
        ____
        iii. When did you ___?
        ____
        ____
        iv. Were you trying to kill yourself when you ___?
        ____
        ____
        v. Did you want to die (even a little) when you ___?
        ____
        ____
        vi. Did you think it was possible you could have died from ___?
        ____
        ____
2. Suicidal ideation:
    a. Have you ever thought about being dead or wished you could go to sleep and not wake up?

b. Have you ever had any thoughts about killing yourself?

   i. *If no, skip to Item C (Protective Factors).*
   ii. If yes, have you ever planned out how you might kill yourself?

      1. *If no, skip to Item iii (Preparation).*
      2. If yes:
         a. What was your plan?

         b. When you made this plan, was any part of you thinking about actually doing it?

         c. When were you thinking of acting on these thoughts?

   iii. Have you done anything to get ready to end your life (e.g., giving things away, writing a goodbye note, getting items you needed to kill yourself)?

      1. *If no, skip to Item iv (Interrupted Attempt).*
      2. If yes, what did you do?

   iv. Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?

      1. *If no, skip to Item v (Aborted Attempt).*
      2. If yes, what did you do?

   v. Has there been a time when you started to do something to end your life, but you changed your mind (stopped yourself) before you actually did anything?

      1. *If no, skip to Item vi (History of Attempts).*

2. What did you do?

____

____

vi. Have you ever attempted to kill yourself?

____

____

1. *If no, skip to Item c (Protective Factors).*
2. If yes, what did you do?

____

____

c. On bad days, what are some of your reasons to continue living (protective factors)?

____

____

3. Homicidal ideation
   a. Have you ever thought about physically harming someone else?

____

____

i. *If no, skip to Brief Trauma Assessment section.*
ii. If yes, did you act on it?
1. If no, what stopped you?

____

____

2. If yes:
   a. What was your plan?

____

____

b. When you made this plan, was any part of you thinking about actually doing it?

____

____

c. When were you thinking of acting on these thoughts?

____

____

Brief Trauma Assessment:

1. Have you ever experienced something that you would consider traumatic?

____

____

a. *If no, skip to Question 2 (Harassment, Bullying, Discrimination).*
b. If yes:
   i. What happened?

____

____

ii. When did this/these event(s) occur?

____

____

iii. Do you think this/these event(s) impacted you in any way?

____

____

2. Have you ever been harassed, bullied, or discriminated against based on any aspect of your identity?

____

____

a. *If no, skip to Question 3 (Healthcare Discrimination/Judgment).*
b. If yes:
i. What happened?

____

____

ii. When did this/these events occur?

____

____

iii. Do you think this/these event(s) impacted you in any way?

____

____

3. Have you ever felt discriminated against or judged by a healthcare provider based on any aspect of your identity?

____

____

a. *If no, skip to Psychosocial History section.*
b. If yes:
i. What happened?

____

____

ii. When did this/these events occur?

____

____

iii. Do you think this/these event(s) impacted you in any way?

____

____

Psychosocial History:

1. Who would you consider to be your "family"?

____

____

a. Family of origin:
i. What is your relationship like with each of the members of your family of origin?

ii. What was it like growing up in your home as a child?

iii. What are some of your family's values?

b. Children/grandchildren:

i. *If none identified, skip to Question 2 (Romantic History).*

ii. What is your relationship like with them/each of them?

iii. Do you have legal custody of your children/grandchildren?

c. Found family/chosen family:

i. What is your relationship like with them/each of them?

ii. What are some of the things (i.e., values, traits, hobbies) that drew you to them?

2. Romantic history:

a. Are you currently in one or more romantic relationships?

i. If no:

1. Have you ever been in a significant romantic relationship?

2. How did that/those relationship(s) end?

ii. If yes:

1. How long have you been with your current partner(s)?

a. If 2+ partners identified:

i. Would you consider your relationship(s) to be hierarchical or nonhierarchical in nature?

ii. How would you describe your position within these relationship(s)?

