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Relationship Goals: How Do Relational Therapists Conceptualize Cases and Treatment Plan When Working With Consensually Non-Monogamous Clients?

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RELATIONSHIP GOALS: HOW DO RELATIONAL THERAPISTS CONCEPTUALIZE CASES AND TREATMENT PLAN WHEN WORKING WITH CONSENSUALLY NON-MONOGAMOUS CLIENTS?

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ABSTRACT

RELATIONSHIP GOALS: HOW DO RELATIONAL THERAPISTS CONCEPTUALIZE CASES AND TREATMENT PLAN WHEN WORKING WITH CONSENSUALLY NON-MONOGAMOUS CLIENTS?

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This study aimed to explore how relational therapists in the United States conceptualize cases and treatment plan when working with consensually non-monogamous clients and how dominant discourses about relationships (mononormativity) influence relational therapists during this process through a queer theory lens. This was a grounded theory study and surveyed a sample of thirty relational therapists or therapists-in- training. Results showed relational therapists conduct conceptualization and treatment planning through a two-part process. Therapists intend to treat CNM clients the same as any other client, but are unable to do so due to dominant discourses of mononormativity. Furthermore, mononormative discourses influenced relational therapists' case conceptualization and treatment planning in three ways: viewing CNM as part of the problem, feeling they cannot use traditional relational therapy models and techniques unless a dyad is practicing monogamy, and/or not consider contexts/resources unique to CNM relationships. These findings provide important implications about the impact of mononormative biases and scripts in relational therapy, and the ways relational therapists reinforce monogamism and dominant discourses in their clinical practice, and the need for more inclusive training. This dissertation is available in open access at AURA (https://aura.antioch.edu) and OhioLINK ETD Center (https://etd.ohiolink.edu).

Keywords: mononormativity, relational therapy, monogamism, queer theory, case conceptualization, treatment planning

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Chapter 1: Introduction

In the year 2023, "#relationshipgoals" is a commonplace phrase, appearing in Instagram tags, article titles, and even as the central theme of television show episodes. According to knowyourmeme.com, the well-known hashtag has come to indicate something "the poster believes exhibits the type of romantic relationship worth striving to achieve with a partner". It was first used this way around 2009, possibly in an article on lifehack.org entitled, "Relationship Goals: 8 Traveling Couples To Follow On Instagram" by Marie Flounoy. An entry on the *Know Your Meme* website indicates this hashtag jumped in popularity in July of 2014, when a Buzzfeed article used the phrase as a title for a collection of pictures depicting couples and a Reddit photo post of an older couple with the same title was posted and gained notable popularity. Since that time, the phrase has been used to indicate things couples should idealize and strive for in their own relationships or types of relationships one should dream about, continuing to show up in articles, advertising, and comment sections.

There are important differentiations between the terms "preference", " value", "ideal" and "norm". Preferences and values do not suggest other forms of a thing are "less than", whether that be in terms of functionality, legitimacy, or worth, while ideals imply the perfect version of something to strive for and norms are inherently prescriptive and comparative (Mayrhofer, 2018). Mayrhofer notes that both of these interpretations of "norm" inherently do create a devaluing of alternatives because a norm might either be the standard upon which understandings of "normalcy" are gauged, and/or a set of rules, requirements, and prohibitions upon which people are expected to behave. Additionally, preferences, values, and ideals can all

be individual in nature, but norms are unique, in that they are shared or understood in the context of a group or society, often standardizing the "ideals' ' for that group.

In western society, monogamy has become a "norm", a required part of what makes up an ideal relationship. Laden with value judgments, monogamous relationships are often described with worlds like "committed", "dedicated", "devoted", and "reliable", while non-monogamous[1] relationships are described as "deceitful" "dishonest", "false", "two-faced", "debaucherous", "immoral" and, "sinful" (Bettinger, 2005, p. 150-151). These are examples of mononormative bias, or the hierarchical positioning that places monogamy at the top and devalues all other relational orientations[2] (Cassidy & Wong, 2018; Ritchie & Barker 2006). There are many mononormative biases (Kean, 2018), which make up "everyday monogamism" (Ansara, 2020), or the instances of mononormative bias that occur and impact people on a regular basis, during routine activities and interactions. The larger systemic structure under which monogamism and mononormative biases operate, is known as mononormativity, or "the dominant assumptions of the normalcy and naturalness of monogamy, analogous to such assumptions around heterosexuality inherent in the term heteronormativity'' (Pieper & Bauer, 2005).

At its core, the phrase "#relationshipGoals" is a symbol for dominant discourses about intimate relationships, markers by which people can gauge how successful and healthy their

[1] The term "non-monogamous" is used here because mononormative bias most often lumps consensual and non-consensual forms of non-monogamy together. Anapol (2010) describes mononormativity as a structure that frames the topic of relationships around notions of "monogamy" and "infidelity" as the only possible options. This tendency perpetuates the monogamist idea that consensual non-monogamy is not a valid or real relational orientation.

[2] The term "relational orientation" refers to "an enduring pattern of sexual or romantic attraction (or a combination of these two) to monogamy (marriage, partnership, serial monogamy), or nonmonogamy (polygyny, plural, polygamy, polyamory, polyandry) or to a degree of both monogamy and nonmonogamy (monogamish, swinging, open marriage, open relationship) (Blumer, et al., 2014; Davis, 2011).

relationships are compared to the ideal. One such dominant discourse about healthy/successful intimate relationships is that they must be monogamous. This is monogamism: the belief that monogamy is the only legitimate relational orientation and the systemic oppression of those who engage in relationships that are not monogamous (Anderson, 2010; Blumer et al., 2014; Twist, et al., 2018).

What is Non-Monogamy?

Despite what dominant discourses might imply, monogamy is not the only possible relational orientation (Twist, 2021). In fact, monogamy is not even the most prevalent relational orientation historically or world-wide, with only 16% of societies enforcing monogamy as a rule (Engber, 2012) and more than 850 societies practicing non-monogamy in some form (Crooks & Baur, 2008). There are a number of different types of non-monogamy practices and structures. Polygamy is the most historically and currently prevalent form of non-monogamy in the world and it involves a relationship structure where one primary person is married to multiple other individuals. Polyandry is a structure where one woman is in a relationship with multiple male partners and polygyny is a structure where one man is in a relationship with multiple female partners. These forms of non-mongamy are most prevalent in Africa, Asia, Oceania, and the Middle East (Al-Krenawi, et al., 2006; Hartung, 1982; Valsiner, 1989). However, some societies, the United States included, have outlawed the legal practice of polygamy (outlawed in 1862 in the United States). This type of legislature has historically and continually harmed indigenous/First Nations populations, Fundamentalist Mormons, Muslim practitioners, immigrants from countries where polygamy is legal, and practitioners of polyamory, who lose access to legal relationship rights (Blumer et al., 2014).

Despite limits to legal recognition of multi-partnered marriages, other forms of consensual non-monogamy are practiced across the globe. Consensual non-monogamy (CNM) is the practice of relationships based on the explicit and voluntary abandonment of sexual and/or emotional exclusivity (Grunt-Mejer & Lys, 2019) and it is an umbrella term that includes other, more specific forms of non-monogamy such as polyamory (polyam). Polyamory, well-known for its literal translation of "many loves", is the assumption that it is possible, valid, and worthwhile to explore and maintain intimate, sexual, and/or romantic relationships with more than one person (Haritaworn, et al., 2006). Some relationships are "monogamish", where often there is a primary dyadic relationship at the core, with understanding by all involved parties that other relationships the partners might pursue will not be equal to the primary relationship (Savage, 2011). Regardless of form, it is important to note that none of these relational orientations fall under the very real category of "non-consensual non-monogamy", also known as infidelity or "cheating".

Mononormativity, Monogamism, & The Halo Effect

The term "halo effect" was first used by Thorndike in 1920 and can be defined as " a heuristic whereby a person evaluates an individual (or object) positively based on a single, obvious attribute" (Conley, et al., 2013, p. 6) and often assume other attributes based on this assessment, which are also positive or preferred. The one single attribute may affect the whole perception of an individual, with positively perceived attributes creating a "halo effect" and negatively perceived attributes creating a "devil effect" (Grunt-Mejer & Lys, 2019). Moors (2019) talks about the need to move past the "rose-tinted lens" of monogamy, which she describes as, "an unduly idealistic, optimistic, and invulnerable perspective—through which

people favor monogamy" (Moors, 2019, p. 57). Moors cites previously discussed research, which suggests the harmful consequences of the halo effect around monogamy and the way rigid parameters and rules around monogamy may be unrealistic and similarly harmful. She proposes, instead, that it might be more beneficial to not expect to find or strive for a universalized human sexual experience (Moors, 2019), as well as developing an ongoing critical consciousness around theoretical frameworks, clinical practice, diagnosis and assessment, research question, and interpretations of research data. Lee and O'Sullivan (2018) also provided research challenging the assumption that monogamy is the most natural relational structure. Through their work, they developed a Monogamy Maintenance Inventory, which they used as part of their study looking at the ways heterosexual couples in monogamous relationships use different strategies to maintain monogamy when encountering attractive alternatives. Through their work, they found 81 different behaviors used by participants to help maintain monogamy in their relationship. While one category of monogamy maintenance involved strategies to enhance the romantic relationship, the two other main categories involved the active avoidance of other potentially attractive individuals and self-degradation. This suggests that while monogamy is often an expectation and an assumption in romantic relationships, attraction to other people is natural and important to normalize. Mononormativity dictates that not only must relationships provide intimacy, tenderness, functioning sexuality, friendship, constructive conflict resolution, common interests and visions of the future, and more, but all of these qualities and needs must be met in a single relationship and sustained for eternity (Mayrhofer, 2018). Mayrhofer is not the first or only person to observe the unrealistic nature of these expectations (White, 2009), but he notes how this sets up a dynamic where when people cannot meet these expectations they feel like

failures and when they feel their partners are not providing these things they feel are owed, they place blame; this is often what bring them to therapy.

Provider Bias Responsibility

To understand why this mononormativity can be problematic in a clinical setting, it is important to understand how mononormativity has impacted relational therapy providers, in both conscious and unconscious ways. One of the most common and detrimental ways is by leading to monogamism in both belief and practice. In 2014, Nicole Graham wrote an article calling for an increase in mental health professional awareness regarding polyamory through the use of a case report of a 21-year-old female client. She reported the client's symptoms had worsened after she decided to end her treatment with a previous provider, who had blamed all her issues on polyamory. According to the client, the provider had recommended she stop her non-monogamous relationships because they were 'likely the source of her problems' and the cause of her current depression (Graham, 2014, p. 1033). Graham reflects that the client's previous provider was dismissive of the importance of her chosen relationships, which led her to inappropriately attribute the client's symptoms to the polyamory lifestyle. Furthermore, the client felt judged and misunderstood, her symptoms actually worsened and she no longer felt comfortable discussing her relationships in therapy, which led her to ultimately stop participating in treatment (Graham, 2014). This is a critical observation, as a large number of studies have shown the importance of the therapeutic alliance on treatment outcomes (Horvath & Bedi, 2002; Martin, et al., 2000), and one also has to wonder whether common goals can exist at all, when there is such a disconnect in perception and understanding.

Echoing Graham's concerns, Baumgartner (2009) asserted it is inevitable that practitioners of relational therapy will be affected by the "monogamy training" they have received both in and out of the classroom. Weitzman (2006) notes that while studies have shown that there is a notable prevalence of polyamorous relationships, there is a significant lack of education about polyamory and the lives and needs of those who practice this type of relational orientation and philosophy, noting that it seldom appears in textbooks, curriculum, or internship training. Citing Knapp (1975) and others, Weitzman (2006) notes that research trends from 1975-2004, indicated a notable percentage of therapists pathologized polyamory and made harmful assumptions such as believing that people who participate in polyamorous relationships are afraid of commitment or are unfulfilled by their marriages. In these instances, polyamorous clients felt that their therapists did not support their relationship practices, causing some of them to even withhold sharing that information throughout the course of treatment.

In 2014, an article in *Family Therapy Magazine* first addressed the idea of monogamous privilege (Blumer, et al., 2014). The authors define monogamous privilege as "those unearned benefits afforded those with a monogamous and/or mono-partnered relational orientation". The field of relational therapy is not immune to the impact or reinforcement of monogamous privilege, with the authors noting that mononormativity and monogamous privilege often lead to the construction of a "wall of invisibility" around the experiences of relationships outside the dominant relational orientation–monogamy (Blumer, et al., 2014). This can be seen both in hesitance to reach out for therapy, due to stigma and even potential legal ramifications (i.e. lack of protections generally afforded by legal marriage, loss of child custody, etc.) and in the lack of training, knowledge and skills on the part of therapists when working with CNM clients. The authors expressed an urgent need for increased awareness, competency, and self-of-therapist

work in order to decrease monogamism in relational therapy and to ethically attend to the needs of CNM clients.

In the social work realm, Williams and Prior (2015) sounded a call for awareness and sensitivity regarding polyamory in 2015. They stated that social work practice includes values of client self-determination, empowerment, human diversity, and cultural sensitivity, but noted that social workers are likely to project their own biases onto vulnerable clients unintentionally without adequate awareness (Williams & Prior, 2015). They point out a belief that there is a very large gap in awareness when it comes to polyamory, making it particularly vulnerable to this type of bias. Despite the body of work in this area so far, Williams and Prior note a continued conflation between non-monogamy and infidelity on the part of social workers and other professionals who practice relational therapy. Weitzman (2006) cites numerous and multinational studies conducted as far back as the 1970's, 1980's, and 1990's, where findings indicate both that there are no significant differences in the psychological functioning or relationship satisfaction of individuals in polyamorous versus monogamous relationships, as well as the fact that polyamorous relationships typically end for many of the same reasons monogamous relationships end (Ramey, 1975).

Researchers suggest the most likely danger is that providers may misattribute problems clients are coming in to address to their relational orientation and then subsequently tailor their treatment plan to center around "correcting" this relationship in order to alleviate the problems, rather than targeting the problems clients are identifying (Twist & Ansara, 2017; Williams and Prior, 2015; Twist, 2021). Pathologizing CNM in this way is another form of monogamism. As such, since CNM and polyam are not diagnosable, CNM clients (and members of their relational systems) are often diagnosed with one of the following American Psychiatric Association (APA;

2013) or International Classification of Diseases (ICD; 1994) diagnoses:relationship distress with spouse or intimate partner (e.g., attachment issues, problems committing), child affected by parental relationship distress (e.g., bad parents/role models), personality diagnoses (e.g., borderline personality disorder, narcissistic personality disorder), or paraphilia diagnoses (e.g., fetish disorder like nymphomania) (Twist & Ansara, 2017; Twist, 2021). While it is important to not fall into this type of thinking, it is also important to balance this with an understanding that polyam and CNM relationships do sometimes include unique challenges, scenarios, and opportunities, in part because of the fact that they have been so marginalized in mononormative society. The need then becomes clear, for therapy providers to be aware of how their own values and interactions may reinforce pressures related to mononormativity and how leaving these unquestioned or unconscious may, in fact, actively increase harm to clients. In the context of the mononormative dominant discourse, therapists practicing monogamism in therapy is more of a question of how, rather than a question of if.

Statement of the Problem

Ideally, relationships would not be understood or accepted in only rigid or restrictive terms. Instead, understandings of "healthy" or "successful" intimate relationships might be understood in terms of whether these relationships are satisfying, consensual, and mutually fulfilling to all involved individuals, rather than prescribing specific labels, roles, goals, or structures as necessary to experience these markers. Definitions of sex positivity have started to emphasize a respect and recognition of valid diversity (Queen & Commella, 2008) and the hope is: such flexibility and inclusivity could be extended to relationship orientations.

There are many experiences and understandings of relationships that challenge the dominant discourse about what intimate relationships "look like" and how they "should be", however the dominant discourse of mononormativity continues to inform research and practice regarding relational therapy. When this one relational orientation is privileged, other experiences of relationships may be unrecognized, misunderstood, or even marginalized. In the realm of relational therapy, this may influence therapists, intentionally or not, to pathologize aspects or understandings of relationships that do not fit these discourses. In other words, mononormativity structures can lead to therapists engaging in monogamism, which in turn may influence their treatment goals.

As it stands, language used in relational therapy and developmental psychology models perpetuate mononormativity and are a reflection of monogamism and couple-centric bias through phrases like "couples", "dyads", and "pair-bonding" in their descriptions of healthy and normal relationships and human development, which falls under monogamous privilege (Blumer et al., 2014; Twist et al., 2018) the concept of "privileged couple domain" (Finn, et al., 2012). They also cite other researchers who have noted the ways broader terms such as "love-bonds" have been used interchangeably with mononormative phrases such as "pair-bonds" (Moors, et al., 2015). When it comes to assessment, Gerard and Brownlee (2015) note how mononormativity is perpetuated through some of the most widely accepted and commonly used measures, such as the Dyadic Adjustment Scale (Spanier, 1976; 2017) and that there measures that look at attitudes and values around extramarital relations (Reiss, 2013), but not co-marital relations (Cassidy & Wong, 2018), implying the absence of CNM.

There is potential for relational therapy providers to either add to CNM experiences of minority stress, or to provide opportunities for CNM clients to participate in a more affirmative

relationship, which would be a divergent experience from larger social pressures and experiences.

Drawing on the work of Knudson-Martin (2013), Kitzinger and Wilkinson (1997), Sutherland, et al., (2017) expressed the need to look more at how relational therapy providers reproduce or challenge dominant discourses through their behavior and interactions, in general, since often they are not aware of power differentials that may contribute to the impact of these actions and interactions (Sutherland, et al., 2017). Schechinger, et al. (2018) also calls for an improvement in therapist education and training to minimize mononormative or monogamist practices, such as assuming a client is in a monogamous relationship, and to increase knowledge of and openness toward relationship diversity. Until now, however, it seems relational therapy providers have demonstrated some hesitancy to speak/act against dominant discourse, or perhaps a dissonance between performative acceptance and their true beliefs (Finn, et al., 2012). As a result, there is a pattern of practitioners often subconsciously pathologizing ethical non-monogamy due to internalized mononormativity, despite years of research showing there is no significant difference in relationship satisfaction between monogamous and CNM relationships (Moors, et al., 2017).

This pattern of pathologizing any relational orientations outside of the dominant definition of monogamy has come to be known as monogamism (Anderson, 2010; Ansara, 2020; Twist, et al., 2018) and monogamous privilege (Blumer et al., 2014). Ansara (2020) addresses a number of ways monogamism shows up in clinical practice, from using language such as "couples counseling", limited symbolic representation in genograms, well-intention advertising such as professing acceptance for "alternative lifestyles", the inaccuracy of the term "marriage equality" (since polygamy and other legally recognized forms of multi-partnered

relationships/families are not allowed in many western countries), and even the fact that the term "consensual non-monogamy" still centers monogamy at its core (Ansara, 2020). In response to the insidious presence of monogamism in therapy practice, Twist, Prouty, Haym, and VandenBosch (2018) developed a monogamism measure for therapists to assess their awareness, knowledge, and skills when it comes to multi-partnered relational orientations and working with these clients. It is clear there is a need to examine monogamism in clinical practice, and while this work has begun, there is still much to be done.

Purpose of the Study

The purpose of this study is to discover more about how relational therapy providers navigate case conceptualization and approach treatment planning when working with consensually non-monogamous (CNM) clients. In this study, I will also how mononormative dominant discourses impact case conceptualization and treatment planning when working with CNM clients. Findings from this study could inform relational therapy training programs about ways current teaching methods and materials might be reinforcing monogamism and mononormativity and areas to focus on in order to expand inclusivity. This is important because in order for treatment goals to be clients-centered and to avoid erasing, pathologizing, and marginalizing aspects of understandings of relationships that do not adhere to dominant discourse scripts, practitioners of relational therapy must be inclusive and flexible about what relationships might mean or look like to different people. Also, if case conceptualization and treatment planning processes are based on mononormativity, it would mean therapy with CNM clients is not meeting ethical standards or best practices for client-informed care.

Research Questions

- How do relational therapists' conceptualize cases and treatment plan when working with consensually non-monogamous clients?
- How does the dominant discourse about relationships (mononormativity) influence relational therapists' case conceptualization and treatment planning when working with CNM clients?

Additional Questions

- Do relational therapists tend to assume monogamy is necessary for a healthy/successful intimate relationship?
- How do discourses about relationships influence the likelihood that therapists pathologize or try to change relationships that do not fit these understandings, as evidenced by case conceptualization and treatment planning?

- What do these conceptualizations suggest about therapists' openness to diverse understandings of intimate relationships and intimate relationship practices?

Theoretical Framework

In this study, a queer theory (de Lauretis, 1991; Berlant & Warner, 1995; Jagose, 1996) framework will be used. This framework serves as a blueprint informing the literature review as norms regarding intimate relationships and their structure were traced through history in the relational therapy realm. In the literature review I demonstrate how those who participate in

CNM relationships have been marginalized throughout the history of relational therapy and how early recognition and validation of these relational therapy structures were only found in other queer social spheres. Furthermore, there is a significant pattern of a halo effect around monogamy in both research and practice, which suggests mononormativity has a strong relationship to privilege and power structures in society–monogamism. This has serious implications for the significance of this study, in which I aim to examine the ways current relational therapy case conceptualization and treatment planning processes may be reinforcing this dominant discourse of mononormativity and the marginalization of clients who practice CNM.

Chapter 2: Literature Review

To understand why CNM has been, at best, underrepresented in the history of relational therapy and relational therapy literature and, at worst- absent (Blumer & VandenBosch, 2015), it is important to understand the relationship between mononormativity, monogamism, and the halo effect in the context of dominant discourse. One way to determine if something has been marginalized outside the dominant discourse is to see whether there is language available to describe the experience. As other studies have noted, relationship language tends to include couple centric and monormative bias (Ansara, 2020). Many CNM individuals express having to navigate discourses around how CNM is different from or similar to monogamy and whether it is a natural state of being or a choice (Barker, 2005)- the former of which still centralizes monogamy and the latter which is not a justification required for monogamous relationships. In their 2006 article, Ritchie and Barker discuss how overall, "the only widely available language that can account for non-monogamous relationships is that of infidelity" (Ritchie & Barker, 2006, p. 589). This dichotomy between monogamy and infidelity, does not leave space for CNM, because as the authors quote from the alt.poly website, "Polyamorous people do not tell partners, lovers, or prospective members of those groups that they are monogamous when in fact they are not…" Ritchie and Barker explore the ways CNM individuals must create new language to combat mononormative dichotomies and hierarchies between "lovers" and "friends", to represent the lovers/partners of their lovers/partners, and to rewrite assumptions about jealousy and possessiveness.