2. What is your level of satisfaction with your relationship(s)?
3. Do you have any concerns about your relationship(s)?
4. Is/are your partner(s) supportive of you and your identity?
5. Do you ever feel unsafe with your partner(s)?

3. Are you currently sexually active?
   a. *If no, skip to Question 4 (Trusted Friend/s).*
   b. *If yes, skip to Physical Health section, Question 3 (Sexual Activity), and then return to Question 4 (Trusted Friend/s) in this section.*
4. Do you have a trusted friend or friend group?
   a. If no:
      i. What do you do when you feel you could use support?
   b. If yes:
      i. What is/are that/those relationship(s) like?
      ii. Do you have any concerns about your friendship(s)?
      iii. When is the last time you were in contact with your friend(s)?
5. What are your religious and spiritual beliefs, if any?
   a. *If none identified, skip to Question 6 (Living Situation).*
   b. Religious/spiritual beliefs identified:
   c. Have you ever felt discriminated against or judged by your religious/spiritual group, based on any aspect of your identity?
      i. *If no, skip to Question 6 (Living Situation).*
      ii. If yes:

1. What happened?

___

___

2. When did this/these events occur?

___

___

3. Do you think this/these event(s) impacted you in any way?

___

___

6. Living situation:
   a. Where do you currently live?

   ___

   ___

   b. Do you currently live with anyone (including pets)?

   ___

   ___

   c. Do you feel safe in your home?

   ___

   ___

   d. Have you ever experienced, or been concerned about, homelessness?

   ___

   ___

7. Education:
   a. What was elementary, middle, and high school like for you?

   ___

   ___

   b. Did you ever skip school or leave school early?
      i. *If no, skip to Item C (Harassment, Bullying, Discrimination).*
      ii. If yes, what was/were the reason(s) for this?

      ___

      ___

   c. While in school, were you ever harassed, bullied, or discriminated against based on any aspect of your identity (by peers, faculty, staff, coaches)?
      i. *If no, skip to Item D (Friends, Acquaintances).*
      ii. If yes:
         1. What was the outcome of the harassment, bullying, or discrimination?

         ___

         ___

         2. Do you ever think about these experience(s) now?

         ___

         ___

   d. Did you have any friends or acquaintances in school?
      i. *If no, skip to Item E (Clubs, Teams).*
      ii. If yes:

1. What were those relationships like?

   ____

   ____

2. Have you maintained any of those friendships?

   ____

   ____

e. Did you ever belong to any academic/social clubs or sports teams?
   - *i. If no, skip to Item F (High School Completion).*
   - ii. If yes:
     1. Which one(s)?

        ____

        ____

     2. What did you like/not like about being a part of those clubs/teams?

        ____

        ____

f. Did you complete high school?
   - i. If no, what got in the way?

     ____

     ____

   - ii. If yes, what is your highest level of education?

     ____

     ____

g. Are you currently in school?
   - *i. If no, skip to Question 7 (Employment).*
   - ii. If yes:
     1. What are you studying?

        ____

        ____

     2. What is the school environment like?

        ____

        ____

     3. Have you experienced any instance(s) of harassment, bullying, or discrimination (by peers, faculty, staff)?

        ____

        ____

8. Employment:
   a. Are you currently employed?
      - i. If no:
        1. Are you looking for employment?

           ____

           ____

        2. *If no, skip to Item b (Financial Concerns).*
      - ii. If yes:

1. Where are you currently employed?
2. How long have you been employed there?
3. How is the work environment?
4. Do you get along with your coworkers?
5. Have you ever had negative interactions with others at work?
6. Has anyone in the workplace made you feel that you needed to change who you are or how you express your identity?
   a. If so, what happened?

b. Do you have any financial concerns at this time?

9. Legal
   a. Have you ever been arrested?
      i. *If no, skip to Item b (Victim of a Crime).*
      ii. If yes:
         1. For what charge(s)?
         2. Are you currently fighting against this/these charge(s)?
         3. What was the outcome of the charges?
   b. Have you ever been a victim of a crime?
      i. *If no, skip to Item c (Custody of Children/Grandchildren).*
      ii. If yes,

1. Was/were this/these crime(s) related to any aspect of your identity?

____

____

c. *[If the client/patient previously identified children/grandchildren in their custody]*: Do you have any concerns about maintaining custody of your children/grandchildren?

____

____

<u>Physical Health</u>:

1. Do you have any physical health concerns/conditions?

____

____

   a. *If no, skip to Question 2 (Negative Healthcare Experiences).*
   b. If yes:
      i. Do you have access to medical care?

      ____

      ____

         1. If no, what are some barriers that get in the way / what are some of your hesitations in contacting a medical health provider?

         ____

         ____

      ii. How are you managing your physical health concerns?

      ____

      ____

2. Have you had any negative healthcare experiences?

____

____

   a. *If no, skip to Question 3 (Sexual Activity).*
   b. If yes:
      i. What about the experience made it negative?

      ____

      ____

      ii. What do you think we could do to make sure this experience is more comfortable for you than your previous experiences?

      ____

      ____

3. Are you sexually active with one or more sexual partners?

____

____

   a. *If no, skip to item "c" (assessing knowledge/engagement in safe sex practices)*
   b. If yes:
      i. How many sexual partners do you currently have?
      ii. What kind of sex do you engage in?
         1. Oral sex on a vagina

2. Oral sex on an anus
3. Oral sex on a penis
4. Vaginal penetration
5. Anal penetration
6. Sex without penetration
7. Another form of sex: ______________________________

c. What does "safe sex practices" mean to you?
____
____
    i. What "safe sex practices" do you use?
    ____
    ____
        1. If none, what gets in the way?
        ____
        ____

d. Do you have any sexual health concerns?
    i. *If no, skip to "Substance Use" section.*
    ii. If yes, how are you managing these concerns?
    ____
    ____

Substance Use:

1. Do you currently - or have you ever used - any of the following substances?
    a. Caffeine
    b. Nicotine
    c. Alcohol
    d. Marijuana
    e. Psilocybin
    f. Cocaine
    g. Ecstasy/MDMA/Molly
    h. Methamphetamine
    i. PCP
    j. Ketamine
    k. Heroin
    l. Another/other substance(s): ______________________________
2. *If none endorsed, skip to Resources section.*
3. If use of one or more substances endorsed:
    a. For each endorsed substance, assess for:
        i. Age of first use
        ____
        ____

ii. Amount used

____

____

iii. Frequency of use

____

____

b. In what circumstances do/did you typically use these this/these substance(s)?

____

____

c. Do/did you engage in the use of this/these substance(s) consensually?

____

____

d. What do/did you like about using this/these substances?

____

____

e. Have you ever used any of these substances intravenously?

____

____

f. Has anyone ever criticized you for your use of substance(s)?

____

____

g. Have you ever felt bad or guilty about your use of substance(s)?

____

____

h. Do/did you ever engage in harmful behavior while under the influence of one or more of these substances (e.g., unprotected sex, driving under the influence, etc.)?

____

____

4. Do you use any over the counter medications or herbal remedies?

____

____

<u>Resources</u>:

1. Are there any resources that you are hoping I can help you to get connected with?

____

____

2. Are there any resources that you have been seeking but have been unable to secure?

____

____

3. How might we be able to tailor this space to fit your needs (what will make you most comfortable in therapy)?

____

____

Appendix B

Proposed Training for Systems: The Significance of CNM-Inclusive Intake Forms

Importance of Inclusive Intake Assessments

- Existing administrative forms perpetuate heteronormative and mononormative biases (Haupert et al., 2019)
- Practices that erase or invalidate their minority identities (i.e., non-inclusive intake or patient history forms) can exacerbate the impact of minority stress and/or internalized stigma (Carlström & Andersson, 2019a; Vaughan et al., 2018)
- Intake assessment is oftentimes the first point of contact for a client/patient

Thus, it is imperative to ensure that the intake assessment is inclusive and validating of all of the client/patient's identities.