In 2013, Conley, Moors, Matsick, and Ziegler published a multi-part study where they examined the perceptions of monogamous and CNM relationships. Participants rated monogamous relationships more positively than CNM relationships on every dimension studied

by the researchers and then rated a monogamous couple more favorably than an CNM relationship by a significant amount upon reading vignettes. The vignettes were identical save for the type of relationship they were a part of (monogamous or CNM). Though both vignettes stated the individuals were happy with their arrangement and planned to continue, participants consistently perceived that relationship in less favorable ways around qualities such as trust, comfort, honesty, safety, reliability, soul mate status, romance, emotional security, commitment, happiness, dependability, faithfulness, meaningfulness, and others. Even more interesting, these ratings not only trended less favorably for the CNM relationship, but participants also perceived the individuals ("Sarah" and "Dan") less favorably as people in the CNM relationship scenario. Their research suggests there is a halo effect related to monogamous relationships and the authors note how despite research indicating there are not significant differences between things like relationship satisfaction and sexual health when comparing monogamous and CNM relationships, the stigma against CNM relationships persists and CNM relationships remain invisible when it comes to popular models of adult functioning, such as Erickson's developmental model and adult attachment theory (Conley, et al., 2013). Likewise, Balzarini, Shumlich, Kohut, and Campbell (2018) studied 641 participants who identified as either "monogamous", "open", "polyamorous", or "swinger" to explore perceptions and attitudes toward different sexual behaviors and relationship types. Even CNM participants rated monogamous relationships as most favorable, even when researchers controlled for religious and political beliefs (Balzarini, et al., 2018), which implies a degree of internalized monogamism.

In 2015, Blumer and VandenBosch conducted a content analysis of all articles published in the *Journal of Marital and Family Therapy* (*JMFT*) through its entire published history at the time (1975-2014). While small improvements were seen over time regarding the number of

articles focused on LGBT (Lesbian/Gay/Bisexual/Transgender) populations, with a still dismal total of 35. However, not one article focused on polyam individuals or multi-partnered relational orientations. In 2017,guidelines for therapists working with couples who are exploring non-monogamy in the *Journal of Sex and Marital Therapy* (Bairstow, 2017) were published, which did exhibit couple centric privilege, but is notable due to the previous lack of inclusion in such journals.

Foundation of Monogamy in the United States

To trace the foundation of monogamy in the United States, it is necessary to first look at European history, since the dominant social and political ideas in the United States are tied to European colonization (first paralleled by Puritan and Protestant religious groups who settled along the eastern coast in the 1600's). Religion has historically been a driving factor in the adoption of monogamous practice on a societal level. Given the prevalence of Christianity in post-Roman Europe, Christian ideology became the dominant discourse. Early Christian texts emphasize the monogamous marital bond as "the most basic of human relationships" (Augustine, p. 401) and praise monogamous marriage as a limiter and confiner of sexual desire and a way to preserve gender hierarchy (patriarchy) (Rothschild, 2018). Monogamous marriage limits sexual interaction to a single partner and Christian religious doctrine centralizes procreation as the purpose of sexual interactions. Historically, this mindset has reinforced gender roles and partiarchal ideas through idealizing virginity, idealizing "saving oneself for marriage" (for women), "slut-shaming" women engaging in any sexual activity outside of marriage, with more than one partner (even serially), and for anything other than procreation (such as pleasure) (Ryan & Cacilda, 2011; Rothschild, 2018). This emphasis on procreation is important, because it is also

tied to ideals about family, which remain core to American values, even outside the context of religious beliefs. Esther Perel, a well-known relational therapy who was born in Belgium reflected on cultural assumptions at a conference she attended by posing the question, “Did the clinicians in the room believe that this couple’s sexual practices, even though consensual and completely nonviolent, were too wild and “kinky,” and therefore inappropriate and irresponsible for the ponderously serious business of maintaining a marriage and raising a family?” (Perel, 2006). In summary, in American culture, sex has historically been seen as “serious business” which serves solely as a vehicle for creating family units.

Rothschild (2018) notes that even as science became a more common basis for social norms, this sex-negative and family-centric perspective remained strong. Even in research in the social sciences (including psychology and sexology), the “importance” of containing sexuality within a marital relationship continues to be emphasized (Barker and Landridge, 2010a). From an anthropological perspective, it is also clear how monogamy and ideals about family became intertwined, as scientific study and language began to focus on the “nuclear family”. This term has come to represent a family unit consisting of one biological mother and one biological father and their mutual children, with the smallest unit being the mother/father/child triad (Ryan & Cacilda, 2011).

Monogamy originally referred to sexual exclusivity, which became a dictate of the marriage contract, but as “love marriages” became romanticized, monogamy came to mean emotional exclusivity, as well (Rothschild, 2018). The current conception of love and monogamous marriage stems from Romanticism at the turn of the 19th century, where the idea of a unique soulmate with whom an individual would share unconditional love was born (Mayrhofer, 2018). Changing social structures, such as an increase in secularism and the growth

of capitalism created uncertainty. Plus, since the basis of this new understanding of love was affection and physical attraction, which were much more unstable than binding land agreements and necessary labor sharing, sexual loyalty became idealized and understood as proof of "true love" (Mayrhofer, 2018). This idea, which really stemmed from the discomfort of change, persists in society today. In the 19th century, as a justification for patriarchy, the Catholic church doubled down on the difference between men and women, an idea that also asserted the natural quality of these differences. From this, the idea of man's superiority to women was accepted as natural fact, as well as the complementary of the differences between men and women becoming the foundation of a good relationship and the basis of erotic attraction (Mayrhofer, 2018).

In the 20th century, due to the advent of psychology, sexuality in love relationships became part of the public discourse, and subsequently, the quality of a couple's "sex life" became a measure of their relationship's quality and health. This too, is still seen today, coupled with the sex positivity movements of more recent history. In the 1960's and 1970's, women's liberation movements and other social changes led to the questioning of more traditional relationship scripts and assumptions, including complementary, patriarchal relationships. This led to a new iteration of egalitarian relationships, which focused more on equal communication around personal views, wishes, and needs (Mayrhofer, 2018). It was during this time that polyamory and non-monogamy became more visible ideas, although within the confines of a "counterculture" label. Mayrhofer (2018) concludes his historical exploration by returning to the idea of capitalism, where people struggled to navigate the demands of performance and success that are part and parcel of this system plus the new added expectations of self-realization and happiness that come with a greater leaning toward individualism. By these standards only a few people could realistically experience all self-realization and happiness at work, so it became the

expectation of the private sphere: relationships. In the words of Mayrhofer, when speaking about modern relationships, “there are significantly fewer social constraints today, but considerably more expectations" (Mayrhofer, 2018, p. 13, [translated from German]).

In addition to the ideals adopted by American culture by way of European colonization, monogamy also has unique historical ties to the United States. *Sex At Dawn: How We Mate, Why We Stray, and What It Means ForModern Relationships* (Ryan & Cacilda, 2011), a well-known book examining the history of human sexual relationship starts a chapter with the following quote by Benjamin Franklin, “Marriage is the most natural state of man, and therefore the state in which you are most likely to find solid Happiness”. This is important, because one thing you will learn very quickly, if you spend any time in the United States, is that Americans really love to quote the “founding fathers” of the country (Franklin being a beloved member of these founding fathers). In a recently published master’s thesis titled: *The United States of Monogamy*, the author provides a historical basis for the ways monogamy has served as a marker of national identity (with non-monogamy then falling into the realm of “otherness”) (Rosengreen Hovee, 2021). The argument here is that as the United States was forming, monogamy became one of the many ways of creating an “Us”, in terms of “legitimacy” and national identity, by creating an “other” to compare against. This is seen through pairing terms tied to non-monogamy, such as “harem” to exotic and foreign lands and practices. Additionally, the author speaks about how the institution of monogamous marriage was also a way to ensure the creation of future, fidelitious citizens, and as capitalist ideals grew in the United States- workers and consumers (Rosengree Hovee, 2021). The author also draws parallels between monogamous marriage and the newly formed, fragile United States through the common use of themes such as “sacrifice”, “hardwork”, “legitimacy”, and “holding together”. Capitalism and monogamy are fairly

entangled practices, as monogamy was a way to ensure paternal certainty, which was necessary to track the path of inheritance and legal rights afforded by marriage and biological lineage. This also pairs nicely with the early colonial religious practices of Puritanism, which emphasized a goal-oriented perspective on all aspects of life and an emphasis on earning a good life (and salvation) through hard work (Perel, 2006). However, a dark side of the pairing of monogamous marriage and property rights also meant a restriction on women's rights, women being considered the property of their husbands, and men being able to behave in any way toward their wives (including physical violence and rape) (Rothschild, 2018).

The legal recognition of only monogamous marriage has served a number of functions over the history of the United States. Continuing with Rosengreen Hovee's idea of monogamy being used to create an "Us vs. Other" dynamic, the United States government passed the the Morrill Act for the Suppression of Polygamy in 1862, which outlawed the practice of polygamy and was a response to a growing awareness of Mormon relational practices. Rosengreen Hovee argues that this was part of the next great solidification of American identity during the Civil War Era- eliminating the "twin relics of barbarism" (polygamy and slavery). Perhaps an early attempt to downplay the role of slavery in the history of the United States, this and other legal mandates that would follow Edmunds/Tucker Act-1887, Defense of Marriage Act- 1996), also served to force groups such as Mormons, Muslim groups, indigenous/First Nations populations, immigrants from other cultures, and queer individuals to assimilate in order to receive all the rights, benefits, and protections of American citizens. This idea has been revisited many times throughout U.S. history, and is most recently exemplified by resistance toward the legalization of "same-sex" marriages. Although so-called "marriage equality" was legalized in 2015 this definition extends only to include same-sex marriage and there remains an intense stigma toward

the idea of multi-partnered marriages. A dissent statement made by Justice John Roberts in the legal case *Obergefell v. Hodges (2015)* expressed fear about a possible move toward recognizing legal marriages of more than two individuals, which he presented as a destruction of the "core definition of marriage". As such, in the current year of 2023, monogamous marriage remains the only form of legal marriage recognized in the United States.

A History of Relational Therapy

It is difficult to know exactly how to frame the history of the type of relational therapy relevant to this topic. Today, a common way to prepare to work with intimate relationships in a clinical therapy setting is to get a degree and license in Marriage and Family Therapy (MFT). Sometimes called Couple and Family Therapy (CFT), in an effort to be more inclusive, this terminology still excludes non-dyadic intimate relationships and a number of other relationships that do not fall under the category of couple or family. The term "couples therapy" will be used when exploring this history because there is not yet an agreed upon, inclusive term to represent intimate relationships.

Despite the discrepancy around the term, "couples" therapy is distinct from individual therapy, because it is centered around the wellbeing of the people involved in relationships and the relationship(s) between them. Unlike family therapy, it does not focus primarily on the multigenerational relationships between parents and children, which involve different hierarchies, developmental stages, and challenges. In 2002, Gurman and Fraenkel compiled a review of the history of couples therapy. They noted family therapists actually tend to work with partners more often than multigenerational family work, making partner relationships one of the

most common reasons clients come to therapy (Gurman & Fraenkel, 2002). They also divided the history into four thematic phases.

In Phase 1 (1930-1963), marriage counseling was provided as an auxiliary service by members of the clergy and professionals like obstetrician/gynecologists (OBGYNs) and social workers. This type of counseling often involved psychoeducation and advice around common, everyday problems. In many ways, this may have set the tone for couples therapy not often being recognized as a mental health discipline (Haley, 1984; Shields, et al., 1994) and is most akin to the "premarital counseling" programs we know today (i.e. Pre Cana, Prepare/Enrich, SYMBIS, etc.). Until 1960, only 15% of couples therapy focused sessions met conjointly and the interventions used were not based in any specific theory, but rather focused on health or religious teachings. The concurrent Phase II (1931-1966) could be best described as psychoanalytic theory applied to couples, and it was here conjoint therapy became popular, as therapists aimed to resolve marital conflicts that arose out of the neurotic interaction of partners. pathology and defensiveness. Overall, this type of therapy was performed from an individualistic lens, but did account for the interaction of individual experiences. Phase III (1963-1985) is when practitioners began approaching couples therapy from a systemic perspective by applying emerging family systems (and later family therapy) theories to work with couples. Eventually, family therapy as a field engulfed marital counseling and most family therapy theories from that point on also attended to marriages to some degree (although couples therapy remains an underrepresented area in MFT training programs). Some of the most influential family systems ideas on couples therapy include Marital Quid Pro Quo (Don Jackson), self-esteem and congruent communication (Virginia Satir), differentiation of self (Murray Bowen), power and reification of systems (Jay Haley), and the importance of love (Chloe Madanes) (Gurman and Fraenkel, 2002).

Phase IV (1986- present time of the study, 2002) was when specific couple or marital therapy theories and models were developed. Some of these included: Behavioral Marital Therapy (BMT) (Stuart, 1969, 1980; Jacobsen & Martin,1976; Jacobsen & Margolin, 1979), Emotionally Focused Couples Therapy (EFT) (Johnson & Greeberg, 1985, 1995; Johnson, 1986, 1996), Insight Oriented Marital Therapy (Snyder, 1999; Wills, Faitler, Snyder, 1987), and refined Psychodynamic Couples Therapy. Currently, some of the most popular couples therapy models include EFT, Acceptance and Commitment Therapy, Cognitive Behavioral Couples Therapy, and Gottman therapy, which are all evidence-based. Relational diagnoses, also known as v-codes, are now included in the *Diagnostic and Statistical Manual of Mental Disorders* and there is recognized interplay between relational and individual distress and experiences leading providers to attend to both individual and relational distress for most presenting problems.

Starting in the 1970's couples therapy became more diversified with the larger incorporation of a feminist lens, multicultural perspectives, postmodern ideas such as social constructionism, and eventually critical theory. In response, there has been a more recent emergence of integrated theories that focus more on common factors and themes. However, it is only within the past couple of years that researchers have begun to explore if and how these models are inclusive/applicable to Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, + (LGBTQIA+) and CNM relationship experiences, since they were developed based on heterosexual, monogamous relationships.

In the mid 2000's LGBTQIA+ perspectives and queer theory began to be more extensively considered and integrated into couple therapy (Allen & Mendez, 2018). Here the beginnings of challenging heteronormativity and later, mononormativity and the differentiation of sex, sexuality, and gender could be seen. Concepts such as "families of choice" and

"intersectionality" also became more widely recognized during this time. Within the past ten years, relational therapy has been working to decentralize white, cisgender, heterosexual, married couples with biological children to extend and attend to the diverse constellations of families and relationships with the so nicknamed "queering" of relational therapy (Reczek, 2020). This trend has now extended into training programs for clinical practice (McDowell, et al., 2014) and clinical practice itself (Gottman, et al., 2020). Unfortunately, a divide between relational therapy and sex therapy has existed historically and continues today, but efforts are being made to better connect the two and it is now fairly accepted in the field that there are links and interplay between relational and sexual functioning (Jones, et al., 2019).

Foundation of Monogamy in Marriage and Family Therapy

Gurman and Fraenkel's millennial review of the history of couples therapy (2002) includes their four conceptual phases of couples therapy as a field and practice. Their first phase (1930-1963), consisted of individuals with other primary professions, such as obstetrician-gynecologists, clergyman, social workers, and family life educations. During this time, "counseling" consisted mainly of one of two modalities: individual consultations about marital concerns (not conjoint) or pre-marital couples/newlyweds who wanted advice about married life (Gurman and Fraenkel, 2002). Given the emphasis on marriage, it is clear why monogamy would be centralized and even required to participate in relational therapy at this time. Phase II (1931-1966) consisted of adaptations to the psychoanalytic model created by Signmun Freud (Gurman and Fraenkel, 2002). Although Freud originally presented monogamy as an oppressive social norm and a source of neurosis, he later stated that monogamy is a necessary evil that is required for modernity to exist (Freud, 1915; Freud, 1930; Rothschild, 2018). Therefore, monogamy

continued to be a central idea in this approach. Phase III (1965-1985) heralded the introduction of family therapy models. However, as suggested by early mention of the "nuclear family", conceptualizations of family during this time generally consisted of two biological parents and their mutual children (Ryan & Cacilda, 2011). Even Bowen's conceptualization of triangulation, rooted in the idea that a triangle/triad is the smallest stable relational unit (Bowen, 1976; Bowen, 1978; Kerr & Bowen, 1988), parallels the idea of the 2 parent and 1 child triad being the smallest unit of a nuclear family (Ryan & Cacilda, 2011). Hierarchy and the structure marriage provides was often at the core of family therapy models, with a lot of attention paid to fostering and ensuring stability for children. Non-monogamy has often been presented as a threat to this stability and this idea is one that activists are actively combatting today (Valsiner, 1989; Elbedour, et al.,, 2002; Twist & Ansara, 2017; Twist, 2021).

Phase IV (1986–present) remains a work in progress. The main marker of this phase was marital counseling receiving a form of licensure (Gurman and Fraenkel, 2002). However, "marriage" became an ever-present buzzword, with the only legal definition in the U.S. being an monogamous one. Gurman and Fraenkel (2002) do address the move from "marital therapy" to the more inclusive "couples therapy", which they suggest means "committed, but not married in the legal sense". This suggests space for other types of committed relationships to exist in the field, but there is still a near absolute focus on dyads and "two". Even sex therapy, which essentially began in 1970 with the work of Masters and Johnson, has historically focused on dyadic sexual relationships. Traditional sex therapy involved four people, two sexual partners, and a team of two co-therapists (one male and one female) (Wiederman, 1998). However, the social scripting perspective in sex therapy does include acknowledgement of how social scripts about sex dictate "what is considered normal" (Laws & Schwartz, 1977; Reiss, 1986). The

language of sex therapy theory and models historically have used terms such as “couple” and “two” in descriptions and training (Wiederman, 1998). Furthermore, most couple and family therapy models would label non-monogamy as something harmful and detrimental to couple and family relationships (Giammattei and Green, 2012), something that is only starting to change with the move toward de-centralizing white, cisgender, heterosexual, married couples with biological children in relational therapy (Reczek, 2020).

Finally, it would be a mistake to overlook couple and family therapy’s roots in pastoral counseling. Before the creation of a license for marital counseling, much of these services were provided by clergy members. These two realms have been intertwined since the early twentieth century, when new information coming out of the social sciences helped inform religious leaders, (Townsend, 2014) with some clergy members expressing gratitude for these resources as they enacted the responsibility of caring for individuals and families in their congregation and providing marriage counseling (Oates, 1955). Nonetheless, it is also important to acknowledge the ways religious traditions inform family life, by providing guidelines for behavior, gender roles, sexual practices, intergenerational relationships, hierarchy, resource allocation, power dynamics and even an understanding of what a family is (Townsend, 2014) and these ideas did not disappear as couple and family therapy added more secular paths and coalesced into a single license. Some early pastoral counselors recognized the unique challenges of counseling congregation members in a religious context, such as blurred lines regarding roles and dual relationships (Oates, 1955). However, the overlap of these realms still exists today, with debates about the ways marital therapy may be undermining the marriage as a concept, such as by encouraging “a reckless pursuit of individual desires whatever the outcome” (Wall and Miller-

McLemore, 2002, p. 259) and concern about the ways modern couples therapy models are moving away from biblical understandings of marriage (Wall and Miller-McLemore, 2002).

A History of Polyamory/CNM & Therapy

Polyamory and therapy literature has an interesting timeline, which has been impacted by historical contexts and language. For instance, "polyamory" as a term was not widely used until 2002, which is discussed by the authors of a literature review published by Barker and Langdridge (2010). As per Baumgartner (2009), the evolution of "polyamory" in the United States, as a recognized term, began in response to the sexual revolution of the 1960's. After the advent of the birth control pill and the growth of social movements that challenged previous understandings of sex and love, the next great influence was the publication of Open Marriage by Nena O'Neil and George O'Neil in the 1970's. In addition to Open Marriage by the O'Neill's, other books such as The Extra-Marital Contract (Ziskin & Ziskin, 1973), Renovating Marriage (Libby, et al., 1973), The Civilized Couple's Guide to Extra-Marital Adventure (Ellis, 1972), and The Future of Marriage (Bernard, 1972) all shaped the dialogue around non-monogamy in the 1970's , with the reception to these books, in turn, shaped by changes in thinking regarding religion, women, contraception, and sexuality, in general (Ziskin & Ziskin, 1975). In response to this book, people began referring to CNM relationships as "open relationships" and then the terms "non-mongamy" and "polyamory" started to become more prevalent in the 1980's and 1990's respectively, although originally, "polyamory" was a term used primarily in the queer community (Baumgarter, 2009). For comparison, the word "polyamory" was not added to the Oxford Dictionary until 2006. The definition of polyamory was expanded to include "the practice of theory of having emotionally intimate relationships with more than one person

simultaneously, with sex as a permissible expression of the caring feelings, openly and honestly keeping one's primary partner or partners (or dating partners) informed of the existence of other intimate involvements" (Benson, 2008), which is a lot more inclusive than definitions and understandings of non-monogamy in the 1970's. Despite this expanding understanding of CNM, it continues to be excluded from mental health training and education (Weitzman, et al., 2009), which raises concern since researchers have shown there tends to be poor treatment efficacy when exposure to and comfort with variations and sexuality is missing for both medical students and psychologists (Muldner-Nieckowski, et al., 2012; Miller & Byers, 2012). More specifically, in the realm of relational therapy, as noted earlier, polyam/multi-partnered relational orientations continue to not be included in articles in top relational/systemic therapy journals, such as *Journal of Marital and Family Therapy* (*JMFT*) (Blumer & VandenBosch, 2015) and the American Association for Marriage and Family Therapy's (AAMFT) 2022 Clinical Guidelines for LBGTQIA Affirming Marriage and Family Therapy (Hartwell et al., 2022) does not include anything about relational orientations (not to mention that the predominate organization of the field itself continues to include "marriage" in its name).

Although by no means a plentiful pool, academic articles expressing interest in providers' attitudes and practices in relation to polyamory and consensual relationships have existed since at least the 1970's. Authors who have written about working with polyam and CNM clients have consistently emphasized the need for providers to be knowledgeable about these types of relationships and to examine their own beliefs and biases about them. In 2018, Twist, Prouty, Haym, and VandenBosch developed a monogamism measure for therapy providers with high rates of validity and reliability, which focuses on three sub-areas of awareness, knowledge, and skills. The sub-area of skills addresses clinical processes such as case conceptualization and

treatment-planning. Overall, however, there are a limited number of studies on managing monogamism and monogamous privilege when providing relational therapy (i.e., case conceptualization, treatment planning, etc.).

The Beginnings of Research on Consensual Non-Monogamy in Therapy

The most prominent themes in articles from the 1970's were introductions to the concept of CNM and a call for therapy providers to become more knowledgeable about these practices and their potential biases, since authors of this time predicted the number of CNM clients would increase exponentially, as "swinging" and "open marriages" were part of the contemporary literary zeitgeist. Constantine, Constantine, and Edelman (1972), asserted the likelihood of therapy providers encountering situations that fell outside of what they had learned to expect in programs is high when training is based only on a "traditional" view of relationships. The authors cited a growing body of evidence, at the time, which indicated what they referred to as a "sizable minority" of people who viewed non-traditional relational orientations and practices as viable, with the implication that the reality might even be greater than these estimates based on published statistics. Given this information, the authors argued therapy providers would be unprepared and irresponsible to not become more informed about non-monogamy practices. Much of this article is still framed from a mononormative and marriage-centric perspective, however, the authors do talk about how families interconnected by co-marital relationships (intimate relationships outside of a marital dyad) committed to working together in the context of these relationships seem to be a "viable alternative to nuclearization" and may be "advantageous even to traditional families" (p. 268).

In a 1975 article, Jaquelyn Knapp also noted forms of non-monogamous relationships were on the rise. She reflected that while many CNM individuals feel non-monogamy has a positive effect on their marriages and personal growth, many individuals would benefit from support to navigate the stigma that comes with deviating from a norm. Like Constantine, et al. (1972), Knapp (1975) warns that although there is a growing number of CNM clients in therapy, therapy providers have not been trained to consider these types of relationship practices, as training has been rigidly traditional and, she adds, literature alerting therapy providers to this growing population have been sparse. Knapp speaks about clients' experience of this by highlighting that many CNM individuals have said therapy providers tend to misattribute problems to their relationship practices/structure, rather than seeing that their relationship practices/structure is actually their mutual attempt to meet all of their needs, address problems, and maintain more honest and open relationships (Knapp, 1975).

In her study, Knapp (1975) found when comparing personal and professional attitudes, most respondents expressed being professionally supportive toward all the types of non-monogamous practices studied (open marriages, swinging, and secret affairs), even if they were not personally supportive, with the exception of swinging. Between 9 and 17% of respondents, however, said they would influence their clients to no longer participate in non-monogamous practices for all three of the types studied, again with swinging being viewed most negatively. Additionally, respondents rated secret affairs as the most "normal" of these and generally felt the others were indicative of possible psychopathy and/or personality disorder, specifically antisocial personality disorder. Personal beliefs and experiences played a greater role in determining biases than any other studied variable such as education level, sex, geographic location, or professional field. Knapp shared a number of examples of feedback participants had given about the study.

Many of these statements provided rigid moral judgements against non-monogamous sex practices, or a high degree of defensiveness, stating that as a counselor, they had no personal opinion about their client and only saw them in a removed and professional way. In her discussion, Knapp wondered what subliminal ways counselors who said they personally disapprove, but professionally are accepting might be revealing their feelings or giving off signals to their clients.

Following Knapp, in 1975, Ziskin and Ziskin (1975) outlined their rationale for thinking that with CNM being "out of the closet", more people would see this an option for how to structure and practice their relationships/marriages, and that like traditional pre-marital counseling, partners might turn to counselors to help support them in working out the details of these arrangements together. This prediction turned out to be true, though not as commonly as they may have thought. For instance, in India, there is an emerging trend of clients coming into therapy for support and assistance as they negotiate an open marriage together (Duggal, 2014). While some of Ziskin and Ziskin's work reflects biases and assumptions of the time, they do raise an important consideration, which highlights the fact that clients considering CNM relationships will likely find themselves "resolving conflicts between what they were taught and what they desired" (Ziskin & Ziskin, 1975, p. 81). Similarly, they believed counselors might also be asked to assist one partner in broaching the subject of opening a marriage or considering a CNM relationship with their partner. Here, they believed it is important to anticipate possible negative reactions, but emphasized that responses were likely to be most influenced by how the idea is presented. Ziskin and Ziskin (1975) end by reflecting on an additional role counselors might take in regard to non-monogamy, such as providing psychoeducation to the public, in an attempt to dispel assumptions and stigma and highlight positives and healthy dynamics.

In 1982, Hymer and Rubin again sounded a call to arms, by noting the growing number of non-monogamous relationships in the United States. Noting the lack of studies focused on therapy provider bias when it comes to CNM clients, Hymer and Rubin set out to conduct their own study of therapists' attitudes and experiences around extramartial sex, open marriages, and swinging. A sample of 57 respondents participated in the study from the 400 questionnaires sent to members of American Association of Marriage and Family Counselors and the American Society of Psychologists in Private Practice as per the 1978 directories. Participants responded to a 17 item survey, which aimed to explore therapists' attitudes, fantasies, and clinical experiences.

Their findings indicate therapists from California had more experience working with these types of clients and the majority of participants' clients who had participated in therapy previously reported their therapists as being unsupportive. The therapist participants reported much higher rates of having personally participated in extramarital sex (cheating) than they reported having open marriages or swinging. Most of the "fantasies" shared about how participants imagined a typical client who would participate in extramartial sex were negative. Like Knapp's findings, Hymer and Rubin also found the most negative responses were toward swinging. This time, however, the researchers found that respondents believed sexually open marriages to be the least pathological. The authors proposed as life expectancy grows, it will be very likely individuals will participate in more than one type of relationship throughout their life and the number of these types of clients will continue to grow, so therapists must examine their conscious and unconscious values about various social relationships. This research is important for understanding therapy provider opinions on CNM, but it lacks an exploration into how these opinions might impact case conceptualization and treatment planning when working with CNM clients.

The Lost Years

After a couple of stray articles in the 1980's, there is a notable lack of academic literature about polyamory/CNM and therapy for the next few decades. In 1982, Peabody produced a study using the Loevinger Ego Development framework to assess whether an individual's lifestyle (monogamous, swinging, open marriage, group marriage) was "normal" or neurotic. Though framed in a way that would likely be considered outdated now, Peabody determined from her results that individuals engaging in non-monogamous relationship types are not automatically "unhealthy" or "maladjusted", but rather engaging in a "unconventional" variant of normal behavior (Peabody, 1982).

Later on, at the turn of the century, a number of published works tracked this dip in literature and hypothesized its cause. In 2001, Rubin proposed one reason for the approximately two decades of a lack of academic research was a lack of funding and reward for researching something that, at worst, was looked down on and, at best, challenged dominant discourses. Other hypotheses included the shift in focus to highlighting cohabitation, single parent families, step-families, and dual earning families, as well as eventually a greater acceptance of and focus on homosexuality. These were all alternative experiences from the "traditional" family and were reflective of salient themes at the time, so academic research attended to these first as acceptance changed and the opportunity to discuss them presented itself (Rubin, 2001). Additionally, Rubin hypothesizes that the focus on acquired immunodeficiency syndrome (AIDS), which increased in the 1980's may have led many to believe people had abandoned these so called "alternative lifestyles" due to an erroneous belief that CNM results in higher rates of sexually transmitted infections. Finally, Rubin discussed that lingering research during this period focused mostly on communes, while other publications on CNM were more likely to be found in popular press than

in academic literature. However, the emergence of the term “polyamory” in the late 1990’s into the early 2000’s represented, to Rubin, a reemergence in interest, which would ultimately prove accurate.

In 2017, Brewster et al. published content analysis on all peer-reviewed articles about consensual non-monogamy from 1926 to 2016. They found, unsurprisingly, that the rate of articles on this topic have increased over time, with 26 articles from 1926 to 2000 and 90 from 2001 to 2016 and only one article between 1926 and 1971. The majority of articles had themes of “relationship styles", “stigma”, and LGBTQIA+ issues, with only 18 articles discussing counseling of any kind (two of which were empirical). The most common types of studies were theoretical/conceptual, editorial/commentary, and literature reviews. The articles were split nearly half and half between purely quantitative or purely qualitative, with very few mixed method studies. Therefore, there continues to be a lack of research on the impact of provider bias on case conceptualization and treatment planning, which could provide more expansive insight into this process.

Barker and Langdridge also published a review of extant literature, in 2010, focusing more on the increase of publications on the topic of CNM in the first decade of the 21st century. The overall takeaway of their findings, according to the authors, is that publications during this time frame fall under either a “celebratory” or “critical” lens, which they argue perpetuates partial understandings of CNM, lacking nuance and intersectionality (Barker and Landridge, 2010). They also note most of the literature focuses on the ways people manage CNM, which has a similar impact on understanding. Most research has focused on specific “types” of CNM practice and most often centralized in the LGBTQ+ community (most significantly- gay males). They also discuss how most studies pit monogamy and CNM or infidelity in comparison with

one another. Barker and Landridge (2010) found there has been an extremely limited number of studies about families, a finding echoed by other studies as well (Brewster et al., 2017). Barker and Langdridge then discussed a great many suggestions for future research directions, mostly bringing CNM to a more down-to-earth-level, both in terms of nuance and everyday interactions and more applied understandings of therapeutic work. Finally, they mention how polyamory might even change the perspective of clinical practice and theory by allowing practitioners and researchers to engage with more than one theoretical orientation rather than rigidly adhering to just one. This study would focus more on these understudied areas, rather than perpetuate these narrow understandings of CNM.

Resurgence

In the early 2000's, there was a resurgence of academic literature about CNM and therapy. This time around, things were a bit different, as social changes and the introduction of queer theory and other critiques of traditional therapy models allowed for new ways of looking at alternative discourses and experiences. Most focused on working with bisexual clients and the first of these which included "polyamory" in the article title, was a study of 217 bisexual individuals of whom 33% reported participating in polyamorous relationships and 54% of whom reported that a polyamorous relationship is their "ideal relationship pattern" (Weitzman, 2006, p. 139). Weitzman's overarching statement was that because of these statistics, if a clinician is working with bisexual clients, they should anticipate that a number of them may be in polyamorous relationships and so clinicians should be familiar with this type of relationship to best meet the needs of their clients. Most of the references Weitzman cites in writing this article come from books, published works from other fields (such as medicine), websites and non-

academic literature, and even some of their own presentations and papers, emphasizing again that this article was one of the first in an newly emerging area of academic study and clinical application. Starting in 2004, a few more articles were published focusing on lesbian and gay male clients and relationships, but most of these did not explicitly talk about polyamory or ethical non-monogamy.

The first articles looking at non-monogamous relationships from the perspective of clinical application focused on gay male clients. This makes a lot of sense when one considers the overall patterns regarding which groups within the larger LGBTQIA+/Queer community first gained mainstream attention and subsequently, legislative changes and social acceptance within the dominant culture. Additionally, early studies in this area, such as Blumstein and Schwartz's work in 1983, found that 65% of gale male respondents reported participating in polyamorous relationships, the highest percentage of any of the participant groups.

Bettinger (2005) suggested the American gay male community, approaches choosing monogamy or non-monogamy as a morally neutral issue, where partners base their decision on the more subjective and contextualized question of whether non-monogamy will help or hurt the relationship, rather than whether it is "good/bad" or "right/wrong". Like Bettinger, Shernoff (2006) asserted non-monogamy is an established and accepted idea within gay "subculture," unlike in dominant western culture. He suggested that because of assumptions and scripts of dominant discourse, some therapists view non-monogamy itself as a relationship problem. Shernoff (2006) discloses the fact that differences regarding non-monogamy ideas and practices are some of the most common reasons gay male couples seek his therapy services, which adds another layer of provider responsibility: how does a relational therapy provider find balance between not pathologizing non-monogamy when the presenting problem may, in fact, be a inter-

partner disagreement about this concept/practice, while also navigating one's own assumptions and understanding of non-monogamy, Shernoff discusses the ways family therapy has often labeled practices of non-monogamy negatively by viewing them through the lens of concepts which traditional family therapy models have deemed "unhealthy" or "dysfunctional" (i.e. triangulation) (Kerr & Bowen, 1988). However, Shernoff also cites Cheuvront, 2004; Green, et al., 1996; Green & Mitchell, 2002; Greenan & Tunnell, 2003; and Kurdek & Schmitt, 1985–1986 as examples of gay-affirmative family and couples therapists who have "discussed how to use aspects of traditional theories of family and couples therapy with the primarily happy yet nonmonogamous male couples they were seeing in their practices" (Shernoff, 2006, p. 410).

In 2014, Hosking found relationship dissatisfaction in CNM relationships comes more from the intersection of individual differences that occur within any relationship, as opposed to from the type of relationship itself, an idea echoed by van Eeden-Moorefield et al. (2016). Brown (2015) expressed a similar idea when exploring open and closed relationships between gay men through a lens of male hetero-normative masculinity and attachment theory. Citing past research suggesting that overall, relationship satisfaction does not differ between gay men in open and closed relationships and that, in fact, greater relationship satisfaction has been reported in open relationships with explicit rules, Brown suggested practitioners should focus their attention to supporting partners in negotiating rules for their relationship.

Baumgartner (2009) introduces "polyamory" in the realm of "queerness", but she notes clearly that polyamory and CNM are also practiced by heterosexual partners, which was not a common recognition up until that point. She also suggested narrow and prescriptive mono-normative therapy training "obscures" the choice for non-monogamous relationships. As a narrative therapist, Baumgartner framed her ideas as a thought exercise for considering alternate

stories and moving away from a narrow and limited single story about what relationships "are" and "can be" and acknowledges how this discourse influenced her interactions with clients. Baumgartner speaks of "training" in monogamy, by which she means both formal training in therapy, but also the "training" received simply by existing in a society with prescriptive dominant discourses.

Barker (2011) expressed how research on CNM and therapy became part of a larger conversation about challenging monogamy. Citing Marianne Brandon's assertion that the challenge of monogamy is bringing it "out of the closet and into the treatment room" (Brandon, 2011), Barker posits that it is likely many or most people are not "actually" monogamous, or at least not by the standard of the rigid and demanding social definition of monogamy that has evolved over time. Brandon (2011) proposed struggling with this understanding of and mandate for monogamy is a top reason for people coming to therapy with sexual and relationship difficulties, and therefore, it is absolutely necessary for therapists to examine their own assumptions and beliefs about monogamy. Without doing this, therapists are at risk for actually exacerbating and reinforcing the presenting problem, under the guise of helping. It seems likely this process can be either conscious or unconscious, but may stem, in part, from a misidentification of the presenting problem where rather than looking at the struggle that has emerged from trying to fit into an unrealistic requirement, the non-monogamous perspective and behaviors are what therapists aim to change or challenge. Some key takeaways that Barker provides from Brandon's work are the ways trying to adhere to monogamy scripts can lead to problems, such as people staying in relationships that are impacting them negatively, rushing to break up because they take any sign of trouble as a partner not being "the One", struggling with commitment because a person cannot find someone who is "perfect", feeling guilt and shame if

they stray from a relationship and rejected if a partner strays (in any capacity), and sexual difficulties from the pressure to constantly be having "great sex" (Barker, 2011).

These articles first brought academic awareness to different forms of CNM, confirmed that CNM relationships do not differ in satisfaction levels from monogamous ones, and focused on ways personal and relational distress can come from mononormativity itself. When taking these themes into consideration, it becomes clear that implicit mononormative bias in relational therapy practice could misplace the identification of the presenting problem, which would have ongoing impact on treatment planning. Additionally, mononormative treatment planning could actually exacerbate distress, rather than working with clients to find ways to alleviate it.

Applied Therapeutic Research

In the last decade, the resurgence of polyam/CNM therapy research has turned toward more clinical application, in terms of case studies and evaluations of different modalities and interventions used with CNM clients. These studies are less abstract than previous musings about "what unique challenges might CNM clients face" and instead are heading in the direction of evaluating practices and adapting established methods.

In 2012, Zimmerman published an article with some guidelines for the assessment phase of therapy when working with CNM clients. His work is framed from a intersystems approach to sex therapy. Zimmerman starts by sharing his own experiences in his graduate training where he worked with a CNM couple and had a colleague who described herself as polyamorous, but they received no training, had no readings, and participated in no discussions about non-monogamy, save in the context of cheating. Zimmerman then extends beyond the assessment phase and demonstrates how the intersystems approached can be used throughout treatment. Some

examples of the systems explored are intrapsychic components: interpretation, definition, prediction and interactional components: congruence, interdependence, and attributional strategy. This perspective allows for a more client-guided therapy process, as it is very open and reflexive in nature. This model also accounts for the consideration of larger system influences such as familial, biological, psychological, sociocultural, and relational ones.

Berry and Barker (2014) published some guidelines on how to use experiential sex therapy with CNM clients. They grounded their work in early research about CNM experiences and expressed a belief that this particular therapy model is non-pathologizing and suitable for use by both therapists who have not worked with CNM clients before and those who have, but are looking to expand their toolbox. This iteration of experiential therapy has a strong focus on meaning-making and is explicit about mononormative influences at a societal level. Core to this work is also the therapist's awareness of their own prejudgements and values (Berry & Barker, 2014). McCoy, Stinson, Ross, and Hjelmstad (2015) published a case study about using sensate focus (a common sex therapy technique) with CNM clients and how they worked with clients to address any unique issues based on the the CNM nature of their relationship (McCoy et al., 2015). In 2017, Kolmes and Witherspoon published a case study style article outlining the use of Gottman and EFT models with CNM clients and Sprott, Randall, Davison, Cannon, and Witherspoon published a case study demonstrating how some kink aware therapy techniques might be used in a parallel way with CNM clients, as well as describing the application of a specifically CNM-focused therapeutic framework (Sprott, et al., 2017), which consolidated many of the recommendations of earlier, more abstract therapy research. These articles represent a great start to determining effective therapy models and practices for working with CNM clients and outlining how existing approaches can be inclusive to CNM relational orientations, but there

is still a gap in the literature regarding the process of case conceptualization and determination of treatment planning. These aspects of clinical work are important because they are interwoven through all stages of therapy and exist regardless of which models are being used.

Within roughly the last five years, there has been a surge of literature starting to address ways for therapists to specifically work with CNM clients from an informed and affirming perspective. This increase seems tied to larger movements toward demarginalization and exploring the experiences of previously underrepresented and underserved populations and identities in clinical practice, such as asexuality (Steelman & Hertlein, 2016) and pansexuality (Belous & Bauman, 2017). In 2017, Twist and Ansara presented a detailed workshop outlining skills for practicing relational and family therapy skills for working with minorized relational orientations, identities, and systems. *Polysecure*, published in 2020, includes information about how to integrate CNM with established models and understandings of adult attachment. More books have been published with the goal of familiarizing therapists with different forms of CNM (Orion, 2018). Plus, in the last two years, a number of books have been published to serve as handbooks and toolkits for therapists working with CNM clients (Kauppi, 2021; Vaughn & Burnes, 2022; Ferrer, 2022) and in 2021 The College of Sexual and Relationship Therapists (COSRT) offered a class (Twist, 2021) for therapists aimed at "helping to further one's understanding and related management of monogamism, while also bolstering polyamory-aware micro-skills in practice (Twist, 2021). That said, the future seems to have potential, when it comes to relational therapists' ethical responsibility to best serve their CNM clients, if they indeed have awareness of and access to these resources and choose to engage with them. The question still remains, however, given dominant discourses tied to mononormativity, do relational therapists currently exhibit monogamism in their case-conceptualization and treatment

planning? This information could help determine how new resources and research could best be used and made accessible to both current relational therapists and those who will participate in training programs in the future.

Chapter 3: Methods

For this study, a queer theory was used to understand how relational therapists and other practitioners of relational therapy understand relationships through meaning-making that aligns with dominant discourses or challenges this discourse. As an offshoot of critical theory, queer theory holds that all understanding of reality is influenced by social, political, cultural, economic, ethnic, and gender-based messages that become reinforced over time until they become social structures viewed as natural or intrinsic. This is because, the crux of critical theory is the idea that the assumption of these structures being "natural" or "intrinsic," which leads to a rigid and less diverse set of accepted behaviors and understanding, needs to be challenged, since these structures are actually socially-constructed. Critical theory challenges the idea that objectivity should be privileged because even practices deemed "objective", such as quantitative research, are impacted by structures and systems that are subjective and socially constructed. Queer theory also challenges the idea of an object or static "normal", but rather a dynamic set of norms with which individuals do or do not align (Illinois University Library, n.d.). Queer theory, instead, is centered around the question "What if instead there were a practice of valuing the ways in which meanings and institutions can be at loose ends with each other? What if the richest junctures weren't the ones where everything means the same thing?" (Sedgwick & Jagose, 2013,, p. 6-7).

Queer theory has its roots in critical theory and is recognized as a specific field of critical theory. Critical theory involves identifying and acknowledging the power structures at work in societies, cultures, and groups in order to reflectively critique and assess them. Critical theory is heavily influenced by the social constructionist ideas of Michael Focault and the work of sociologist, Max Horkheimer, who asserted that a theory might be described as critical if it

"seeks to liberate human beings from the circumstances that enslave them (Horkheimer, 1982, p. 244). From this perspective, social problems are viewed as stemming from the impact of societal structures, cultural assumptions, and socially constructed meaning-making (i.e. dominant discourses) and the lived experiences of individuals and groups.

From critical theory emerged both feminist and queer theory, focusing on differing elements of marginalized experiences and groups. Queer theory includes focus on sexual activity and identity and the way these fall within or outside of "normative" social and cultural categories and discourses. The purpose of this theory is to "act as a lens or tool to deconstruct the existing monolithic social norms and taxonomies and investigate how and why they came into being"(Worthen, 2016, p. 94) as well as the ways the existence of these norms correlates to power, privilege, oppression and marginalization. Dominant discourses and the ways they define "normal" and "deviant" experiences and identities are seen as reductive and inherently tied to social power structures. "Queer" in this context can be understood to mean those who feel marginalized as a result of standard social practices (Giffney, 2004), most specifically in the realm of sexuality, gender, and relationships. Sutherland, Lamarre, and Rice (2017) spoke about the way a growing understanding of the importance of discourse, which began in the early 20th century with the increased application of social constructionist, postmodern, poststructural, feminist, and critical theories, has led to a shift in understanding "family" as "objectively knowable to the discursive construction of (different versions of) family and the sociohistorical relations of power shaping and constraining local meaning making and interaction" (Sutherland, et al., 2017, p. 671). By extension, the same could be said about relationships, marriage, and other such concepts, making this a logical lens through which to look at meaning-making around intimate relationships.

Research Design

I used a constructivist grounded theory approach in this study because it is meant to be an initial look into how practitioners of relational therapy conceptualize healthy/successful intimate relationships and use those understandings to inform their practice. This focus is a good fit because there are a limited number of studies that focus on the process of treatment planning and case conceptualization, as well as examine clinical and training implications of dominant discourses about partner relationships. A constructivist grounded theory approach means data was coded and a theory was proposed based on interpretations of these findings (Charmaz, 2014). This is the first time this type of study has been done and there are no existing theories that speak to the process by which therapists conceptualize cases and treatment plan when working with consensually non-monogamous (CNM) clients.