Proposed CNM-Inclusive Intake Assessment Tool: Identifying Information

CNM-Affirming Semi-Structured Intake Assessment

Identifying Information:

Name: ____________________

Age: ____________________

Pronouns: ____________________
Alternatively, you may choose from the following options (please select all that apply):
- ☐ Ae/aer
- ☐ He/him
- ☐ She/her
- ☐ They/them
- ☐ Ze/zir
- ☐ Decline to answer

Gender identity: ____________________
Alternatively, you may choose from the following options (please select all that apply):
- ☐ Female
- ☐ Genderqueer / gender fluid
- ☐ Intersex
- ☐ Male
- ☐ Nonbinary
- ☐ Transgender female / transgender woman
- ☐ Transgender male / transgender man
- ☐ Two-spirit
- ☐ Decline to answer

Sexual orientation: ____________________
Alternatively, you may choose from the following options (please select all that apply):
- ☐ Asexual
- ☐ Bisexual
- ☐ Gay
- ☐ Heterosexual
- ☐ Lesbian
- ☐ Queer
- ☐ Questioning
- ☐ Decline to answer

Relationship status: ____________________
Alternatively, you may choose from the following options (please select all that apply):
- ☐ Consensually/ethically non-monogamous
  Please specify your relationship style, or choose from the following (select all that apply):
  ____
  - ☐ Monogamish
  - ☐ Open relationship
  - ☐ Polyamorous
  - ☐ Relationship anarchist
  - ☐ Swinging relationship
- ☐ Divorced
- ☐ Domestic partnership / living with partner(s)
- ☐ Married
- ☐ Partnered, not living together
- ☐ Single, never married
- ☐ Widowed
- ☐ Decline to answer

Race: ____________________

Ethnicity: ____________________

Emergency Contacts:

	Name	Relationship	Contact Information (phone number, email address)
1			
2			
3			
4			
5			
6			

[For insurance purposes only]

Name on insurance card: ____________________

Sex assigned at birth: ____________________

Proposed CNM-Inclusive Intake Assessment Tool: Presenting Concerns

Presenting Concern(s):

1. Referral source:
2. Reasons for seeking treatment:
3. History of current symptoms:
   a. Onset
      i. Precipitating factors
   b. Duration
   c. Intensity
      i. Level of subjective distress
   d. Frequency
4. Barriers to care:
   a. Have you experienced any difficulty (past or present) accessing services?
      i. Patient-level:
         1. Financial constraints:
         2. Time constraints:
         3. Transportation concerns:
         4. Language barrier:
      ii. Provider-level:
         1. Lack of provider knowledge regarding your presenting concerns:
         2. Discrimination concerns / history of discrimination in the healthcare system:
      iii. System-level:
         1. Lack of insurance coverage:
         2. Long wait times for scheduling appointments:
         3. Limited office hours:
      iv. Other identified barriers to care:

Proposed CNM-Inclusive Intake Assessment Tool: Psychiatric History

Psychiatric History:

1. Have you ever been in therapy before?
   a. If no:
      i. Have you ever considered engaging in therapy before now?
         1. *If no, skip to Question 2 (History of Diagnosis/es).*
         2. If yes, what stopped you from going at that time?
   b. If yes:
      i. What was your experience like?
      ii. How did your therapeutic relationship end?
      iii. What felt helpful?
      iv. What did not feel helpful?
2. Have you ever been diagnosed with a psychiatric disorder, or have you ever suspected that you had a psychiatric disorder?
   a. *If no, skip to Item C (Medications).*
   b. If yes, which one(s)?
   c. Are you currently prescribed any psychotropic medication(s)?
      i. If no:
         1. Have you ever been prescribed psychotropic medications in the past?
            a. *If no, skip to Question 3 (Hospitalization).*
            b. If yes:
               i. Which medications?
               ii. What was/were the medication(s) prescribed for?
               iii. How long were you prescribed the medication(s) for?
               iv. Did you take them as prescribed?
                  1. If no, what got in the way?
      ii. If yes:
         1. What medication(s)?
         2. What is/are your medication(s) prescribed for?
         3. Do you take your medication as prescribed?
            a. If no, what gets in the way of doing so?
         4. How happy are you with your current medication(s)?
3. Have you ever been voluntarily/involuntarily hospitalized?
   a. *If no, skip to Question 4 (Familial Psychiatric History).*
   b. If yes, what was the reason?
4. Does anyone in your family of origin (birth family) have a history of mental illness?
   a. *If no, skip to Question 5 (Other Psychiatric History).*
   b. If yes, who?
5. Does any other significant person in your life (chosen family, partner(s), friends) have a history of mental illness?
   a. *If no, skip to Risk Assessment section.*
   b. If yes, who?

Proposed CNM-Inclusive Intake Assessment Tool: Risk Assessment

Risk Assessment:

1. Non-suicidal self-injury:
    a. Have you ever cut, scratched, or burned yourself when you were upset?
    b. Have you ever intentionally caused harm to yourself?
        i. *If no, skip to Question 2 (Suicidal Ideation).*
        ii. What did you do?
        iii. When did you ___?
        iv. Were you trying to kill yourself when you ___?
        v. Did you want to die (even a little) when you ___?
        vi. Did you think it was possible you could have died from ___?
2. Suicidal ideation:
    a. Have you ever thought about being dead or wished you could go to sleep and not wake up?
    b. Have you ever had any thoughts about killing yourself?
        i. *If no, skip to Item C (Protective Factors).*
        ii. If yes, have you ever planned out how you might kill yourself?
            1. *If no, skip to Item iii (Preparation).*
            2. If yes:
                a. What was your plan?
                b. When you made this plan, was any part of you thinking about actually doing it?
                c. When were you thinking of acting on these thoughts?
        iii. Have you done anything to get ready to end your life (e.g., giving things away, writing a goodbye note, getting items you needed to kill yourself)?
            1. *If no, skip to Item iv (Interrupted Attempt).*
            2. If yes, what did you do?
        iv. Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?
            1. *If no, skip to Item v (Aborted Attempt).*
            2. If yes, what did you do?
        v. Has there been a time when you started to do something to end your life, but you changed your mind (stopped yourself) before you actually did anything?
            1. *If no, skip to Item vi (History of Attempts).*
            2. What did you do?
        vi. Have you ever attempted to kill yourself?
            1. *If no, skip to Item c (Protective Factors).*
            2. If yes, what did you do?
    c. On bad days, what are some of your reasons to continue living (protective factors)?
3. Homicidal ideation
    a. Have you ever thought about physically harming someone else?
        i. *If no, skip to Brief Trauma Assessment section.*
        ii. If yes, did you act on it?
            1. If no, what stopped you?
            2. If yes:
                a. What was your plan?
                b. When you made this plan, was any part of you thinking about actually doing it?
                c. When were you thinking of acting on these thoughts?

Proposed CNM-Inclusive Intake Assessment Tool: Brief Trauma Assessment

Brief Trauma Assessment:

1. Have you ever experienced something that you would consider traumatic?
    a. *If no, skip to Question 2 (Harassment, Bullying, Discrimination).*
    b. If yes:
        i. What happened?
        ii. When did this/these event(s) occur?
        iii. Do you think this/these event(s) impacted you in any way?
2. Have you ever been harassed, bullied, or discriminated against based on any aspect of your identity?
    a. *If no, skip to Question 3 (Healthcare Discrimination/Judgment).*
    b. If yes:
        i. What happened?
        ii. When did this/these events occur?
        iii. Do you think this/these event(s) impacted you in any way?
3. Have you ever felt discriminated against or judged by a healthcare provider based on any aspect of your identity?
    a. *If no, skip to Psychosocial History section.*
    b. *If yes:*
        i. What happened?
        ii. When did this/these events occur?
        iii. Do you think this/these event(s) impacted you in any way?