The grounded theory approach consists of the following steps (Glaser and Strauss, 1967; Strauss and Corbin, 1990): First, determine initial research questions. Next, recruit and collect data. Then, analyze data using iterative data collection and inductive analysis. This means there will be multiple iterations of data collection until theoretical saturation is reached. Once theoretical saturation is reached, in other words, analysis no longer reveals new codes and categories in the collected data, a central idea that represents the data is determined and this central idea becomes the basis of the grounded theory that is then stated and discussed. In this case, theoretical saturation was reached quickly because of the number of responses that were collected.

Participants

Participants in this study consisted of 32 of pre-licensed, provisionally licensed, or fully licensed marriage and family (MFT)/couple and family therapists (CFT) or trainees currently in MFT or CFT programs who are actively seeing relational clients (i.e. graduate students participating in a clinical practicum/internship). All participants are located in the United States and are over the age of eighteen. All participants also hold at least a bachelor's degree, because that is the minimum degree to practice relational therapy in a clinical setting; usually as part of a graduate practicum or internship. The minimum license-eligible degree in the field of relational therapy is a master's degree, so all participants who reported some degree of clinical license held this degree or higher.

Recruitment

This study used a mix of criterion sampling and snowball sampling. Although this study was conducted with a constructivist grounded theory approach, recruitment was done using criterion sampling, because participants must meet specific criteria (outlined above) in order to be included. Participants must be pre-licensed, provisionally licensed, or fully licensed marriage and family (MFT)/couple and family therapists (CFT) or trainees currently in MFT or CFT programs who are actively seeing relational clients (i.e. graduate students participating in a clinical practicum/internship). Snowball sampling was used when respondents shared access to the study in their academic and professional circles to others who met the criteria, but were not accessed directly through initial recruitment strategies.

Recruitment was conducted using sites such as LinkedIn, Facebook groups for practicing therapists, state associations for relational therapists, and by contacting program directors for

every COAMFTE (Commission on Accreditation for Marriage and Family Therapy Education) accredited relational therapy program in the United States (graduate, doctoral, and certificate). From these initial channels, participants were also gathered through word-of-mouth recruitment by therapists who either already participated or who did not meet the criteria but knew others who did. Using this online format and starting at the level of online professional groups and academic programs will help ensure a more diverse sample of practitioners than recruiting solely through word-of-mouth, or geographically specific participant pools, such as local professional networks or specific academic programs would.

It was important to ensure participants were motivated and engaged enough to complete the study in order to yield the most accurate results. To help increase response rates, participants who completed the survey were given the option to receive a $5 dollar Amazon gift card, as outlined in the informed consent form at the start of the survey. If the participants did not complete the survey in its entirety, they were not eligible to receive this gift card. To ensure this, there was a link at the end of the survey, which led to a separate Google Form, asking participants to submit their email address if they wanted to receive a gift card.

Gatekeeping

Despite my best efforts to create a streamlined data collection process, I encountered a variable I had not accounted for and had not experienced while conducting previous research. Although not an issue the last time I conducted research, SurveyMonkey now has a significant problem with bots, artificial intelligence (AI), and reward-seekers, because it does not have any security measures in place to protect against these issues. Bots are programs designed to complete tasks for a human user. In the case of surveys, these programs fill out surveys with

either random responses, or responses that are created with the assistance of AI technology. Reward seekers are people who, with or without the assistance of bots, fill out surveys simply to earn the reward and do not necessarily meet the criteria and do not provide usable answers.

I first realized something was wrong when responses to my survey started pouring in. Given that this is a qualitative study and not a quantitative one, and the survey questions were open-ended, I was not expecting a high number of responses, nor was a high number of responses likely necessary to reach saturation. I had over 50 responses within the first couple of hours that my survey was live. Upon reviewing the data coming in, I quickly became alarmed, as responses included everything from random symbols, Chinese characters and assorted numbers, to blanket responses of "no" and scripted responses lifted from somewhere else, talking about irrelevant concepts. Worried, I began looking online to figure out what was going on and discovered the now rampant pitfalls of using research software without the necessary protections.

I first tried a couple of techniques to manually discourage these unusable responses such as creating a write-in question asking respondents to type the name of their degree subject and using the example of "Chemistry" to hopefully confuse bots or anyone who was not actually a relational therapy provider. I also tried to create and use a ReCaptcha-type question, which is a fraud detection service created by Google to distinguish between human and non-human responses. I read dozens and dozens of articles and guides to understand the issues and how to prevent them. Theorizing that the breach may have come from LinkedIn, because most of the groups were not "members only" and requiring approval to join, I removed my recruitment posts from this platform. Nonetheless, questionable responses were still coming in, albeit at a slower rate. Eventually, I removed my recruitment posts from all social media platforms, even private groups that did require approval for membership. Conceding to my frustration with the

protections SurveyMonkey offered (not many), I decided to recreate my survey using the Qualtrics platform, which was recommended online due to having most, if not all, of the available protections against bots and other fraudulent responses.

In the meantime, I consulted with multiple faculty and committee members about my predicament who all were shocked and alarmed by my experience. After many consultations, committee members and my chair determined that my research assistant and I should create a list of exclusion factors to determine which responses could be included in the study. This system was created in a series of steps, first general guidelines were discussed by my dissertation chair, my research assistant, and I. Next, I removed the responses that were left blank or included random symbols, numbers, or repeated, single word answers (such as "No"). After this, my research assistant and I reviewed each set of responses and separately created charts outlining whether we believed it was a usable response or not, how certain we felt about our choice, and our rationale. Once we did this, we met for multiple hours reviewing each set of responses together. Our exclusion criteria will be outlined in more detail below. Any response sets where my research assistant and I did not agree on whether the response was usable or not were eliminated from the usable data pool, as were any response sets where we felt unsure of our choice.

During the process of determining which responses could be included, the Qualtrics platform collected two more responses. However, after completing the inclusion determination process, consulting with my dissertation chair about the nature of the responses retained, and beginning to code the data, it was determined that saturation had been reached and all surveys were closed. It was a very complicated process, but it was extremely important to do everything possible to ensure respondents included in the study actually met the criteria for participation,

especially since this study focuses on qualified relational therapists and therapists-in-training and not just the general public.

Procedures

Data Collection

All documents and measures for this study were distributed and collected via an online platform. Two different research software platforms were used: SurveyMonkey and Qualtrics. First, the participants completed the informed consent form. If they agreed to the terms of the study a demographics questionnaire, asking about the participant's identity, as well as contextual questions about their clinical training and education Appendix II) was disseminated to participants to provide context for the clients' lived experiences and responses. Participants were then given a clinical vignette with three open-ended, short-answer questions regarding case conceptualization and treatment planning, followed by a fourth short-answer question which they completed after submitting the first three.

Instruments

Data was gathered by asking the participants to answer three main, open-ended survey questions about the consensually non-monogamous partners in the vignette, inspired by the work of Grunt-Mejer and Lys (2019) and adapted with the authors' permission. These questions (Appendix IV) asked about initial hypotheses regarding the source of the presenting problem, what other information the participant would want to know in order to create a treatment plan and work with these clients, and initial thoughts about treatment planning and recommendations.

After answering these three questions, the fourth question was provided, asking if they would change anything about their responses if a monogamous relationship was described instead.

Vignette Construction

Participants received a vignette about partners ("Riley" and "Jaime") facing various challenges, who are seeking therapy. Following the approach used by Grunt-Mejer and Lys (2019), the first paragraph contained a general description of the partners, the second paragraph described the dyad as participating in a consensually non-monogamous relationships structure that they would like to continue, and the third paragraph described the challenges the partners are currently experiencing. For the purposes of this study, the introductory descriptions of the partners have been adapted from the vignettes used in studies by Grunt-Mejer and Lys (2019) and Conley, Moors, Matsick, and Ziegler (2013) with the permission of the researchers. The second paragraph, describing the relational orientation has been adapted from Conley, Moors, Matsick, and Ziegler (2013) with considerations made from discussing with Katarzyna Grunt-Mejer editor feedback given about her study, which emphasized the importance of the descriptions being as similar as possible so as to not seem "friendlier" toward one relational orientation or the other. Finally, the third paragraph, describing the current challenges, were generated by combining some common themes this author has encountered when working with both monogamous and CNM partners in relational therapy.

Data Analysis

Multiple steps were involved in the data analysis, including determining data inclusions and three levels of coding. The entire data analysis portion of the study was done with the

assistance of a master's level research assistant. This person met Antioch University of New England (AUNE) IRB requirements and approval for the use of her assistance in the analysis process was obtained through the AUNE IRB. This research assistant is currently enrolled in the Couple and Family Therapy Masters Program at AUNE and is familiar with both the qualitative research process generally, and the topic of study in particular.

Determining Data Inclusion

As described above this study had some additional demands regarding determining which responses could be included in the data. First, any responses with random letters, numbers, symbols, characters, repeated single-word answers for every question or left incomplete were eliminated. Out of an original 203 responses, this exclusion criteria alone brought the number of responses down to 82. Additionally, my research assistant and I opted to eliminate any responses that included a listed program that would not lead to a license-eligible degree for relational therapy. For instance, since this was my example, many unusable responses had "Chemistry" listed. We also eliminated scripted or lifted responses, which were responses that did not make sense for the questions and felt automated, such as "It is alway important to evaluate customer satisfaction" in response to Question #2 about what other information therapists would like to know about the clients or a couple of answers that spoke about monogamy in bird species and risk factors for diabetes. Next, we looked for compatibility between responses and eliminated responses where there were incompatibilities, such as respondents who responded that they only had a bachelor's degree, but were fully licensed. Additionally, we eliminated response sets that were identical or very similar and submitted within seconds of one another. My research assistant also took it upon herself to submit survey questions, in a few different forms, through

ChatGPT, which is a language processing AI program that can respond to questions in a dialogue-like form by drawing on collected data banks of information. Luckily, the responses she received when "communicating" ChatGPT about these prompts were not similar enough to the responses collected to cause concern.

At a point, if none of our exclusion criteria were met, we had to use our best judgment to decide if a response should be kept. Even though some responses were very harsh toward CNM clients, and we felt ourselves hoping therapists would not respond this way, we had to ensure our own values and perspectives were not compromising what we decided to include. That said, we included all data that did not meet our exclusion criteria and that we agreed could be a usable response. After our careful sorting through the data, and consulting about our general findings with my dissertation chair, who felt the themes we were noticing aligned with past and current research and trends, we had 32 usable responses remaining.

Coding

The data was analyzed using Corbin and Strauss' procedure for grounded theory coding (Corbin & Strauss, 1990). The steps for this type of coding include the following: 1. Divide data into excerpts (open coding), 2. Group excerpts into codes (open coding), 3. Group codes into categories (axial coding), 4. Collect more data, 5. Analyze new data and compare with current codes and categories, 6. Adjust codes and categories to best represent all data, 7. Repeat until you reach theoretical saturation, 8. Define the central idea (selective coding), 9. Write your grounded theory. One thing that makes qualitative research and more specifically grounded theory research unique is that it is recursive, which means that analysis and data collection happens simultaneously or in the form of a give and take. Usually, initial data is collected and

then coding begins. Then, more data is collected and compared with the themes identified through the initial coding, which helps inform whether more data is still needed to reach theoretical saturation and whether codes and categories need to be adjusted. This technique also allows space for things like member checking, by going back to participants and seeing if initial coding matches their experience or the ability to add new questions and collect data on these as a way of ensuring the data is providing as complete of an answer to the research question as possible. In this study, since it was an anonymous survey, member-checking was not an option. However, data analysis and collection still happened side-by-side and data collection only stopped when it was determined that theoretical saturation had been reached.

The first phase of coding was open-coding and it consisted of two stages. First, participants' responses were reviewed and repeating words, phrases, and ideas were highlighted, usually in the form of excerpts. My technique for doing this was to go through and highlight repeated words or ideas, or ones that seemed thematically similar with different colors. An example of my open coding process can be seen in Appendix V. Next, I went through and began to determine a name or an inclusive theme embodied by all the excerpts in this color. This began the second stage of open coding, which is separating the excerpts out into thematic categories. A list of my categories can be found in Appendix VI.

Around this point, after a few rounds of comparing emerging themes from data that was coming in, my research assistant and I determined theoretical saturation had been reached. While Glaser and Strauss (1967) initially framed theoretical saturation as the point at which no new information emerges from continued data analysis, more recent researchers have challenged this definition and instead frame it as “conceptual rigor” (Low, 2019). In other words, the point at which no new concepts are emerging (instead of data itself), and since grounded theory aims to

generate an “explanatory theory of the social processes” (O’Reilly and Parker, 2012), theoretical saturation can also be viewed as the point at which you are seeing enough conceptual repetition to outline an emergent conceptual model and theoretical explanations (Roy, 2015; Low, 2019).

At this point, coding became more process oriented as I reviewed the data with my research questions in mind: what were these emergent themes telling me about the process I was trying to learn more about? This is the mindset I used as I moved into process-oriented axial coding (Figure 1) and selective coding. I grouped the themes into groups that seemed to be related to one another in terms of their chronological or ideological location in the process being studied. It is from here that the two part process I discuss later began to emerge. I could see how there were a number of themes that fell into the “intention stage” and then others that fell into the “action” stage, or the reality of what happened when relational therapists started really trying to conceptualize and plan treatment for a case with CNM clients. From here, I was able to more clearly see a central idea: a conceptual map of this two-part process, which also helped me identify an addition to the theory, which addressed the second research question: how do mononormative dominant discourses influence relational therapists when working with CNM clients? From the conceptual map of the two-part process, I was able to pull themes from the data that represented what the end results of this process are. As will be discussed in more detail in the next sections, this central theme involved three possible outcomes from this two-part case conceptualization and treatment planning process. The full proposed grounded theory can be seen in Figure 2.

My entire analysis was informed by the tenets of critical inquiry, bolstered by the foundations of constructivist grounded theory. Kathy Charmaz, who established constructivist grounded theory, has spoken frequently about the ways constructivist grounded theory can be

used for critical inquiry. Citing Cannella, 2015; Cannella & Lincoln, 2007, 2015; Pasque & Pérez, 2015; and Strega, 2005, Charmaz defines critical inquiry as " a transformative paradigm that seeks to expose, oppose, and redress forms of oppression, inequality, and injustice" (Charmaz, 2017, p. 35) and continues by saying proposing, "notions of justice and injustice become '*enacted processes*, made real through actions performed again and again' (Charmaz, 2017, p. 508). Studying questions about justice and injustice as enacted processes can inform critical inquiry and initiate new research directions" (Charmaz, 2017, p. 35). So, when moving from content to process, in terms of thematic coding, I looked for the ways these thematic groups centered around oppression, inequality, and injustice. Once this lens was applied, I was able to see how many responses all followed a pattern (the two-part process) and yielded a similar set of results (the influence of mononormative dominant discourses).

Trustworthiness

Trustworthiness involves verifying whether research findings have value by asking questions about whether findings can be believed, how they've been determined credible, and how this was evaluated (Guba and Lincoln, 1981). Trustworthiness includes rigor, credibility, transferability, and dependability, which are all important aspects of ensuring the worth of qualitative research.

Rigor

Rigor in qualitative research is involves addressing reflexivity or the degree of influence the research has on the data and results, either intentionally or unintentionally (Jootun et al., 2009), this influence is due to the researcher's positionality and is present at all stages of the

research process (Primeau, 2003). In this study, memoization was used to track researcher decisions on methodology, data analysis, and triangulating data with the masters level research assistant, as well as reflexive reflection on researcher's experiences during this process. This was important because since the author/researcher cannot separate from her own positionality, it is essential that research decisions made do not move too far away from highlighting the participants' perspectives. Memoing on important research decisions is a way of tracking the rationale behind them and being mindful of how personal experiences and perspectives could be influencing them. Likewise, choices around data analysis should be tracked to ensure the identified themes are coming from the data and noting how they are influenced by the author/researcher's beliefs and positionality. Researcher reflexivity is discussed in greater detail at the end of this section and an excerpt from the researchers memos/journal can be found in Appendix VII.

Credibility

Credibility refers more specifically to the process of ensuring the reporting of data remains true to the actual data obtained (Guba & Lincoln, 1981). In qualitative research, this refers to ensuring that themes pulled from participant responses are "faithful" representations of the participants' actual thoughts, feelings, and experiences. One way this can be done is through the process of triangulation, which is a strategy to determine whether interpretations and meaning obtained from multiple sources or observations converge (Carter, et al., 2014). Triangulation is used to test validity in qualitative research and there are four different types (Denzin, 1978; Patton, 1999). In this study, investigator triangulation in particular was used, which is when two or more researchers in the same field of study provide their observations and

conclusions about the data (Denzin), which can help confirm the validity of findings, while also adding different perspectives that can add to the depth of the eventual themes, or in this case- proposed theory(Carter, et al., 2014).

To help with this, I worked with a masters level research assistant who reviewed all the data, helped determine the usability of responses, and coded the data. She is versed in relational therapy in a clinical setting and specifically has experience working with non-monogamous clients. This research assistant was provided with clear expectations regarding her involvement and the tasks she was asked to do via virtual meetings and email correspondence. She also participated in collaborative planning and feedback meetings and conversations with myself and my dissertation chair. The first task this assistant helped with was determining the viability of inclusion for each response set. The process for this is outlined in the next section. Next, she participated in both stages of open-coding independently and then we compared our findings. For the axial and selective coding stages, she took on more of a peer reviewer role, where she was asked to provide feedback on the axial codes I pulled together from the data and then on the selective coding process that led to the proposed grounded theory. This research assistant's role was to help counter any potential biases I may have been bringing as the researcher by conducting the initial coding process separately and then by ensuring my proposed axial codes and selective coding were accurate representations of both the data and these initial codes. This assistant was also encouraged to engage in memoing, and research meetings included reviewing any questions, concerns, or experiences the research needed to process. I also maintained an audit trail, which kept track of all of my raw data, inclusion determinations, coding, and decision making.

Transferability

Transferability is the ability to transfer the design of the study to a different setting (Kuper, et al., 2008). One way to ensure transferability is to be clear in defining the requirements for sampling as well as operationalizing the concepts being studied. By outlining recruitment requirements that are easily understood: practicing fully licensed professionals, associate licensed professionals or students/interns in training who practice relational therapy, this will ensure consistency in the sample. Furthermore, the clear definitions provided for the concepts being studied, as well as a concrete measure to study these concepts, helped ensure reliability and validity, which increases transferability. Survey responses provided information about whether participants used language similarly or made similar meanings about the concepts discussed in these responses. The common themes identified in the coding process and the reaching saturation in the responses suggests a significant degree of transferability.

Dependability

Dependability refers to the ability of a study to be repeated in terms of analysis (Schwandt, 2001) and it is similar to the concept of reliability in quantitative research (Creswell, 2014). I worked to ensure consistent coding by having a second person re-code the data and compared my interpretations with hers. Also, I kept a researcher journal to document my decision-making process, specifically around decision-making for operationalization and coding of themes. This helped my research assistant and I understand whether we were using the same definitions for coding and ensure we were using the same standards for the inclusion of response. These interpretations, discussed further in the Results chapter and included in Appendices V & VI and Figures 1 & 2, help others to better replicate the study in the future.

Researcher Reflexivity

One of the core tenants of the queer theory paradigm is that there is not one reality but many realities based on values, standpoints, positions, context, and identity. This is also related to what makes constructivist grounded theory different from other types of grounded theory. Charmaz, the main founder of constructivist grounded theory, posits that the researcher is not a neutral observer, but instead data, analysis, and the eventual theory are constructed by the researcher based on their past and present experiences (Charmaz, 2014). Therefore, the discussion of these findings are a single interpretation of these individuals' experiences, based on my lens as a sex-positive, asexual, cisgender woman who has been in a committed, open-relationship for the past five years. I am also a recently licensed CFT in my early thirties, who has just become fully licensed in her home state and opened her own private practice.

Researcher Role

Given the nature of this study, I did not interact directly with the participants. However, I tried to pay attention to the language and wording used in the survey so as not to skew the survey in any direction. It was interesting to consider how to frame the different parts of my study, particularly the demographics questionnaire, because as I was creating it, I realized there were some categories where including certain identities would automatically reveal something about me. Currently, in this country, there is a lot of political turmoil regarding gender identity. Unlike some other political debates, this one is not only about differences in opinion, but also one that at its extremes includes a division in believing whether certain gender identities are real/exist. This is not something I have encountered before when doing research, a situation where I was perhaps saying something about my political leanings simply by acknowledging groups of people exist.

By extension this debate is tied to larger conversations about "wokeness" and the fact that my demographics questionnaire includes diverse options for many prompts could also lead people to make assumptions about my political leanings and my identity. Given the "wokeness" conversation, the inclusion and acknowledgement of diverse identities in and of itself has become equated with being a "social justice warrior", "virtue signaling" associated with condescension, or a liberal dog whistle. While I do not aim to hide my identity, per se, since I am a human researcher who does have beliefs and experiences that cannot be neutralized, but my aim in wording my demographics questionnaire the way I did was in an effort to create an inclusive experience to anyone participating in the survey who would hopefully see their reality included and not relegated to a place of "other". I can recognize that part of my motivation for doing so was informed by my own experiences of seeing my reality not included on forms and needing to decide whether to approximate based on how others might perceive me, choose others, or expand on what "other" was. For example, this has often been my experience when noting my sexual orientation, since "asexual" is rarely listed on forms and the two relationships I have been in throughout my life have both appeared "straight-passing", even though this was not the reality in either case. My hope is that regardless of potential assumptions about me, I was able to create a questionnaire that felt inclusive and conveyed openness that I hope participants took with them when they reached the open-ended questions section so that they could answer honestly.

Researcher Bias

Another important part of researcher reflexivity is for the researcher to explore and examine the ways they might feel personally connected to the topic they are studying. Usually

this reflection provides some insight into why the researcher decided to study this topic. In my case, my reasons for choosing this topic were not especially personal at the start.Originally, I was set on writing my dissertation about asexuality and the compulsory sexuality discourses that are seen in couples therapy. This original research idea came from two realms of personal, lived experience. First, as mentioned above, I identify as asexual, and I have experienced first hand how little information is out there about asexuality, particularly in the relational therapy realm. Second, I had personally experienced a number of microaggressions while in classrooms and behind the mirror of therapy sessions, where fellow relational therapists in training had made assumptions and derogatory comments from a place of compulsory sexuality (or, allonormativity). However, as I was trying to begin my research, I kept running into the problem of needing to say and explain way too much about social views and dominant discourses about sexuality to even provide enough information to get to what I actually wanted to study. So, I decided to shift my focus to general dominant discourses about what a "healthy" or "good" dyadic relationship looks like, which eventually led me to the idea of mononormativity.

Alongside this, while working in the couple and family therapy clinic in my doctoral program, I had my first real exposure to working with CNM clients, mostly through observing the sessions of peers and then supervising masters level students who were starting to see their own clients. Like many people, before this, I had really only been exposed to the idea of non-monogamy in the media, presented as something scandalous and counterculture in nature, or as a hush-hush or gossipy topic whispered among friends, about others. However, as my time in my doctoral program progressed, I now frequently heard about the lived experiences of clients and also some of my supervisees, who practiced consensual non-monogamy in various forms. What surprised me, as someone who had only been in one, monogamous relationship in her life at that

point, was that the idea of non-monogamy conceptually made a lot of sense to me. I have always been someone who views relations from a bottom-up, rather than a top-down perspective. I often wonder if this is due, in part, to the fact that as an asexual person, I found myself not understanding a lot of dominant discourses about relationships and, I realized I viewed many components of relationships as separate entities, rather than as a bundle. For instance, sexual attraction did not go hand in hand with romantic attraction or aesthetic attraction or intimacy for me, since I had not ever even experienced sexual attraction. So, viewing relationships from this "new" perspective of non-monogamy did not really feel "new" for me, it actually clicked in a way that dominant discourses had not.

Fast forward a couple of months and I found myself in a position where my partner relationship was no longer working for a number of reasons and, at the same time, I was also reconnecting with a person I had strongly connected with in college, before my current relationship began. As time went on, I decided to end my relationship and after reflecting on what we knew now about ourselves, that we had not before (such as my asexuality), my past connection and I became close once again and understood one another in a new way. Since this self-reflection and sharing was at the core of our reconnecting, it became fairly commonplace for us to talk very openly about relationships and sexuality in a general sense. He shared some of his past negative experiences in relationships and his apprehension about future committed relationships, which was in part due to his own, current exploration of pansexuality and gender fluidity. In the context of one of these conversations, I mentioned the concept of consensual non-monogamy, as I was in the beginning phases of exploring existing literature on this topic for my dissertation. The idea of consensual non-monogamy really intrigued him, as it was not something he was familiar with beforehand. As time went on, we found ourselves in a committed, intimate

relationship, quite unintentionally, and ultimately acknowledged this growing relationship as a partnership.

I am still in this relationship today and I am very happy in it. Our relationship is also an open relationship, which I will admit, has not always been easy for me due to my personal experiences of relationships and sexuality. After a lot of self-reflection, I have come to consider myself "CNM-minded", but functionally monogamous. That is, I still think in a way about relationships, that is aligned with CNM, but personally, I only want one partner relationship that may or may not be sexual or romantic. This is different from my partner, who is open to more than one sexual relationship. Wrestling with understanding this about myself and my personal struggles navigating CNM often caused a lot of confusion, guilt, and imposter syndrome when working on this study. However, I believe the nuances of my experience helped me to really have an open mind regarding the results of my study, since my own relationship with CNM has been multifaceted and multidimensional.

Researcher Assumptions

In all honesty, I was not sure what to expect regarding participant responses. It was hard to know in my personal life whether my fears about how others might respond to or perceive my CNM relationship were grounded in reality, or extrapolated from the many mononormative messages I had received my whole life. Similarly, as I began working with more CNM clients on my own caseload, few of them had lived experiences to share regarding others' perceptions of CNM, but they did often share their fears about what that could look like. It was only more recently that some clients shared that they had had negative interactions with previous therapists when bringing up CNM.

Given my awareness of mononormative messages, it was clear to me that I assumed respondents would generally have a negative or suspicious view of CNM. However, I realized I also assumed that many participants would be new therapists or therapists in training who were still in school and I think I assumed this group might be more accepting of CNM. This was due to general trends I have noticed with how my younger clients talk about and acknowledge non-monogamy more readily and easily. I suppose my own experiences with my masters level supervisees also led me to assume this. Additionally, once I started reviewing the literature, I assumed more of the responses would focus on possible individual personality traits or pathology that respondents would connect with non-monogamous practices, since many past studies found this trend in their results. However, I was surprised by how many respondents focused on non-monogamy as a potential problem despite how it was spoken about by the clients and I was definitely surprised by how many participants spoke about CNM, as a concept, being a problem or not viable in general. I suppose I thought people might be more likely to suggest "maybe it works for some people", but still remain wary about it, rather than condemning it outright.

Chapter 4: Findings

The main purpose of this study was to begin to explore two research questions. This first of these questions is: How do relational therapists' conceptualize cases and treatment plan when working with consensually non-monogamous (CNM) clients? The second question is: How does the dominant discourse about relationships (mononormativity) influence relational therapists' case conceptualization and treatment planning when working with CNM clients? Results were analyzed using Corbin and Strauss' procedure for grounded theory coding (Corbin & Strauss, 1990). This analysis involved analyzing the data using layered coding types: Open coding, axial coding, and selective coding in order to develop a proposed grounded theory.

Previous research and literature in this area is limited, with the majority of studies focusing more on the opinions people (generally) and therapists (specifically) have about consensual non-monogamy and those who practice these types of relationship structures. However, previous research and literature also revealed that therapists often demonstrate mononormative thinking and tend to have a lack of experience or training when it comes to CNM clients. Furthermore, relational therapy training programs often provide little to no specific training regarding CNM or working with CNM clients and many mainstream models, theories, and techniques are embedded with mononormative ideas and even examples of monogamism.

Alongside this, previous literature and research has demonstrated, time and again, how important it is for clients to feel their therapist accepts and has some understanding of who they are and what they do and experience. When clients suspect therapists hold biases about non-monogamy or demonstrate mononormative thinking and monogamism, they tend to not speak about this importanted and often very integrated aspect of their lives. Furthermore, clients do not want to provide all of the education about consensual non-monogamy, as this can be

uncomfortable, take time away from the sessions they are paying for, and shift the focus completely onto content learning about CNM, rather than clients' treatment goals.

In this chapter, I outline findings similar to previously conducted research, in that mononormativity is woven throughout the collected responses. However, the results in this chapter also provide details about mononormative dominant discourse and how these assumptions show up in case conceptualization and treatment planning. Additionally, the results reveal the beginnings of an understanding about the process of how relational therapists conceptualize cases and treatment plan when working with CNM clients. Based on the results presented in this chapter, the process appeared to consist of two parts.

Demographics

This study includes responses from 32 relational therapists. Information gathered using the Demographics Form (Appendix II) provides context regarding the respondents' identities and educational and clinical experience. This information is presented more fully in Table 2 found at the end of this section. The majority of respondents identified as cisgender females (21 respondents). Nine respondents identified as cisgender males, one as non-binary, and one as genderqueer. This means nearly 94% of respondents were part of the dominant group in regard to gender identity. The highest levels of representation came from the dominant group for race/ethnicity (White/Caucasion >59%), sexual orientation (Heterosexual= 75%). religious affiliation (Christianity >62%), and relational orientation (Monogamous >81%), as well. In terms of race/ethnicity, participants also identified as African/Afroamerican (9), Asian/Pacific Islander (2), Hispanic/Latina/Latino/Latiné/Latinx (2), Indian-Asian Continent (1), and First Persons/Indigenous (1). Some respondents identified as gay (1), bisexual (4), and asexual/demi

(1). Aside from Christianity, reported religious affiliations included Islam (3), Judaism (1), Nature-based religion (1), Atheism (2), No affiliation (4), and Catholicism (1). Although a staggering 81.25% of respondents identified their relational orientation as monogamous, partnered consensual non-monogamy (1 respondent), Degree of both monogamy and CNM (3 respondents) and non-partnered consensual non-monogamy (2 respondents) were all represented. Political alignment was fairly split between Liberal (15) and Moderate/Centrist (7) or Independent (7). Additionally, Conservative (2) and Libertarian (1) alignments were present, as well. Around 39% of the respondents reported having children, while about 41% did not. Of the respondents who have children, the number of children ranged from 1-3. Finally, 50% of respondents were in the 25-34 age bracket, followed by about 31% in the 35-44 age bracket, 12.5% in the 18-24 age bracket, and one respondent each in the 45-54 and 65+ ranges.

In terms of education and training respondents had an interesting spread in terms of both clinical practice and level of education. This data is presented more fully in Table 3 found at the end of this section. Most respondents fell into the ends of these spectrums. For instance, 37.5% of respondents reported being at the level of student intern, but the second highest percentage of respondents reported being fully licensed (31.25%). Five respondents reported being provisionally licensed and five reported being a pre-licensed graduation. For education level, most respondents (62.5%) held bachelor's (31.25%) or master's degrees (31.25%). Seven respondents (nearly 22%) of respondents held a doctoral degree, and five (nearly 16%) held a post-graduate certificate. Fifteen respondents reported having more than one license eligible degree or certificate. The majority of respondents went to public training programs for the license-eligible degrees (68.75%), with nearly 19% of respondents attending private (not religiously affiliated) schools and 12.5% of respondents attending religiously affiliated private

schools. Out of the 32 respondents, 28 of them attended schools in cities (12) or major cities (250,000+) (16) and only 3 went to schools in suburban areas, and 1 in a rural area.

The Two Part Process

The first part of this process centers around intention. Therapists appear to approach working with CNM clients by intending to treat them the same as they would any other client in terms of focus, assessment, and interventions. The second part of the process centers around reality or action. Therapists appear to be unable to follow through on their intention and treat CNM clients the same due to dominant discourses of mononormativity. The two main themes here were Pathologizing Non-Monogamy and Dissonance. The subcategories of this theme were: Make Them Change, Not Viable, Unsustainable, Not On The Same Page, and Poor/Forced Choice. The subcategories encompassed in Dissonance were: Misconceptions, Dissonance With Client, and Dissonance Within Self. From this emergence of the two-part process, it became apparent that the dominant discourse about relationships (mononormativity) does influence relational therapists' case conceptualization and treatment planning. This influence manifested in three main ways: CNM was viewed as part of the problem, Therapists feel they cannot use traditional relational therapy models and techniques unless a dyad is practicing monogamy, and/or Therapists do not consider contexts/resources unique to CNM relationships

Part 1- Intention

Relational therapists in this study tended to put emphasis on the importance of treating all clients equally, or the same. Most respondents indicated they would not change or adjust any

of their responses if the clients described had a monogamous relationship structure. Although this intention usually did not match the reality of the rest of their responses, it does seem that "sameness" is an important factor in how therapists approach inclusivity and diversity. There seemed to be an assumption that the models, assessments, and interventions the therapists have learned and used before would be a good fit for clients regardless of context, identity, or relationship structure. Although not mentioned often, taking a curious stance and trying to allow treatment to be client-guided was mentioned in a few of the responses. The only respondent who demonstrated this perspective well was Therapist #27, who said, " I would approach this couple by asking them about what they think the source of their problem is". As will be seen later, this is a complicated assumption, but nonetheless, this assumption particularly informed the therapists' treatment recommendations and what other information they would want to know about the clients, and informed their hypothesis about the presenting problem, to a lesser degree.

Some of the additional information therapists wanted to know included some more extended demographics information, relationship history, family patterns, styles of conflict resolution, and coping skills. Some of the demographics areas the respondents mentioned were social location, environment, individual personality traits, individual mental health concerns, and history of trauma or violence. There was also mention of the impact of family pressures and expectations and, more, rarely, the impact of societal pressures. These were generally centered around marriage and/or having children, and there were no explorations of the pressures and expectations about relationship structure/monogamy or any others.

Respondents spoke about stress in terms of assessing individual and external stressors as well as exploring how the clients manage and navigate stress. Interestingly, these were rarely relational in nature, that is, respondents did not talk about stress in terms of relational stressors or

how the dyad manages and navigates stress together. However, some respondents did mention it could be a challenge if the clients had different ways of dealing with stress. Similarly, boundaries were discussed in the responses for all of the first three questions. Respondents mainly focused on boundaries between the clients/one partner and one partner's parents/family. In these examples, respondents suggested there should be firmer boundaries between the one partner and their family, who were putting pressure on the partners to get married and have children. There was also some discussion about boundaries between the client dyad and any of their other partners. For example, Therapist #11 said, "I recommend them to give themselves space and stop having relationship with other partners".

Many respondents shared that they would work with the clients to explore whether they were truly compatible and satisfied in the relationships. Sometimes this compatibility was centered around coping/attachment/conflict resolution/stress management styles, sometimes around role expectations and needs, sometimes around expectations or goals for the relationship. Compatibility in regard to values was also discussed here. Respondents felt some of these were workable, by trying to help the clients find more alignment in conflict resolution, coping, and stress management styles or teaching the clients new skills in these areas that they could use collaboratively. Similarly, respondents suggested working with the clients to help build secure attachments and safety in emotional expression or working to understand and meet one another's relationship needs or expectations. On the other hand, the implication was that some compatibility issues could not be resolved and would mean accepting the end of the relationship. Few really expanded on this, but a number of respondents suggested the clients might not be compatible regarding their "true" feelings about being in a non-monogamous relationship and again, the implication was that this type of difference would mean the end of the relationship or,

in this case, a suggestion to “return” to monogamy. For instance, Therapist #20 wrote, “ I will want to know about how they view their relationship, whether they are still ok and on the same page about having an open relationship, how they want their present relationship to look like.”

Communication was, far and away, the most talked about concept throughout the responses. Respondents spoke about communication in the context of all four open-ended questions. Communication issues or differing communication styles were hypotheses about the presenting problem, respondents wanted to know more about communication patterns and style, and providing the clients with better communication skills and helping them create new communication patterns was part of many preliminary treatment plans. Here too, non-monogamy was discussed in interesting ways. First, many respondents felt better communication between the partners would reveal disagreement between them about actually wanting to engage in CNM, as seen when Therapist #3 wrote, “ They need to communicate openly and discuss their relationship together, especially their non-monogamy agreement. They need to determine if their expectations and needs are being met and if adjustments need to be made”. In another example, Therapist #25 wrote, “Open Relationship is not what this couple needed they only agreed cause of failure of proper communication” when speaking about their hypothesis about the source of the problem for the clients, suggesting the partners would not have decided to be in a CNM relationship if they had better communication. Secondly, in response to the last question, asking therapists if they would change anything about their answers if the relationship described was monogamous, respondents tended to say that communication would be something they would focus more on if the partners were monogamous, which became something of a theme.

Like communication, intimacy/connection and quality time were potential problems and interventions discussed most when referring to a monogamous dynamic: “If they both agree to be

monogamous, there would be no need to focus my attention on if either of the couple is attracted to someone else currently. I would emphasis that they find pleasure in activities together and suggest bonding activities exclusive to just the two of them" (Therapist #5), "if the relationship was monogamous, the issue of engaging in relationships with other partners would not be present, and the focus of therapy would likely be on improving communication, emotional processing, and connection between Riley and Jaime" (Therapist #16), "Yes I think I would focus more on the family of origin, communication and coping styles than how they view the open relationship and whether it is still a good fit for them" (Therapist # 20). Additionally, when responding about treatment planning, a number of the respondents suggested all relationships outside of the dyad coming for therapy should either cease or pause in order allow the dyad to work on intimacy/connection and/or spend quality time together (i.e. including learning new hobbies, trying new things, or going out).

Part 2- Action

Despite an intention of treating clients with "sameness", the reality of therapist responses show they feel unable to treat the CNM clients the same as monogamous clients due to the impact of mononormative dominant discourses. This part of the proposed grounded theory is rooted in two major axial codes: Pathologizing CNM and Dissonance.

Pathologizing CNM. Pathologizing CNM appeared across a spectrum of intensity, ranging from skepticism and doubt to outright condemnation and firm intolerance. On the lower end, were categories of Not On the Same Page and Unsustainable and on the higher end were categories of Not Viable, Poor/Forced Choice, and Make them Change. While all of these types of responses reveal assumptions, biases, and monogamism, the Make them Change category is

also in direct opposition to both taking a curious stance (and related lenses such as cultural humility) and client-guided goal-setting.

Not on the Same Page. One assumption respondents made was that the partners who were coming to therapy were not on the same page about being in a non-monogamous relationship. In some cases this was presented vaguely, such as when Therapist #3 wrote, "Riley and Jaime have varying degrees of disagreement about non-monogamy, which can lead to conflict and miscommunication". Perhaps this was meant to indicate disagreements about aspects of their relationship agreement/dynamic, rather than about non-monogamy itself. In other instances, respondents felt the partners failed to define their relationship and assumed they were not in agreement: "My first hypothesis is, they both failed to define the relationship. They obviously both have different (not mutual idea of what their relationship is" (Therapist #4). Another assumption was that only one partner instigated or wanted a non-monogamous relationship: "...whose idea was it to open the relationship. Who first suggested it and the events that led to that" (Therapists #7) and "One of the clients was monogamous. I recommend that both of them should iron out the changes in their actions" (Therapist #24). Finally, there was also an idea that although the partners might be saying they are in agreement when together, they may not actually feel that way privately. This idea was implied in a few responses, but stated clearly by Therapist #18: "I would also assess their feelings toward their non-monogamous relationship through individual meetings to see if both of them are actually satisfied with their arrangement".

Unsustainable. While not directly stating CNM as a problem, some respondents felt it was not a sustainable relationship structure. For example, Therapist # 20 wanted to know "how they view their relationship, whether they are still ok and on the same page about having an open relationship" and "how they want their present relationship to look like". Another respondent,

Therapist #11, expressed certainty that a CNM relationship could not last: “Assuming they continue to be non-monogamous, sooner or later they will split up because their values are not in line with family values and persisting will only create more conflict”. There seemed to be a widespread assumption that multi-partner relationships were an acute reaction to something (such as stress or disconnection) and could not or do not exist long-term.

Not Viable. Approaching the more pathologizing end of the spectrum, another theme found in the responses was the idea that CNM is not viable. Sometimes there were conditions to this assertion, such as Therapist #6 suggesting there is a difference between having other partners “just for the moment without any feelings attached to it” and longer term, emotional partnerships. Other respondents were more firm and clearly stated non-monogamy was the cause of the clients’ problems. This theme was seen time and again and could be found in responses for all four of the open-ended questions. Given the frequency and the breadth of this theme (CNM is not viable), the general idea that CNM is only negative and is the source of the problem was carried forward into the selective coding process and became a significant part of theorizing how the dominant discourse about relationships (mononormativity) influence relational therapists’ case conceptualization and treatment planning when working with CNM clients.

Poor/Forced Choice. Another pathologizing take on the clients’ non-monogamous relationship structure was the idea that it was a poor choice born out of individual flaws or a forced choice due to being at a loss of what to do. Luckily, there were not too many responses that fell in this specific category of Pathologizing CNM, but the standouts were notable in their negative assessment of the clients’ ability to make healthy, consensual decisions. One such response came from Therapist #24, who felt the clients were not “matured enough to choose the

right path". Similarly, Therapist #25 believed the clients only agreed to an open relationship, because of "failure of proper communication".

Make Them Change. Though others may debate this as an escalation along the pathologizing spectrum, the most intense sub-theme in this category is "Make Them Change". In order to be grouped here, responses needed to contain an element of forceful directing or influence toward monogamy. Examples of these types of responses also ranged in intensity. One respondent said they would "recommend them to give themselves space and stop having relationship with other partners" (Therapist #11). Another respondent wrote that that they would "first encourage all of their ideas and then later tell the the [sic] effect of allow them self to have other partners" (Therapist #6). Or, most clearly, Therapist #1's entire answer regarding initial interventions simply said, "I will direct by persuasion". It can be argued that these types of responses, which include forceful direction and influence, are the most mononormative, since they serve to maintain and reinforce the "norm".

Dissonance. The other axial category included in the action part of the therapists' process of case conceptualization and treatment planning when working with CNM clients was Dissonance. Dissonance encompassed three sub-themes: Misconceptions, Dissonance With the Client, and Dissonance Within Self. Unlike the Pathologizing CNM axial category, this one was a little harder to define in a completely unifying way, but it also provides powerful insight into how therapists seem to get stuck trying to treat CNM clients the same as monogamous clients, while also failing to do so.

Misconceptions. The first sub-theme contained within Dissonance is Misconceptions. In these responses, respondents based their answers off of a misconception about non-monogamy, that was not necessarily pathologizing, but led to confusion regarding how to proceed. One

misconception that has already been discussed in other contexts was the idea that brief, "no strings attached" dynamics with other partners were more "permissible" or viable than long-term relationships or emotionally-committed relationships. Another misconception was that having other partners "reduced the feelings and understandings they had for each other" (Therapist #6) and " I think being away from each other and giving more time to the other partners that was a means of them drifting apart not having good communication" (Therapist #28). Similarly, this respondent spoke about trying to "mend the the [sic] wasted days with the other partner" (Therapist #28), suggesting that time spent with another partner was taking away from the dyadic relationship between the partners coming to therapy. Lastly, a few respondents seemed to assume marriage and having children (the two familial pressures noted in the vignette) are diametrically opposed to the concept and practice of consensual non-monogamy. Therapist #1, who felt the partners would inevitably split up if they continued to be non-monogamous, specifically noted that this was largely because, "their values are not in line with family values and persisting will only create more conflict". Nowhere in the vignette does it say either partners' family is opposed to CNM, so this is either a general assumption or has been extrapolated from the information about one partner's family putting pressure on them to get married and have children. Therapist #5 addressed this more directly, saying they believed the source of the problem was this "pressure to get married, especially from Jaime's parents since they want to remain non monogamous".

Dissonance With the Client. The focus on ideas not presented in or at odds with the vignette was also seen in the next sub-theme: Dissonance With the Client. These types of responses include instances where the respondent assumed something that is in direct conflict with what the clients stated about their experience of their relationship or demonstrated

skepticism about the validity of these statements. Some respondents said that they would help the clients in "re-evaluating their non-monogamous relationship" (Therapist #8) and discuss "expectations and desires to be in a monogamous relationship verses [sic] non-monogamous relationship" (Therapist #18). Others, such as Therapist #20 wanted to assess their feelings more to see if they are really "still okay and on the same page about having an open relationship" and others, as noted earlier, felt it was necessary to separate the clients to see if they revealed that they were not actually happy with the relationship structure when the other partner was not present. Therapist #15 said that as part of their assessment, they would want to know "why the issue of each having other partners arose". These are just a few examples, given that every response in the Pathologizing CNM subtheme would also fit in this category, since the vignette directly states, " A year and a half ago, Riley and Jaime both mutually agreed that it is okay if they have other sexual partners. For about a year, they have been engaging in relationships with other partners. They are finding themselves to be happy with this arrangement and plan to continue to be non-monogamous". The feeling of missing the skills or knowledge about how to approach this case, where the clients state their satisfaction and happiness with a CNM relationship structure, is well-represented in Therapist #7's response about whether they would change any of their responses if the clients' relationship was monogamous: "Yes. I would look into if being in the relationship itself was the problem. Seeing that being with Jaime helps and the open relationship gave them more happiness, it gets a little bit complicated from there". This respondent seems to feel uncertain about how to balance the idea of a positive dyadic relationship and satisfaction with and a desire to continue a CNM relationship structure.