Proposed CNM-Inclusive Intake Assessment Tool: Psychosocial History

Psychosocial History:

1. Who would you consider to be your "family"?
   a. Family of origin:
      i. What is your relationship like with each of the members of your family of origin?
      ii. What was it like growing up in your home as a child?
      iii. What are some of your family's values?
   b. Children/grandchildren:
      i. *If none identified, skip to Question 2 (Romantic History).*
      ii. What is your relationship like with them/each of them?
      iii. Do you have legal custody of your children/grandchildren?
   c. Found family/chosen family:
      i. What is your relationship like with them/each of them?
      ii. What are some of the things (i.e., values, traits, hobbies) that drew you to them?
2. Romantic history:
   a. Are you currently in one or more romantic relationships?
      i. If no:
         1. Have you ever been in a significant romantic relationship?
         2. How did that/those relationship(s) end?
      ii. If yes:
         1. How long have you been with your current partner(s)?
            a. If 2+ partners identified:
               i. Would you consider your relationship(s) to be hierarchical or non-hierarchical in nature?
               ii. How would you describe your position within these relationship(s)?
         2. What is your level of satisfaction with your relationship(s)?
         3. Do you have any concerns about your relationship(s)?
         4. Is/are your partner(s) supportive of you and your identity?
         5. Do you ever feel unsafe with your partner(s)?
3. Are you currently sexually active?
   a. *If no, skip to Question 4 (Trusted Friend/s).*
   b. *If yes, skip to Physical Health section, Question 3 (Sexual Activity), and then return to Question 4 (Trusted Friend/s) in this section.*
4. Do you have a trusted friend or friend group?
   a. If no:
      i. What do you do when you feel you could use support?
   b. If yes:
      i. What is/are that/those relationship(s) like?
      ii. Do you have any concerns about your friendship(s)?
      iii. When is the last time you were in contact with your friend(s)?
5. What are your religious and spiritual beliefs, if any?
   a. *If none identified, skip to Question 6 (Living Situation).*
   b. Religious/spiritual beliefs identified:
   c. Have you ever felt discriminated against or judged by your religious/spiritual group, based on any aspect of your identity?
      i. *If no, skip to Question 6 (Living Situation).*
      ii. If yes:
         1. What happened?
         2. When did this/these events occur?
         3. Do you think this/these event(s) impacted you in any way?
6. Living situation:
   a. Where do you currently live?
   b. Do you currently live with anyone (including pets)?
   c. Do you feel safe in your home?
   d. Have you ever experienced, or been concerned about, homelessness?
7. Education:
   a. What was elementary, middle, and high school like for you?
   b. Did you ever skip school or leave school early?
      i. *If no, skip to Item C (Harassment, Bullying, Discrimination).*
      ii. If yes, what was/were the reason(s) for this?
   c. While in school, were you ever harassed, bullied, or discriminated against based on any aspect of your identity (by peers, faculty, staff, coaches)?
      i. *If no, skip to Item D (Friends, Acquaintances).*
      ii. If yes:
         1. What was the outcome of the harassment, bullying, or discrimination?
         2. Do you ever think about these experience(s) now?
   d. Did you have any friends or acquaintances in school?
      i. *If no, skip to Item E (Clubs, Teams).*
      ii. If yes:
         1. What were those relationships like?
         2. Have you maintained any of those friendships?
   e. Did you ever belong to any academic/social clubs or sports teams?
      i. *If no, skip to Item F (High School Completion).*
      ii. If yes:
         1. Which one(s)?
         2. What did you like/not like about being a part of those clubs/teams?