Dissonance Within Self. Perhaps most interesting is the last sub-theme within this category: Dissonance Within Self. Most respondents replied "No" to Question #4, when asked if

they would change any of their responses if the clients described were in a monogamous relationship. However, a large number of respondents answered "No" to this question even when it did not match their responses to the previous four questions. Despite stating they would "direct" the clients with "persuasion" and talking about the inevitability of CNM failing for this couple, Therapist #1 said "Won't" in response to Question #4. Therapist #6 said, "Not at all, I wouldn't change anything about my hypothesis" despite every one of their responses to the other three questions being entirely centered around the clients' CNM relationship, which was also true for Therapist #16, who said, "I think nothing would change even [sic] the issue changed because [sic] seems nothing about them being polygamous is affecting them. Likewise, Therapist #14, Therapist #10, and Therapist #29 who all felt CNM was a major contributor to the clients' problems, answered, "No", "Helping each partner feel heard and validated in their concerns and feelings would still be important in a monogamous relationship", and, "If the relationship described is monogamous, I do not change my assumptions and treatment plan, because each client should be treated with respect and tolerance." Even Therapist #25, who said the clients only began a CNM relationship because of bad communication said, "Nope I won't change a thing because of [sic] the basis of a good lasting relationship whether polyamory or Monogamy is a [sic] good communication skills" and Therapist #24 who thought the clients were not mature enough to choose the right path said, "No". This dissonance within the self most clearly demonstrates the two part process by which therapists conceptualize cases and treatment plan when working with CNM client because the respondents spoke about treating clients all the same (even after they have conceptualized the case and have begun to treatment plan) but they do not actually do this when working clinically with the clients.

Summary of Findings

From here, it is possible begin to answer research question #2: How does the dominant discourse about relationships (mononormativity) influence relational therapists' case conceptualization and treatment planning when working with CNM clients? It is evident that mononormativity does influence relational therapists' case conceptualization and treatment planning, but what does this look like in practice? The results of this study indicate the mononormative dominant discourse influences therapists in three main ways: therapists treat CNM as part of the problem, therapists feel they cannot use traditional relational therapy models and techniques unless a dyad is practicing monogamy, and therapists do not consider contexts/resources unique to CNM relationships.

Table 1 - Themes & Sub-themes

Pathologizing CNM	**Dissonance**	**Influence of Dominant Discourse**
● Not On the Same Page ● Not Sustainable ● Not Viable ● Poor/Forced Choice ● Make Them Change	● Misconceptions ● Dissonance With Client ● Dissonance Within Self	● CNM viewed as part of the problem ● Therapists feel they cannot use traditional relational therapy models and techniques unless a dyad is practicing monogamy ● Therapists do not consider contexts/resources unique to CNM relationships

Figure 1 - Axial Coding Map

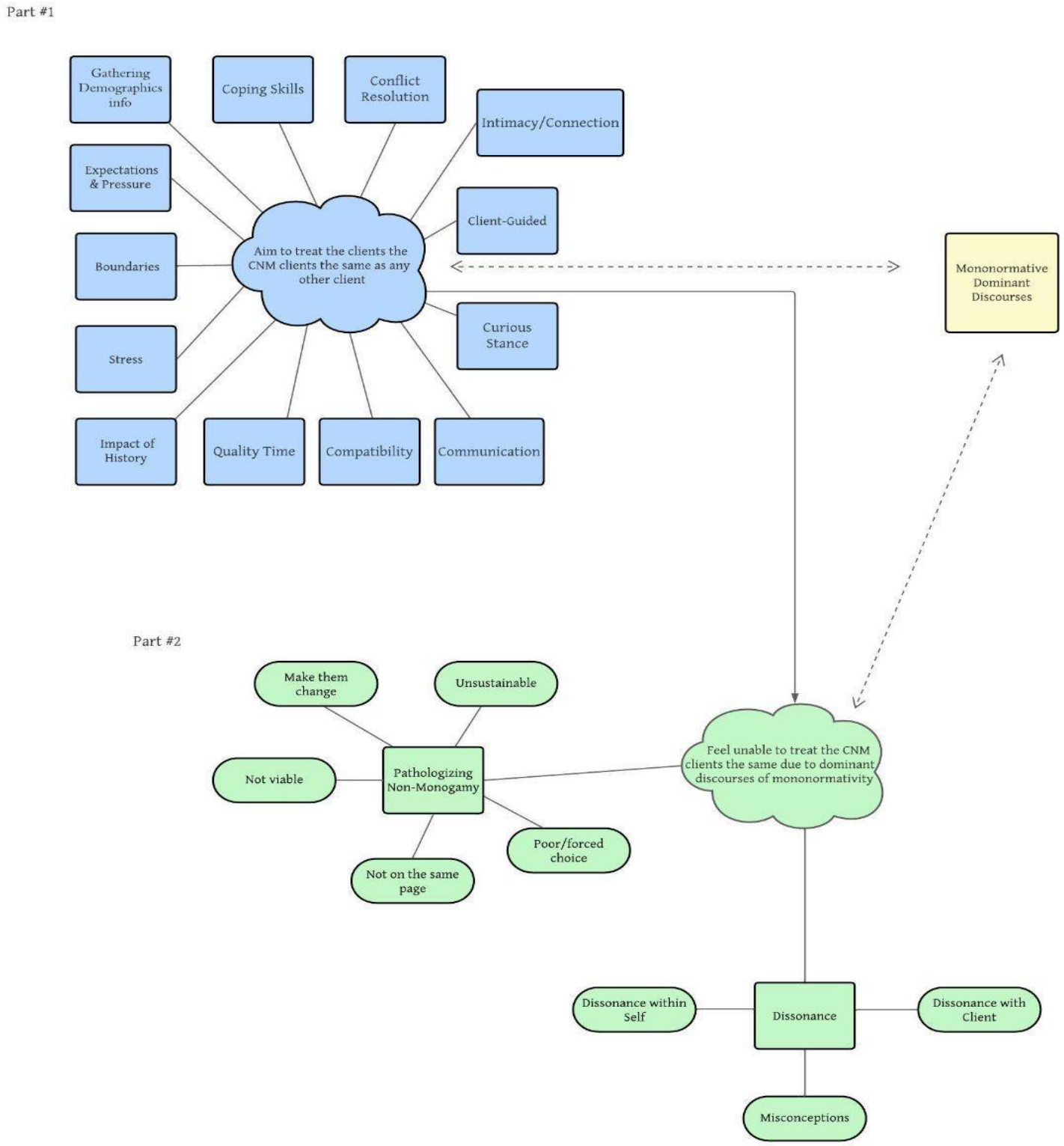

Figure 2 - Proposed Theory

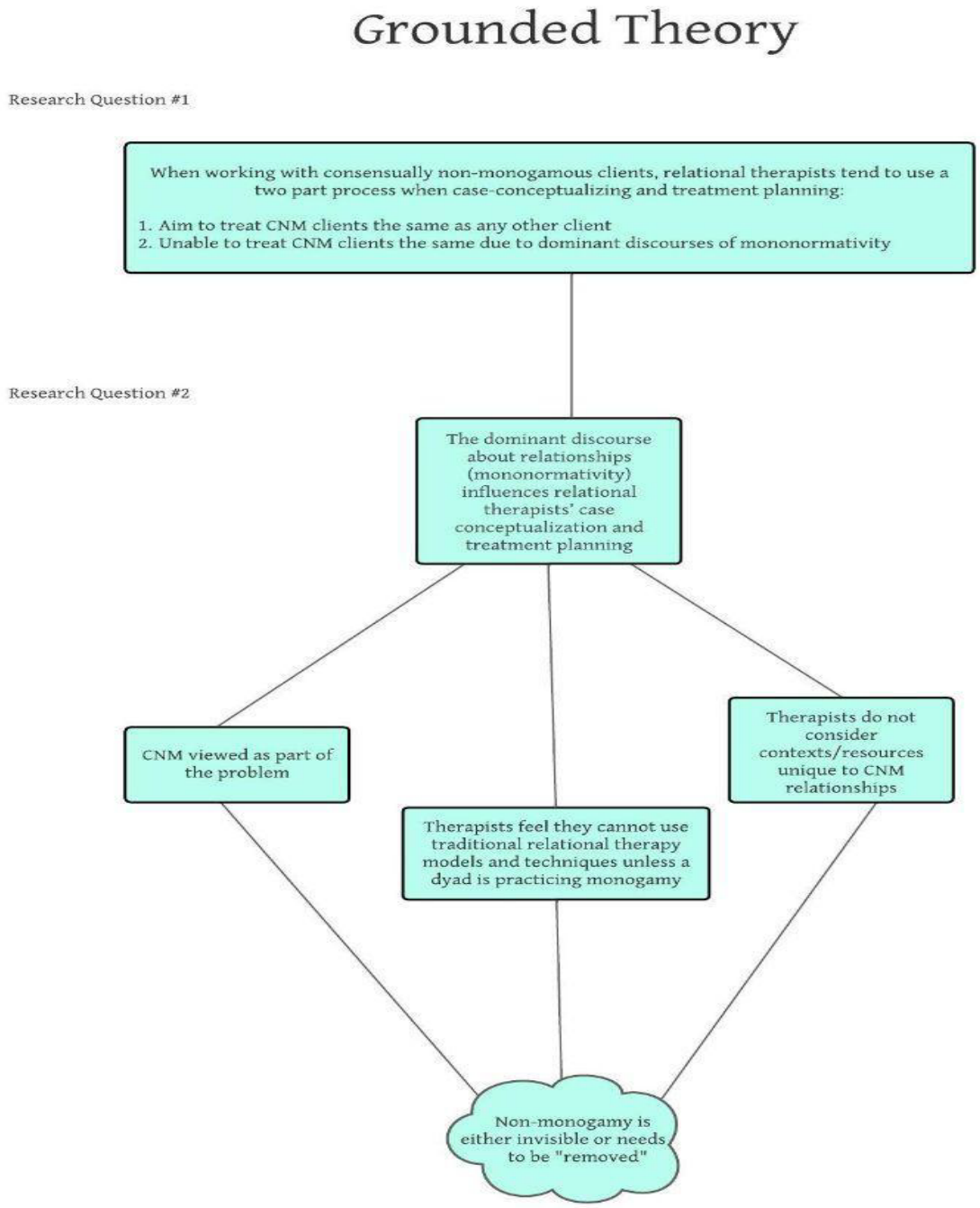

Table 2 - Demographics of Participants' Identities

Gender Identity	**# of participants**	**% of participants**
Cisgender Female	21	65.625
Cisgender male	9	28.125
Transgender woman	0	0
Transgender man	0	0
Non-binary	1	3.125
Agender	0	0
Genderqueer	1	3.125

Race/Ethnicity	**# of participants**	**% of participants**
African/Afroamerican	9	28.125
White/Caucasion	19	59.375
Asian/Pacific Islander	2	6.25
Hispanic/Latina/Latino/Latiné /Latinx	2	6.25
Middle eastern/Mediterranean	0	0
Indian-Asian Continent	1	3.125
First Persons/Indigenous	1	3.125
Multiracial	0	0

Sexual Orientation	**# of participants**	**% of participants**

Gay	1	3.125
Lesbian	0	0
Heterosexual	24	75
Bisexual	4	12.5
Polysexual	0	0
Pansexual	0	0
Asexual/Demi	1	3.125

Religious Affiliation	**# of participants**	**% of participants**
Christianity	20	62.5
Islam	3	9.375
Buddhism	0	0
Judaism	1	3.125
Hinduism	0	0
Nature-based religion	1	3.125
Atheism	2	6.25
No affiliation	4	12.5
Catholicism (not listed)	1	3.125

Political Alignment	**# of participants**	**% of participants**
Conservative	2	6.25
Moderate/Centrist	7	21.875
Libertarian	1	3.125

Liberal	15	46.875
Independent	7	21.875
Green Party	0	0

Relational Orientation	**# of participants**	**% of participants**
Monogamous (i.e. marriage, partnership, serial monogamy)	26	81.25
Partnered Consensual Non-monogamy (i.e. polygyny, plural, polygamy, polyamory, polyandry)	1	3.125
Degree of both (i.e.monogamish, swinging, open marriage, open relationship)	3	9.375
Non-partnered Consensual Non-monogamy (i.e. relationship anarchy, solo-polyam)	2	6.25

Do You Have Children?	**# of participants**	**% of participants**
No	19	59.375
Yes	13	40.625

Current Age	**# of participants**	**% of participants**

18-24	4	12.5
25-34	16	50
35-44	10	31.25
45-54	1	3.125
55-64	0	0
65+	1	3.125

Table 3 - Demographics of Participants' Education and Training

Level of Clinical Practice	**# of participants**	**% of participants**
Fully licensed	10	31.25
Provisionally licensed	5	15.625
Pre-Licensed Graduate	5	15.625
Student Intern	12	37.5
Level of Education	**# of participants**	**% of participants**
Bachelors	10	31.25
Masters	10	31.25
Post-Graduate Certificate	5	15.625
Doctorate	7	21.875
Type of Training Program	**# of participants**	**% of participants**
Public	22	68.75
Private (religiously affiliated)	4	12.5
Private (not religiously affiliated)	6	18.75
Not listed	0	0
Training Program Location	**# of participants**	**% of participants**
Major City (250,000+)	16	50
City	12	37.5
Suburban Area	3	9.375
Rural Area	1	3.125

Chapter 5: Discussion

There have been a good amount of studies done to understand general opinions regarding non-monogamy and studies about the biases people hold about non-monogamy and the people who practice this type of relationship structure (Barker, 2005; Ritchie & Barker, 2006; Anderson, 2010; Conley, Moors, Matsick, and Ziegler, 2013; Blumer, et al., 2014; Blumer & VandenBosch, 2015; Balzarini, Shumlich, Kohut, and Campbell, 2018; Moors, 2019; Ansara, 2020). There have also been a couple of studies conducted to explore mononormativity biases and monogamism practiced by therapists and how this impacts the clients they work with (Knapp , 1975; Weitzman,2006; Baumgartner, 2009; Finn, et al., 2012; Graham, 2014; Gerard and Brownlee, 2015; Williams and Prior, 2015; Twist & Ansara, 2017; Cassidy & Wong, 2018; Twist, 2021 . However, there has been a very limited amount of study done to try to understand the process of how relational therapists navigate case conceptualization and treatment planning when working with non-monogamous clients (Twist, Prouty, Haym, and VandenBosch, 2018; Grunt-Mejer and Lys, 2019). This interpretative qualitative study, informed by a queer theory lens aimed to help generate a greater understanding of the case conceptualization and treatment planning process which informs relational therapists when working with CNM clients and how these processes are influenced by mononormative dominant discourses. The hope was that after obtaining the results of this study, open, axial, and selective coding could help coalesce the findings into a constructivist grounded theory answering, “How?”. A secondary aim of this study was to use this grounded theory to help inform adjustments to relational therapy training, such as masters/doctoral programs, workshops, and other literature and curricula, so future generations of relational therapists could be more aware of the ways mononormativity can impact therapeutic

practice. Ultimately, the hope would be that future training would be more inclusive, provide exposure and experience regarding CNM practices, and challenge mononormativity and monogamism.

In this chapter, deeper discussion of the previously proposed grounded theory is presented and explored in the context of previous research and through the constructivist lens of queer theory. After a discussion on the grounded theory and the thematic categories found within the data, possible implications for future relational therapy training is discussed. Finally, limitations of this study and implications for future research are presented, as well. These discussions provide a better understanding of how the proposed theory is grounded by the results of this study and situated within existing literature and can provide guidance for future researchers or therapists who would like to use or further this research.

The Two Part Process

Upon exploring the results, a two-part process began to emerge, providing insight into how relational therapists approach case conceptualization when working with CNM clients and subsequently begin treatment planning. The two part process can best be understood as an intention phase, followed by an action phase. This conceptualization of a two part process of decision-making, divided in this way, is not new, Prochaska and DiClemente's Transtheoretical Model of Behavior Change comes to mind (Prochaska & DiClemente, 1983). What makes this two-part process interesting though, is that the intention and the action are dissonant. Therapists initially approach consensually non-monogamous clients with the intention of treating them like any other client or, in other words, the same as monogamous clients. When they reach the action

stage, however, the influence of mononormative dominant discourses leads therapists to feel unable to treat CNM clients the same way.

The intent part of the process is worth discussing, because it is based on the idea that "sameness" is how one should approach diversity and inclusion. This too is not an unfamiliar idea, it echoes similar sentiments such as: "I don't see color" , "We are all one race: the human race", "Love is love", "People are people". Although this type of perspective may seem innocuous at first glance, or even a step in a positive direction, it is important to remember that not pathologizing is not the same thing as de-pathologizing. This difference is key to understanding why the "sameness" approach is harmful in its own way. Just as saying, "I don't see color" is dismissive of the realities of present systemic racism and a history of oppression and inequality structured around race, and "Love is love" is ignoring current systemic heterosexism and a history of oppression and inequality structured around sexuality/sexual identity (Hardy, 1989). There are many phrases, like these, which ignore the real differences that exist between the experiences of people occupying different dimensions of identity. Perhaps the historical mandate for therapists to be "neutral" (Hamilton, 2013) has led to this, but therapists have tended to continue approaching diversity from a "sameness" perspective (Portuges, 2022) and can even become defensive if it is suggested they are not. Knapp (1975) discussed this when sharing study results where therapist participants stated that as counselors, they had no personal opinions about their client and only saw them in a removed and professional way.

However, a queer theory lens helps see why these differences cannot be ignored. A real power differential exists between groups in power and marginalized groups. Critical theory, and by extension queer theory, contextualizes people's lived experiences in the context of this history of power and oppression and the systemic structures born out of this dynamic over time. So, the

lived reality of a black woman in the United States is not the same as the reality of a white woman in the United States. The lived reality of a gay man is not the same as the reality of a straight man. The lived reality of a bisexual man is also not the same as a gay man. Nor is the lived reality of a non-binary person the same as any of these. Intersectionality adds to the complexity of this. The lived realities of a wealthy, white, gay man in Los Angeles and a black trans woman living paycheck to paycheck in rural Georgia are very different. So too are the lived realities of that black trans woman and black cis gender woman living in the same town and working the same job. Queer theory (de Lauretis, 1991; Berlant & Warner, 1995; Jagose, 1996), once again, is based on the idea that reality is influenced by social, political, cultural, economic, ethnic, and gender-based messages that become reinforced over time until they become social structures viewed as natural or intrinsic. As an offshoot of critical theory, a queer theory lens involves identifying and acknowledging power structures and can be used as a tool to deconstruct social norms and understand how they came to be (Worthen, 2016). As suggested earlier, queer theory provides a useful framework for looking at relationship structures (non-monogamy/monogamy), which have also been divided into social categories of "deviance" and "norm".

As a therapist, working with clients, it is particularly important to not dismiss the historical, personal, and systemic realities of a person's identity and experience. Clients come to therapy to share about themselves with a stranger, who is supposed to provide safety and establish trust and rapport. It stands to reason that a person will likely not feel safe or experience trust and positive rapport if the therapist dismisses the reality of their experience, smoothes over trauma they have faced, or ignores the realities of systemic oppression they face. Similarly, it can be extremely uncomfortable or even unsafe for the onus to be on the client to bring up or point

out the ways their experiences differ from dominant discourses. Knudson- Martin (2013), Kitzinger and Wilkinson (1997), and Sutherland, et al. (2017) have all spoken about the need for relationship therapists to examine the ways they may reinforce, reproduce or challenge dominant discourses through their behavior interactions, since there is an inherent power differential between therapists and clients, which can greatly exacerbate or significantly deconstruct the power differentials between dominant and marginalized groups via discourse.

Despite these intentions, harmful or not, when therapists move from the intention phase to the action phase, they found themselves unable to treat CNM clients the same as other clients; this sameness approach to inclusivity quickly fell apart. To understand how this happened, it is easiest to divide the action phase into two interrelated themes: Pathologizing CNM and Dissonance. Pathologizing CNM involves the ways respondents identified CNM as problematic or in opposition to the health and satisfaction of the clients and their relationship, despite this perspective directly challenging the clients' own assessment of their CNM relationship. Dissonance, on the other hand, looks more at the "how", exploring more about what leads to this breakdown in the attempt to treat CNM clients the same as any other clients.

Pathologizing CNM

As mentioned earlier, in participant responses, pathologizing CNM appeared across a spectrum of intensity: Not On the Same Page, Unsustainable, Not Viable, Poor/Forced Choice, and Make them Change. It is here that some of the assumptions seen historically in CNM research appeared. Somewhat surprisingly, given past research about the halo effect and mononormativity (Conley, et al., 2013; Grunt-Mejer & Lys, 2019), none of the respondents overtly suggested either partner had negative personality traits, a personality disorder, or

pathologized their individual mental health as has been seen in past studies (Twist & Ansara, 2017; Twist, 2021). However, some of these factors were listed when respondents spoke about areas they would want more information about in order to help with their case conceptualization and treatment planning. Also, one category of responses did emphasize poor decision-making and decisions made due to unhealthy relationship dynamics that the respondent felt would not have been made otherwise. Instead of the individual pathologizing seen in previous research (Knapp, 1975); Weitzman, 2006; Conley, et al., 2013) , responses in this study seemed to focus on non-monogamy existing in opposition to a healthy and satisfactory dyadic relationship. That is, rather than non-monogamous practices suggesting something negative about the partners involved, respondents seemed to view CNM, as a relationship structure, to be a barrier in the way of accessing what partners in a dyad would need in order to improve their relationship or the catalyst for relationship issues. In this sense, the results of this study suggested a more relational framework being used to consider CNM, rather than one that has often focused on the "self-centered" nature of one of the partners or individual pathology. Given that the participants in this study were relational therapists, seeing this relational lens is reassuring, but unfortunately it was largely still used to pathologize CNM.

A common assumption therapists made about the clients' CNM relationship was that the decision to have this type of relationship structure was not a mutual one. When Therapist #3 suggested Riley and Jaime have "varying degrees of disagreement about non-monogamy" which they believed could lead to conflict and miscommunication, they were not wrong about that fact that disagreement about the boundaries and expectations of their relationship could lead to these challenges (Shernoff, 2006). However, the only thing mentioned in the vignette about the clients' CNM relationship is that they have had this relationship structure for over a year and are both

happy with it and plan to continue. Therefore, the hypothesis that Riley and Jaime have varying degrees of disagreement about non-monogamy is an idea that had to come from somewhere other than the clients. This was not the only response suggesting the partners had not clearly or adequately defined their relationship. Again, it is not clear where these ideas came from, as the clients' definition of their relationship is stated with certainty and had been in practice for over a year at the time of initiating therapy. The implication here is that either mononormative discourse, personal monogamist bias, or (likely) both led therapists to not believe clients would choose a CNM structure if they had been able to clearly define their relationship and ensure they were in agreement. In other words, since they were practicing CNM, it could only be because of miscommunication, an idea seen in both the Not On the Same Page and the Poor/Forced Choice coded response categories.

Alternatively, some therapists felt maybe the partners decided on a CNM structure due a degree of coercion or pressure. For instance, perhaps one partner had not been able to express their unhappiness in the relationship and turned to the idea of other partners as a way to avoid talking about this. Perhaps the other partner agreed to these terms against their will in order to not "lose" their partner. Although these particular hypotheses were not stated explicitly, there were a number of responses suggesting a CNM relationship was just one partner's idea and that if the partners were able to talk about their relationship in an individual session with the therapist, one of them was likely to reveal they were not actually happy with the dynamic.This assumption may harken back to the historical trend of non-monogamy being viewed as just another word for infidelity (Ritchie & Barker, 2006). Remember, consensual non-monogamy is the practice of relationships based on the explicit and voluntary abandonment of sexual and/or emotional exclusivity (Grunt-Mejer & Lys, 2019). So, a key thing to note about these responses

is that if these assumptions were true, it would not really be a consensually non-monogamous relationship. This begs the question of whether therapists believe non-monogamous relationships can be consensual.

In both of these categories, the CNM relationship structure is seen as an attempt to navigate relationship issues in an avoidant or misguided way; a salve for pre-existing struggles. It would be interesting to know if this assumption is coming from just the disbelief that clients would consensually choose a CNM dynamic or if it is influenced by lived experiences the therapists may have had or observed in clinical practice. Personal clinical experience has shown that there are clients who suggest exploring a CNM dynamic in an attempt to save a struggling relationship they are having a hard time letting go of or admitting is not working. This type of attempt at "saving" a relationship showing up in the therapy room may be a product of a growing awareness of non-monogamy as a possible relationship structure, even if it is not always done ethically or consensually in these instances. However, to think this is the only reason clients would have a CNM relationship structure is very mononormative. Furthermore, thinking about CNM in this way also dismisses the idea that non-monogamy can be a relational orientation, as in, not something a person chooses to participate in, but rather the way they inherently experience and understand relationships (similar to sexual orientation or gender identity) (Barker, 2005).

CNM as a relational orientation and not a choice about how to structure relationships is an idea that responses falling in the Unsustainable and Not Viable categories overtly dismiss. In terms of CNM being unsustainable, respondents felt either that a CNM relationship could not last, in general or that even if a non-monogamous relationship was consensual, sooner or later, one partner would not be happy. Opening one's mind to the idea that non-monogamy could be a

relational orientation while viewing non-monogamous relationships as unsustainable or not viable would mean believing non-monogamous folks would never be able to have satisfying, long-term, committed relationships. This would be a deeply harmful message to give a therapy client, which leaves the options of encouraging them to change who they are (akin to conversion therapy) or by asserting non-monogamy must be a choice, both of which are monogamist and dangerous. That said, it seems in this case, therapists were more likely to view the unsustainability of CNM relationships as further evidence that practicing non-monogamy is more of a reaction to something such as stress or disconnection.

Therapist #11 suggested the unsustainability of the relationship was in part due to CNM not being" in line with family values", so it would create more conflict with family over time. Again, it was unclear if this respondent was specifically talking about the family values of the clients in the vignette, or an assumed standard of "family values" likely based on dominant discourse. Nonetheless, this response suggests an idea that the opinions of others may serve as a negative feedback loop (Bertalanffy, 1968; Bateson, 1972), reinforcing mononormativity. In other words, therapists may recognize that when individuals do practice CNM, others may respond in ways that ostracize, shame, judge, or otherwise discourage, which may lead CNM folks to either hide the realities of their relationships, not reach out for therapy (Blumer, et al., 2014), dismiss the possibility of having non-monogamous relationships (Baumgartner, 2009; Finn, et al., 2012; Blumer, et al., 2014), or force themselves to participate in or remain in unhappy monogamous relationships (Lee and O'Sullivan, 2018; Brandon, 2011; Barker, 2011;). If therapists demonstrate this type of behavior either by directly suggesting non-monogamy is not viable or by privileging the negative reaction of others and the conflict this will cause clients, clients will hide aspects of themselves in order to feel safe and not judged (Knapp, 1975;

Weitzman, 2006; Graham, 2014) or will demonstrate internalized mononormativity (Balzarini, et al., 2018) (as outlined above) in the therapeutic relationship. The therapeutic relationship is at the core the Common Factors model (Frank, 1971; Bailey & Ogles, 2023) and a major predictor of clinical success (Horvath & Bedi, 2002; Martin, et al., 2000), harming this relationship would lead to negative outcomes for everyone involved. Furthermore, approaches described in the "Make Them Change" response category, especially "directing by persuasion", directly goes against the AAMFT Ethical Guidelines (AAMFT, 2015). Standard 1.7 talks about abuse of power in the therapeutic relationship and Standard 1.8 focuses on client autonomy in decision-making. At a higher level, the four principles of clinical ethics also include specific mention of autonomy, alongside beneficence, nonmaleficence, and justice (Beauchamp & Childress, 2013). Yet, tailoring treatment around "correcting" the relationship rather than focusing on the problems the clients' are identifying continues to be seen in clinical practice and is well documented historically in past research (Williams and Prior, 2015; Twist & Ansara, 2017; Twist, 2021).

Dissonance

To understand more about how therapists were unable to treat CNM clients the same as other clients, as they intended, the three types of dissonance evident in the therapist demonstrated during this process are important. The three types of dissonance observed were: Misconceptions about CNM, Dissonance with the Client, and Dissonance Within Self. Each of these represents a disconnect which impacts case conceptualization and treatment planning. The first two types are interrelated and also echo ideas already discussed, but the last: Dissonance Within Self, introduces a new component to the process. This third type was unexpected and could be a great foundation for future research.

Misconceptions. The Misconceptions sub-theme centered around misconceptions about CNM, held by therapists, which contributed to the assumption that they could not effectively work with the clients until or unless the dyad was monogamous. Unlike overt pathologizing, responses in this category featured perceived challenges in treatment planning due to incorrect information about CNM. Sometimes these misconceptions were paired with pathologizing ideas and assumptions, but other times, they were not. One might liken these misconceptions to other forms of microaggressions (Pierce, Carew J, Pierce-Gonzalez D., Willis D., 1978; Sue, 2010), because while not overtly negative, they still created a sense of othering and uncomfortable difference. Misconceptions included the idea that a new/second long-term and/or emotionally committed relationship would harm or undermine the first. Said another way, by Therapist #6, having other partners "reduced the feelings and understandings they had for each other". This thinking is a common misconception people have (Easton & Hardy, 2009; Burleigh et al., 2017; Fern, 2020), which seems to be more related to misguided math about relationships than purely judgemental in nature. Mononormative discourse says successful intimate relationships are defined by finding someone who will meet all of your relational needs and you will do the same in return (White, 2009; Mayhorfer, 2018). Again, mononormativity dictates relationships provide intimacy, tenderness, functioning sexuality, friendship, constructive conflict resolution, common interests and visions of the future, and more, found all in one person (Mayrhofer, 2018). By this logic, intimacy or connection with one, means giving less to others. None of the therapists participating in the study spoke about concern for Jaime and Riley's other partners and how much quality time or connection they might be needing/wanting, which demonstrates couple or

dyadic privilege (Finn, et al., 2012: Blumer et al., 2014; Twist et al., 2018). In this context, couple or dyadic privilege is where one dyadic relationship is viewed as the "core" relationship that other partners are impacting with their presence. This is exemplified by Therapist #28 saying they wanted to help the clients "mend the the [sic] wasted days with the other partner". Some CNM relationships are hierarchical, where there is one primary relationship and other relationships are secondary or tertiary (Savage, 2011; Twist, 2021), but these relationship dynamics are agreed upon by all parties and not every CNM relationship involves hierarchy. More importantly, even in hierarchical CNM relationships, non-primary relationships and partners are not viewed as harmful, detrimental, or limiting to the primary one. Furthermore, not every primary relationship in hierarchical CNM is a dyadic one, there can be primary partnerships consisting of a triad or a larger polycule. This represents another aspect of dyad or couple privilege- the idea that a dyad is the healthiest or most satisfying type of relationship Blumer et al., 2014; Lee & O'Sullivan, 2017; Twist et al., 2018; Moors, 2019). At its core, this misconception seems tied to a related idea: it is not possible for a person to have or want more than one long-term, emotionally committed relationship at a time, so, when presented with this reality, therapists seemed at a loss of how to move forward with clients. This misconception makes sense, since monogamy has expanded to mean emotional exclusivity as well as sexual exclusivity (Rothschild, 2018). However, polyamory can be defined as "the practice of theory of having emotionally intimate relationships with more than one person simultaneously, with sex as a permissible expression of the caring feelings, openly and honestly keeping one's primary partner or partners (or dating partners) informed of the existence of other intimate involvements" (Benson, 2008) and is centered around that idea that it is possible, valid, and worthwhile to

explore and maintain intimate, sexual, and/or romantic relationships with more than one person (Haritaworn, et al., 2006).

Another common misconception therapists seemed to hold was the idea that marriage and having children are diametrically opposed to the concept and practice of consensual non-monogamy. Far from a new idea, not only have non-monogamous relationships been framed as being at odds with marriage and having children, they have also been framed as a threat to the stability of families and relationships (Valsiner, 1989; Elbedouet al., 2002; Perel, 2006; Giammattei and Green, 2012; Twist & Ansara, 2017; Twist, 2021). This type of thinking was seen when therapists felt there would be conflict between the clients and their extended families if they continued to have a CNM relationship, because CNM would not allow for clients to do what their families were hoping for, in this case: get married and have children, as well as when Therapist #5 directly said the problem was coming from the "pressure to get married, especially from Jaime's parents since they want to remain non-monogamous". This is a good example of a perceived barrier that was non-pathologizing because there is a recognition that the clients wish to continue with a CNM relationship structure, but the therapist then stuck because of the assumption that this would mean the clients did not have a desire or were even against the idea of getting married. The reality is, that while polygamy is not legally recognized in the United States, many individuals in CNM relationships are legally married to one of their partners. Nonetheless, a lack of knowledge about the realities of CNM relationships, means therapists can only operate off of misconceptions. Many of these misconceptions are not something therapists would have heard stated overtly anywhere, but rather are extrapolations they make based on mononormative discourse. For instance, mononormative discourse puts a lot of emphasis on legal and/or religious marriage as the highest form of relationship (Mayrhorfer, 2018) and

because it is so intrinsically tied to our societal understanding of monogamy, logic might dictate that non-monogamy (the "opposite) would be very disconnected from the idea of marriage. Or, another assumption might be that if marriage is the ultimate form of a successful intimate relationship, then individuals who are non-monogamous would want to marry all of their partners, which is not only a challenge to the idea of "soulmates" or having that type of connection with only one person, but also (as mentioned earlier) currently illegal in this country. Perhaps it is easier to assume people in non-monogamous relationships want nothing to do with marriage than to process what it would mean if they did. Even so, continuing to believe these ideas are at odds is resisting a general movement toward decentralizing white, cisgender, heterosexual, married couples with biological children in relational therapy (Reczek, 2020). Again, it is important to highlight that all of the assumptions in this sub-theme were presented as "understood", suggesting they are "understood" within the dominant, mononormative discourse, because they were not ideas stated in the vignette.

Dissonance with Clients. There have been a number of studies where results show people tend to pathologize non-monogamy. However, there are fewer examples of studies, like this one, where people persisted in their belief that non-monogamy was creating or born of problems when its participants were directly saying they were happy, satisfied, and planning to continue this type of relationship structure. This dissonance between the person engaging in a CNM relationship and an outside observer becomes more complicated when the person engaging in CNM is a client and the observer their therapist. In the last few decades, there has been a movement toward client-centered treatment planning and approaches to therapy, as well as viewing the client as the expert when it comes to their lived experiences. Not only does continuing to believe and act upon assumptions or conclusions that contradict what the client is

saying about their experience defy movements in these directions, it also stands in direct conflict with the ethical mandates of the field. For instance, ethical standards emphasize the importance of making clinical decisions based on the best interests of the client, and not letting personal bias dictate these decisions. Furthermore, client autonomy is a core part of the ethical code and research has shown that therapy is most successful when clients and therapists are aligned in the the goals they are working toward.

Nonetheless, many therapists in this study continually framed CNM as a problem or having a negative impact on the clients despite no evidence of this and only positive experiences of CNM being presented in the vignette. Therapist #15 went so far as to say they would want to know "why the issue of each having other partners arose" stating it as an "understood" issue, when the clients were saying quite the opposite. This dissonance is not new and is discussed at length by Conley et al. (2013) and Grunt-Mejer & Lys (2019). For many respondents, it seems their confusion and this dissonance may come from a lack of exposure to CNM as a concept and/or practice and training around working with CNM clients.This is a major issue and researchers have been sounding the alarm about the dangers since at least 1972 (Constantine, Constantine, and Edelman, 1972; Knapp, 1975; Weitzman, 2006; Weitzman, et al., 2009; Muldner-Nieckowski, et al., 2012; Miller & Byers, 2012; Graham, 2014; Williams & Prior, 2015; Schechinger, et al., 2018; as noted earlier, one of the best examples of this possible lack of exposure and skills comes from Therapist #7's response, where they said, " I would look into if being in the relationship itself was the problem. Seeing that being with Jaime helps and the open relationship gave them more happiness, it gets a little bit complicated from there". Therapists seem uncertain about how to balance the idea of a positive and satisfying dyadic relationship with a desire to continue a CNM relationship structure, since mononormative ideas about

relationships say this is not possible. Dominant mononormative discourses would say either the clients are exploring other relationships because they are unhappy in their dyadic relationship, or, they should not want to explore other relationships because they are happy in their dyadic relationship. Mononormativity does not leave room for both of these things to be true. When presented with the idea that both are true, therapists are unsure about how to proceed.

Dissonance Within Self. The most unexpected finding in the results of this study was the "Dissonance Within Self" theme. It should be noted that nearly all of the respondents answered the fourth question about whether they would change their answers if the clients were in a monogamous relationship, with "No". This aligns with the intention part of therapists' process of case conceptualization and treatment planning when working with CNM clients- "Aiming to treat CNM clients the same as any other client". However, a large number of clients answered "No" to this question despite pathologizing non-monogamy in their responses to the earlier questions. Other respondents focused on non-monogamy when hypothesizing about possible sources of the presenting problem, identifying other information they would like to know, and determining recommendations and interventions, but still claimed nothing about their responses would change if the clients were monogamous. This cannot possibly be true. Furthermore, this was clearly seen when respondents did provide examples of how they would conceptualize and treatment plan differently if working with monogamous clients. These respondents spoke about focusing on traditional ideas and interventions used in couples therapy, such as communication, connection, sexual intimacy, suggesting partners spend more quality time together, coping and attachment skills, and stress and conflict management, rather than focusing on the clients' non-monogamous relationship.

So, why does this dissonance in the process occur? Is it possible they are not aware of their own biases? The research suggests that is very often true. It still seems surprising that therapists can answer questions with very pathologizing responses, but still not realize they were doing so and still maintain they would approach monogamous and non-monogamous clients the same way, even when they just did not. It is possible that therapists can acknowledge when clients say they are happy in their CNM, but are then unsure how to conceptualize that reality? Do therapists approach working with CNM couples from a lens where they feel the need to protect them from the "realities of CNM relationships" that the clients must be unaware of? Is it possible therapists think CNM relationships could work, if only mononormative discourses were inconvenient truths that stand in the way? Again, research literature on this topic suggests the answer to all of these questions is yes. Finn,et al. (2012) talk about a possible dissonance between performative acceptance and true beliefs. Once again Knapp (1975) found when comparing personal and professional attitudes, most respondents expressed being professionally supportive toward non-monogamous practices, even if they were not personally supportive, but Between 9 and 17% of respondents said they would influence their clients to no longer participate in non-monogamous practices. Knapp (1975) also spoke about the subliminal ways therapists who said they personally disapprove, but professionally are accepting might be revealing their feelings or giving off signals to their clients.

The Influence of Mononormative Discourse

Clearly, the dominant discourse about relationships (mononormativity) influences relational therapists' case conceptualization and treatment planning when working with CNM clients in significant ways. This should not be surprising, as researchers have long warned

relational therapy is not immune to the impact or reinforcement of monogamous privilege (Blumer, et al., 2014) and the inevitability of therapists being affected by the "monogamy training" they have received both in formal training settings, and simply existing in a society with mononormative dominant discourses (Baumgartner, 2009). These influences result in one of three things happening: Therapists treat CNM as part of the problem, therapists feel they cannot use traditional relational therapy models and techniques unless a dyad is practicing monogamy, and therapists do not consider contexts/resources unique to CNM relationships. Ultimately, this means non- monogamy is treated as something that is either invisible or needs to be removed.

Part of the Problem

A large number of respondents were influenced by mononormative dominant discourse to view CNM as part of the problem when working clinically with this case. Again, the provided vignette clearly stated that the partners were happy with this dynamic and planned to continue. Additionally, the dyad has been practicing CNM for over a year, which does not align with their recent increase in stress, which is what led them to seek therapy. Nonetheless, CNM was named as the problem again and again. This reflects research going back to 1975, through 2004 (Weitzman, 2006), and still continuing up through today. As Knapp (1975) noted, many CNM individuals have said therapy providers misattribute problems to their relational orientation, rather than seeing that their relationship structure is actually their mutual attempt to meet all of their needs, address problems, and maintain more honest and open relationships.

Unlike the other two themes discussed here, CNM as Part of the Problem was most frequently stated overtly by the respondents. Some examples include: "They engaged in relationships with other partners…I see that non-monogamous [sic] is the cause of their

problem" (Therapist #11), "According to me, the problems began when they agreed to be in a mutual relationship with other people" (Therapist #14), "The main problem is for the partners being in an agreement to be in a polygamous [sic] state" (Therapist #15), "I think the whole problem started when they decided to go into a non monogamous relationship" (Therapist #28), and "My preliminary hypothesis is that couples' marital problems may be related to their practice of multi-partner marriage habits" (Therapist #29). You can see there is a wide range of language and terminology to express the idea (which seems to be related to a lack of understanding or exposure), but the sentiment remains consistent.

Two responses notably challenged this idea, without exhibiting dissonance within the self. Therapist #26 said, "The vignette doesn't say anything negative about non-monogamy and reports that the clients want their relationship to continue in that way" and Therapist #32 said, "It isn't a problem unless they feel it is a problem". These two responses are the only ones who acknowledge the clients' CNM, do not speak about it negatively in their responses, and assume the validity of what the clients' have expressed regarding their satisfaction with a CNM relationship structure. It is concerning that only two responses overtly stated that the clients' CNM relationship was not a problem. Research has consistently shown that there are no significant differences in the psychological functioning or relationship satisfaction in CNM vs. monogamous relationships (Weitzeman, 2006), dissatisfaction in CNM relationships comes from individual differences rather than from the type of relationship (Hosking, 2014; Brown, 2015; Benson, 2016), and CNM relationships typically end for many of the same reasons monogamous relationships do (Ramey, 1975).

The ongoing tendency for therapists to view consensual non-monogamy as part of the problem is an <u>actual</u> problem. Nicole Graham (2014) outlined some of the reasons well, by

speaking in depth about her experiences with a client who came to her after ending therapy with another therapist. Graham shared how the client admitted her previous therapist had blamed all of her issues on non-monogamy and recommended she end them, since they were likely causing her depression. The client reported feeling judged and misunderstood, her symptoms worsened, and she no longer felt comfortable discussing her relationships in session, which ultimately led her to stop therapy altogether. Like the clients in the vignette from this study, Graham's client reported how her CNM relationship was actually a positive in her life, but this idea was completely dismissed by her therapist. Brandon (2011) felt it is necessary for therapists to examine their own assumptions and beliefs about monogamy, otherwise they are at risk for actually exacerbating and reinforcing the presenting problem, under the guise of helping. This harm often comes from the misidentification of the presenting problem where rather than looking at the struggle that has emerged from trying to fit into an unrealistic requirement, the CNM relationship is what therapists aim to change (Brandon, 2011; Barker, 2011).

Can't Use Models

The next way therapists were influenced by mononormative dominant discourses was by making them feel like they cannot use traditional relational therapy models and techniques unless a dyad is practicing monogamy. This was expressed explicitly in just a couple of instances, but showed up in other ways throughout the responses. Therapist #15 wrote, "For them to solve their issues, they first should address the polygamous issue" and Therapist #16 said, "They have been able to successfully navigate the non-monogamous aspect of their relationship, but now they are experiencing issues with communication, emotional processing, and motivation". Although, Therapist #16 does not speak about CNM as a per se, they still draw a separation between

"navigating non-monogamy" and general relationship struggles. Most common, however, were the many responses where therapists answered Question #4 by saying that if the clients were monogamous they would focus more on things like intimacy/connection, quality time, communication, coping skills, and conflict resolution. There was a clear trend felt among the therapists that non-monogamy needed to be focused on and addressed first, before being able to engage in couples' therapy work or using traditional couples therapy models and interventions.

Again, this thinking likely comes from a lack of training and exposure, especially because research already exists on how to adapt or pull from extant theories and models of relational and sex therapy to effectively work with CNM clients. Shernoff (2006) cites Cheuvront, 2004; Green, et al., 1996; Green & Mitchell, 2002; Greenan & Tunnell, 2003; and Kurdek & Schmitt, 1985–1986 as therapists who have "discussed how to use aspects of traditional theories of family and couples therapy with the primarily happy yet nonmonogamous male couples they were seeing in their practices" (Shernoff, 2006, p. 410). There have been adaptations of an intersystems approach to sex therapy (Zimmerman, 2012), experiential sex therapy (Berry & Barker, 2014), sensate focus (McCoy, Stinson, Ross, and Hjelmstad, 2015), Gottman and Emotionally-Focused Therapy models (Kolmes & Witherspoon, 2017), and kink-aware therapy techniques (Sprott, et al., 2017). These adaptations and applications exist, but if CNM is not talked about in training, therapists and therapists in training will not hear about them. Furthermore, there are so many other applications of traditional relational therapy models and techniques that can be used with CNM clients, if only therapists can stop viewing CNM intimate relationships and monogamous intimate relationships as wildly different and even mutually exclusive.