Proposed CNM-Inclusive Intake Assessment Tool: Psychosocial History

   f. Did you complete high school?
      i. If no, what got in the way?
      ii. If yes, what is your highest level of education?
   g. Are you currently in school?
      i. *If no, skip to Question 7 (Employment).*
      ii. If yes:
         1. What are you studying?
         2. What is the school environment like?
         3. Have you experienced any instance(s) of harassment, bullying, or discrimination (by peers, faculty, staff)?
8. Employment:
   a. Are you currently employed?
      i. If no:
         1. Are you looking for employment?
         2. *If no, skip to Item b (Financial Concerns).*
      ii. If yes:
         1. Where are you currently employed?
         2. How long have you been employed there?
         3. How is the work environment?
         4. Do you get along with your coworkers?
         5. Have you ever had negative interactions with others at work?
         6. Has anyone in the workplace made you feel that you needed to change who you are or how you express your identity?
            a. If so, what happened?
   b. Do you have any financial concerns at this time?
9. Legal
   a. Have you ever been arrested?
      i. *If no, skip to Item b (Victim of a Crime).*
      ii. If yes:
         1. For what charge(s)?
         2. Are you currently fighting against this/these charge(s)?
         3. What was the outcome of the charges?
   b. Have you ever been a victim of a crime?
      i. *If no, skip to Item c (Custody of Children/Grandchildren).*
      ii. If yes,
         1. Was/were this/these crime(s) related to any aspect of your identity?
   c. *[If the client/patient previously identified children/grandchildren in their custody]*: Do you have any concerns about maintaining custody of your children/grandchildren?

Proposed CNM-Inclusive Intake Assessment Tool: Physical Health

Physical Health:

1. Do you have any physical health concerns/conditions?
   a. *If no, skip to Question 2 (Negative Healthcare Experiences).*
   b. If yes:
      i. Do you have access to medical care?
         1. If no, what are some barriers that get in the way / what are some of your hesitations in contacting a medical health provider?
      ii. How are you managing your physical health concerns?
2. Have you had any negative healthcare experiences?
   a. *If no, skip to Question 3 (Sexual Activity).*
   b. If yes:
      i. What about the experience made it negative?
      ii. What do you think we could do to make sure this experience is more comfortable for you than your previous experiences?
3. Are you sexually active with one or more sexual partners?
   a. *If no, skip to item "c" (assessing knowledge/engagement in safe sex practices)*
   b. If yes:
      i. How many sexual partners do you currently have?
      ii. What kind of sex do you engage in?
         1. Oral sex on a vagina
         2. Oral sex on an anus
         3. Oral sex on a penis
         4. Vaginal penetration
         5. Anal penetration
         6. Sex without penetration
         7. Another form of sex: ______
   c. What does "safe sex practices" mean to you?
      i. What "safe sex practices" do you use?
         1. If none, what gets in the way?
   d. Do you have any sexual health concerns?
      i. *If no, skip to "Substance Use" section.*
      ii. If yes, how are you managing these concerns?

Proposed CNM-Inclusive Intake Assessment Tool: Substance Use

Substance Use:

1. Do you currently - or have you ever used - any of the following substances?
   a. Caffeine
   b. Nicotine
   c. Alcohol
   d. Marijuana
   e. Psilocybin
   f. Cocaine
   g. Ecstasy/MDMA/Molly
   h. Methamphetamine
   i. PCP
   j. Ketamine
   k. Heroin
   l. Another/other substance(s): ______
2. *If none endorsed, skip to Resources section.*
3. If use of one or more substances endorsed:
   a. For each endorsed substance, assess for:
      i. Age of first use
      ii. Amount used
      iii. Frequency of use
   b. In what circumstances do/did you typically use these this/these substance(s)?
   c. Do/did you engage in the use of this/these substance(s) consensually?
   d. What do/did you like about using this/these substances?
   e. Have you ever used any of these substances intravenously?
   f. Has anyone ever criticized you for your use of substance(s)?
   g. Have you ever felt bad or guilty about your use of substance(s)?
   h. Do/did you ever engage in harmful behavior while under the influence of one or more of these substances (e.g., unprotected sex, driving under the influence, etc.)?
4. Do you use any over the counter medications or herbal remedies?

Proposed CNM-Inclusive Intake Assessment Tool: Resources

Resources:

1. Are there any resources that you are hoping I can help you to get connected with?
2. Are there any resources that you have been seeking but have been unable to secure?
3. How might we be able to tailor this space to fit your needs (what will make you most comfortable in therapy)?

Considerations for Additional Assessments

- Patient experiences in healthcare
- Internalized stigma screener
- Depressive symptomology screener
- Trauma assessment
- Relationship satisfaction measure
- Attachment style assessment

Suggestions for Clinical Practice

Use inclusive language (verbal, on forms) (Vaughan et al., 2018)

Avoid assumptions of monogamy and equating sexual exclusivity with healthy relational functioning (Moors & Schechinger, 2014)

Practice open-mindedness, hold affirming attitudes toward, and avoid pathologization of CNM clients/patients (Borgogna et al., 2021; Schechinger et al., 2018; Vaughan et al., 2018)

Appreciate the uniqueness of CNM, including unique benefits that individuals in CNM relationships experience (Moors et al., 2017)

Consider the impact of stigma and discrimination on CNM individuals, especially related to identity formation, minority stress, and internalized stigma (Schechinger et al., 2018; Vilkin & Sprott, 2021)

Suggestions for Clinical Practice

Promote safe sex practices instead of discouraging CNM or encouraging monogamy; provide sexual health resources (Flicker, 2019)

Ensure that there is ample space in the therapy room for multiple partners to engage in treatment (Flicker, 2019)

Intentionally include overt messages or symbols to communicate CNM affirmation on websites or in office spaces (Flicker, 2019; Schechinger et al., 2018)

Identify self as CNM-affirmative therapists on therapist locator websites, personal websites, bio pages of organization websites (Schechinger et al., 2018)

In cases of infidelity... be careful not to pathologize non-monogamous desires while simultaneously highlighting that deceitful behavior is inappropriate and hurtful (Moors & Schechinger, 2014)

Suggestions for Clinical Practice

- Prioritize commitment to continued education regarding CNM practices and common CNM issues (Schechinger et al., 2018)
- Identify, monitor, and challenge biases based in heteronormativity and mononormativity (Vaughan et al., 2018)
- Remain up to date on best practices for working on LGBTQ+ clients and kink-oriented clients, since there is a significant overlap in sexual minority and CNM communities (Borgogna et al., 2021; Vilkin & Sprott, 2021)
- Assess CNM clients'/patients' experiences with mental health systems (Schechinger et al., 2018)
- Practice cultural humility (Vaughan et al., 2018)

Suggestions for Systems

- Allow clients/patients to self-identify their relationship status on intake and demographic forms (Committee on Consensual Non-Monogamy, n.d.)
- Require employees and clinicians to provide clear, comprehensive information regarding insurance coverage to clients/patients at various points of contact and throughout treatment (Allen et al., 2017)
- Offer support groups (e.g., managing CNM stigma and experiences of discrimination, raising children as a CNM parent) and educational classes (e.g., insurance coverage information) to clients/patients and community members (Committee on Consensual Non-Monogamy, n.d.)
- Actively recruit CNM-affirming or CNM-identifying clinicians and include search terms for CNM-affirming clinicians on healthcare organization websites (Flicker, 2019)
- Graduate schools, training programs, medical schools, healthcare organizations…
    - Incorporate CNM into periodic diversity training
    - Bias-awareness training (Zestcott et al., 2016)