Ignoring CNM Context

The most difficult influence to talk about is the one that leads to CNM being invisible, because one must talk about what is not being said. Despite the overwhelming focus on CNM in the respondents' answers, the majority of therapists did not speak about or consider contexts/resources unique to CNM relationships.This should not be surprising, as Blumer, et al. (2014) spoke about how mononormativity and monogamous privilege often lead to the construction of a "wall of invisibility" around the experiences of relationships outside the dominant relational orientation–monogamy (Blumer, et al., 2014) and Marianne Brandon spoke about the challenge of bringing non-monogamy "out of the closet and into the treatment room" (Brandon, 2011).

To be fair, five of the respondents did start to go in this direction or make some of these considerations. For instance, it was not clear exactly what Therapist #21 meant when they said they would want to know more about the clients' "connectedness to other sexual partners outside of this specific relationship" or that they would recommend "seeking support within the relationship and the community for anxious and depressive feelings and thoughts". These responses could be talking about the distinction some respondents drew between short-term, "no strings attached" relationships vs. long-term emotionally committed relationships and the general "community" in terms of mental health resources or local groups, activities, etc., or this therapist could have been talking about using connections the clients' have with other partners as a strength and a resource and turning toward the larger CNM community. Some respondents, such as Therapist #8, clearly indicated that CNM brings a "unique" set of needs, goals and dynamics, which they wished to understand, but they seemed uncertain about where to go with that: "I would need to tailor their approach to the specific needs and goals of Riley and Jaime, as well as

the unique dynamics of their relationship". Therapist #32 and Therapist #31 spoke to this as well, writing, "I think asking about their sex life is always a good thing to bring up when working with couples of polycules…. When talking about their different types of intimacy or their sex life it is good to consider the unique dynamic it can bring to a relationship" (Therapist #32) and "I would also be curious about what agreements they made related to ENM relationships and the potential impact to their relationship" (Therapist #31). Notably, Therapist #32 was the only respondent who indicated they had possibly worked with CNM clients before, but it is not known whether they have or if they were making a statement based on what they imagined would be useful when working with CNM clients. Finally, Therapist #23 provided an addendum in their response to Question #4: "One thing I did not mention earlier, but this question made me reflect upon is that if the relationship is non- monogamous, I would screen for support. It is important to have support in non-traditional relationships as they are more stigmatized". Therapist #23 was the only respondent to talk about mononormativity and its impact on CNM clients, even though research shows this is critically important. Knapp (1975) suggested CNM clients would benefit therapeutic support to help them navigate the stigma that comes with deviating from a norm, even though many of them feel CNM has been an overall positive experience, had a positive impact on their relationships, and on their personal growth.

However, these five therapists were the outliers and most of the respondents did not explore strengths, resources, or even specific challenges facing CNM clients. For instance, perhaps (to Therapist #23's point), the clients were feeling isolated from family members or friends because they are not "out" regarding their CNM relationship and thus do not feel comfortable sharing about certain elements of their lives. Or, maybe, one of the clients' other partners has dealt with pressure from parents and could be a good resource to talk through this

experience and how they navigated it for themselves. Alternatively, therapists could have highlighted the clients' positive experience with CNM as a strength, a positive and stable part of their relationship during a time of change and turmoil. Even therapists who did focus on CNM and why they thought it was a problem rarely actually detailed anything about what makes it different from monogamous relationships. The exception to this was when Therapist #29 spoke about how couples in open marriages face challenges such as " issues of affection and envy, as well as difficulties dealing with complex relationship dynamics". When therapists did not focus on non-monogamy, they tended to not talk about CNM at all. Granted, the clients' were not coming in to address issues regarding CNM, but they did include this information as part of their initial summary of who they are and their current life circumstances. While it is not useful to focus on CNM if it is not relevant to the clients' goals, it is also potentially a problem when this part of clients' lives is entirely absent from case conceptualization and discussion. There is a difference between something not being a priority and being taboo.

Implications for the Field

So, what needs to happen now? What do the results of this study suggest about what changes need to be made in the field, specifically in regard to training relational therapists? Well, we know CNM clients report the most positive therapy experiences when providers educate themselves about CNM issues, hold affirming/ nonjudgmental attitudes toward CNM, help their clients feel good about being CNM, remain open to discussing issues related to a client's relational orientation when brought up by their client, and use helpful techniques that align with their CNM clients' goals (Schechinger, et al., 2018). Some models that promote these qualities already exist in the form of workshops like the one presented by Twist and Ansara

(2017), books aimed specifically at increasing understanding of CNM (Orion, 2018) and working with CNM clients (Fern, 2020; Kauppi, 2021; Vaughn & Burnes, 2022; Ferrer, 2022), courses like the one offered by The College of Sexual and Relationship Therapists (COSRT) in 2021 (Twist, 2021), and models like experiential therapy model developed by Berry and Barker (2014), which they presented as non-pathologizing and suitable for use by both therapists who have not worked with CNM clients before and those who have, but are looking to expand their toolbox. A lack of exposure and comfort with variations of relationships and sexuality has been shown to lead to poor treatment efficacy (Muldner-Nieckowski, et al., 2012; Miller & Byers, 2012), but with the growing availability training and material that centers or at least includes consensual non-monogamy, there is no excuse for a lack of exposure. Regardless of how therapists may feel about non-monogamy, non-monogamous clients exist and therapists need to be prepared to work with them effectively and ethically, which means therapists will also need to explore their own biases, knowledge, and monogamism.

Again, many resources already exist to help relational therapists be more aware of these things. Berry and Barker's experiential therapy model also centers therapists' awareness of their own prejudgements and values. Twist, Prouty, Haym, and VandenBosch (2018) developed a monogamism measure for therapy providers, focusing on three sub-areas of awareness, knowledge, and skills. Like this study, the sub-area of "skills" addresses case conceptualization and treatment-planning. Markie Twist and their students developed a Polyam-Centric roleplay, which flips the script on mononormativity and imagines a world where non-monogamy is the "norm" and monogamy is the "other" (Twist, 2016). The responses in this study are nearly identical to the questions, assumptions, and discourses this roleplay flips, demonstrating suspicion, misconceptions, skepticism, pathologizing, and judgment, as well as microaggressions

like not considering clients realties and invasive questions. Observing and engaging in activities like this can highlight just how rampant monormativity and monogamism are in relational therapy, especially since the results of this study show that therapists are often very unaware of how mononormative dominant discourses are influencing their clinical work with clients. There is dissonance between therapists intentions and how they ultimately interact with CNM and think about their relationships. At this point in time, pathologizing CNM remains a steady trend in relational therapy. When not being pathologizing, CNM is often viewed as a barrier to using tried and true techniques and interventions in relational therapy, or, it is not talked about at all.

Luckily past research provides suggestions for an alternative role relational therapists can take on when working with CNM clients. Constantine, Constantine, and Edelman (1972) present a very optimistic lens of what therapy providers might do with this opportunity by championing the idea that therapy may be a place where clients may be supported in tailoring their family structure to their needs, rather than being forced to fit into a single idea about what a "family" or "relationship" looks like. Likewise, Bettinger (2005) highlighted the way the American gay male community approaches choices about relationship structure as a "morally neutral issue" and relational therapists can take a similar approach, working with clients to determine whether a given relationship structure will will help or hurt the relationship, rather than whether it is "good/bad" or "right/wrong". Likewise, Finn, Tunariu, and Lee (2012) suggest moving away from encouraging the client to do what is "right" for them, because they propose the identification of what is "right" shuts down an exploration of what is possible. Instead, the authors suggest providers openly discuss the "situated" nature of the clients' identity, which would be a radical deviation from the "let's try to make the best with what we've got" outlook

and movement toward the actual incorporation of CNM as a viable and positive relational and identity-forming practice (Finn, et al., 2012).

This type of thinking is aligned with the core tenets of critical and queer theory and leaves so much room for the development of new resources, courses, and trainings that do not yet exist. Baumgartner (2009) spoke about considering alternate stories and moving away from a narrow and limited single story about what relationships "are" and "can be". As someone who, like Baumgartner, is greatly informed and inspired by Narrative therapy (White & Epston, 1990), my own musings about how to teach these ideas have started to formulate through a narrative therapy lens. I have started to put together ideas for a course I would call: A Narrative Therapy Approach to Diverse Relationships, in which I would divide the course into parts based on the general phases of Narrative Therapy: Deconstruction, Reconstruction, and Witnessing (White & Epston, 1990). This course would deconstruct dominant discourses and limited stories about what relationships look like, provide examples and promote greater understanding of diverse types of relationships by pulling from work centered on typically marginalized or invisible groups or relationship experiences. The course would also introduce terms and concepts that literally deconstruct relationships, by breaking into individual components, aspects of relationships that are generally lumped together or even understood to be one in the same. For instance, I would talk about differences between different types of attraction, explore the concept of the relationship escalator (Gahran, 2017), types of intimacy, polysaturation, and other such ideas. Finally, I would include an application component to the course, to ensure these ideas do not stay in the realm of academia or continuing education, but rather can be understood as real and usable in a clinical setting. Some ways I might achieve this would be through having students complete an interview with someone whose relationship challenges dominant discourses

and by creating a community resource plan that is inclusive of diverse relationship aspects and experiences. I would pull from the experiences of groups like the trans and gender diverse communities, kink community, neurodiverse community, asexual and aromantic communities, and of course, the CNM/polyam community. Who's to say whether I will actually get to create and implement a course like this, but completing this study has shown how necessary a course like this is and has inspired me to try. I hope this study might inspire others to do the same.

Limitations

All studies have limitations, especially when they are exploring a new area of study or using a new approach. This study meets both of those criteria, so it naturally has a few limitations. One limitation of this study, as discussed in Chapter 3, was the influx of questionable survey responses due to the use of bots and AI. Although my masters level research assistant and I used a multi-faceted vetting process and triangulation to determine viable responses, the fact that this breach of access to participate in the survey occurred is still concerning. My research assistant and I agreed on criteria that would preclude responses from being added to the usable data pool and then went through multi rounds of separating data out into usable and unusable responses. After this, we compared our determinations and provided rationale for each of them. Only responses where we both agreed they were usable were included. If there was a difference between our assessments, those responses were not used and if there were any either of us were uncertain about, we chose not to use them as well. That said, even with this approach to the useability of the data, if I were to do this study again, I would take additional precautions in order to better ensure all of the responses were coming from licensed relational therapists or relational therapists-in-training. Unfortunately, respondents could not include license numbers

for two reasons: 1. Pre-licensed relational therapists and relational therapy interns currently in graduate and doctoral programs were included, and 2. Providing license numbers would eliminate the anonymity of participants. In the future, I would use a different survey software that includes multiple levels of protection to protect against bots and AI programs such as ChatGPT. One reason this was not done in this study was because the prevalence and use of bots and AI has grown exponentially over the course of completing this study. AI programs such as ChatGPT started appearing in news stories more and more over the last year of completing this study and at the time of writing, multiple strikes are going on, including one by actors and writers worried about being replaced by or used to create AI generated work. However, these concerns were not present in the same way in the past and were not discussed in research methods courses during my training. Additionally, the research software available through my doctoral program, with whom we have a program account, does not include these protections or precautions. Going forward, I hope academic programs will partner with software companies who provide bot protection services such as reCaptcha questions to distinguish between humans and bots and other measures to limit fraudulent activity such as providing unique links to prevent reward-seekers from submitting multiple responses. I would also hope to see these new considerations included in research courses required in training programs. Luckily, there has been a rise in published research about exactly this, including a 2020 study published by Storozuk, Ashley, Delage, and Maloney, which provides a number or recommendations to help protect future research from these threats.

Related to this, another limitation of this study was that since an online survey was used, responses relied on self-report and were surprisingly short on average. When determining the methodology of this study, I opted to use an online survey because I felt an interview would not

be as analogous to the typical way therapists case conceptualize and treatment plan, which is usually in the form of clinical documentation. This allows the therapist time to reflect on the information and their ideas before moving forward with documenting case conceptualization and treatment planning. I also hoped allowing participants to think about their answers alone and respond would limit the impact of participants potentially being influenced by me and/or trying to guess what types of responses I was looking for when answering. However, if I were to do this study again, I would try to figure out a way to provide clinical supervisors these research questions and then sit in on or record interactions between therapists/therapists-in-training and their supervisors. Supervision is another setting besides clinical documentation where therapists discuss case-conceptualization and treatment planning frequently. Allowing therapists to remain in the supervision context would eliminate the unfamiliarity of talking about these things in an interview setting, since these types of discussions are commonplace during clinical supervision. Of course, using this approach would require an entirely different set of ethical considerations and would eliminate the possibility of anonymity. That said, with the proper adjustments, confidentiality considerations, and consent, this type of study seems possible and could provide a deeper understanding of the process explored in this initial study.

Another possible limitation of this study was the decision to make the clients in the vignette part of a "couple". Although the initial intent of this choice was to provide participants with a scenario that was similar to clients they would have worked with or examples they would have learned about during a training program, with the only exception being a change in relationship structure that challenges the dominant discourse. Upon reflection, however, I thought about the possibility of presenting clients who are part of a polycule, or a triad, or some other non-monogamous relationship constellation that would include more partners in the

scenario in an active way. Perhaps having a dyad come in for therapy contributed to the tendency to not consider the clients' non-monogamous relationship context or other partners. That said, I believe the fact that most participants did still talk about or even focus on the clients' non-monogamous relationship lends credence to the fact that the data does provide valuable insight regarding the research questions and also provides a focused look at whether therapists think a healthy dyadic relationship and a non-monogamous relationship structure can coexist. Plus, many options for presenting other types of non-monogamous relationships in clinical vignettes just lends itself to a wide variety of future research directions.

Finally, as is always the case in qualitative research, but even more specifically accounted for in constructivist grounded theory, there is the potential for researcher bias. One unique quality of constructivist grounded theory is the framing of researcher bias or context as an expected part of qualitative research, which can even be a strength in some cases (Charmaz, 2014). Nonetheless, I still took precautions to try to limit the breadth and depth of my researcher bias, most especially to ensure the results I presented were a realistic representation of the data collected. I included my position statement in a previous chapter to highlight the ways my dimensions of identity and my experiences may impact my interpretation of the data. All of the data collected was also viewed and coded separately by a masters level research assistant and coding decisions were all triangulated to ensure both of us felt they were accurate representations of the data collected. These codes were further triangulated by reviewing coding decisions during check-ins with my dissertation chair. Finally, memo writing was something I did throughout the process to track assumptions, challenges, new ideas that could influence my interpretation of the data, and personal experiences that impacted my mood, motivation, and relationship with the work.

Future Research

This study was only an initial attempt at trying to understand more about the process relational therapists use when doing case conceptualization and treatment planning in their work with CNM clients. This type of study, focusing on the "how" and the components of this process has not been done before and as such, this study is an attempt to start to give this theory a shape, with the acknowledgment that there may be barriers, pitfalls or revisions needed to do this most effectively. Research always involves some trial and error when new paths are started and ideal or not, learning as you go is the only way to learn. The exciting part about this being a newer path for research is that there are so many options of where to go next. First, it would be helpful to repeat this study with the changes outlined in the limitations section. Finding ways to ensure all participants meet the qualifications of the group being studied (licensed and pre-licensed relational therapists and relational therapists in training) and collecting more expansive responses to these open-ended questions will provide more information about whether the proposed theory holds. This study only included relational therapists in the United States, but it would also be interesting to learn whether responses from relational therapists in other parts of the world differ from the ones collected here. Grunt-Mejer & Lys's work suggests similar responses can be found in Poland (2019), but this may not be the case in all regions. For instance, would responses change when looking at a region where non-monogamy is more accepted and less marginalized?

Additionally, as mentioned above, it could be beneficial to change the format of the study. By observing participants in supervision, not only would the responses be more in depth and in a context where they would likely feel more comfortable speaking about these topics, but it could also provide insight into the dialogue about working with CNM clients that occurs between therapists and supervisors. Do supervisor responses challenge or reinforce dominant

discourses? How are therapists influenced by their interactions with their supervisors? In a similar vein, having participants role-play interactions with CNM clients in a first session would also provide added layers of information. An example of this would be: do therapists say what they are thinking to clients? Even in the context of a roleplay, where the "clients" are just other therapists acting, it could still mimic the difference between theorizing privately or in the safety of supervision and speaking directly to a person in a therapeutic context.

Finally, I believe an important direction to go with this research is to more actively incorporate the role of training. One of the main reasons I wanted to conduct this study was to help inform best practices for training relational therapists in a way that is inclusive and does not reinforce messages that marginalize and harm clients. Future research might explore the link between training (or lack of training) therapists have received about non-monogamy and working with CNM clients and the responses they give to questions like the ones in this study. To go further, subsequent research might look at using training programs/material about non-monogamy and working with CNM clients that others have developed and comparing before and after results using a clinical vignette and questions like the ones in this study to see if this two-part dissonant process remains the same or changes. Future researchers might also use scales such as the one developed by Twist, Prouty, Haym, and VandenBosch (2018), which look at awareness, knowledge, and skills when working with CNM clients, to help identify monogamism and therapist bias. Before and after these trainings/courses, etc. to see if participants' scores on these measures increase. Overall, now that there is research on this topic covering each of these components individually, I believe it is time to start combining findings to see if research results can be applied in a practical way to help ensure future therapists are using best practices for their clients and adhering to the ethical standards of the field.

Chapter 6: Conclusion

In summary, the purpose of this study was to learn more about how relational therapists in the United States conceptualize cases and treatment plan when working with consensually non-monogamous clients and how dominant discourses about relationships (mononormativity) influence relational therapists during this process. Based on the results of this study, a possible theory about this process emerged. Relational therapists tend to approach case conceptualization and treatment planning via a two-part process when working with consensually non-monogamous clients. First, relational therapists aim to treat CNM clients the same as any other client, but then are unable to treat CNM clients the same due to dominant discourses of mononormativity.

There is dissonance between the intent and the action. Two main themes emerged regarding why relational therapists were unable to treat CNM clients the same way they would monogamous clients: Pathologizing CNM and Dissonance. Dissonance came in three different forms: misconceptions about CNM, dissonance with the client, where relational therapists continued to doubt the clients' positive experience of CNM or continued to pathologize CNM despite the clients' reporting satisfaction with this relationship structure, and dissonance within the self, where therapists claimed they would not change their approach if they were working with monogamous clients instead, even though their answers did not reflect this.

Mononormative discourses influenced relational therapists' case conceptualization and treatment planning in three ways: viewing CNM as part of the problem, feeling they cannot use traditional relational therapy models and techniques unless a dyad is practicing monogamy, and/or not consider contexts/resources unique to CNM relationships. The end result of these influences is that CNM experiences were either pathologized, marginalized, or erased. In order to

combat the negative effects of these influences, relational therapists must receive more training about diverse relationships and relationship structures, become more aware of their own mononormative biases and scripts, challenge mononormative discourses, and limit the ways they reinforce monogamism and dominant discourses in their clinical practice.

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Appendix I- Consent Form

This is a survey about case conceptualization and treatment planning when conducting relational therapy. This survey will give you an opportunity to add to the knowledge of work in this area and it may also help to improve the care of relational clients in therapy and training of relational therapy providers in the future.

Your responses will generate a greater understanding about what considerations relational therapy providers make when conceptualizing cases and treatment planning.

Participation Requirements

You are being asked to complete this study as a pre-licensed graduate/doctoral student intern, prelicensed, associate licensed, or fully licensed provider of relational therapy (CFT/MFT) over the age of 18. You will be asked to read a clinical vignette and respond to four, open-ended questions about hypotheses, recommendations, and initial treatment planning ideas.

There are minimal, if any, risks from participating.

Minimal stresses may occur related to asking about professional opinions and values. It is possible, given that a vignette will be used, elements of the described scenario may cause discomfort depending on personal experiences and positionality.

Your identity will be anonymous. You will not be asked for your name and all demographic data being collected will be reported as aggregated information. No personally identifiable

information will be associated with your responses to any reports of these data. The survey will take approximately 30 - 45 minutes to complete.

You will receive a $5 Amazon gift card for completing the study.

At the completion of this study, you will be asked to input your email address onto a Google Form. This information will be completely separate from your responses to the survey, allowing your responses to remain anonymous and tied only to the information you provide on the demographics form. This email list will be used to send out the giftcards.

This survey is part of my dissertation research at Antioch University in the PhD in Couple and Family Therapy. The information may be used for future research without additional consent, but data will continue to remain anonymous.

Your participation is voluntary.

You may elect to discontinue your participation at any time. If you have any questions about the survey or the research study, please contact me at: [redacted].

This project has been approved by the Institutional Review Board at Antioch University. If you have any questions about your rights as a research participant, please contact Dr. Kevin Lyness, AUNE IRB Chair- [redacted] or [redacted] or Dr. Shawn Fitzgerald, AUNE Provost and Campus CEO- [redacted] or [redacted].

By checking the box below and clicking "Next" I am indicating that I have read and understood this consent form and agree to participate in this research study.

Please print a copy of this page for your records.

Thank you for your participation!

Appendix II- Demographics Form

1. How would you describe your current level of clinical practice in the field of CFT/MFT?

_____ Fully-Licensed _____ Provisionally Licensed _____ Pre-Licensed Graduate Student/Intern_____

2. What is the highest level of education you currently hold?

_____ Bachelors (0) _____Masters (1) _____Post-Graduate Certificate (2) _____ Doctorate (3)

3. How would you describe the institution where you obtained your mental health degree?

_____ Public (0) _____ Private (religiously affiliated) (1) _____ Private (not religiously affiliated) (2) _____ Not listed: _____ (3)

*If you have a second, post-graduate degree, please indicate please indicate the institution type below (if not, please leave BLANK):

_____ Public (0) _____ Private (religiously affiliated) (1) _____ Private (not religiously affiliated) (2) _____ Not listed: _____ (3)

4. Where was the institution where you received your license eligible degree located?

_____ Major City (250,000+) (0) _____City (1) _____ Suburban Area (2) _____ Rural Area (3)

5. How would you define your gender identity?

_____Cisgender female (0) _____Cisgender male (1) _____Transgender woman (2)

_____Transgender man (3) _____Non-binary (4) _____Agender (5)

_____Genderqueer (6) _____Not listed: _____(7)

6. What is your race/ethnicity? (check all that apply)

_____African/Afroamerican (0) _____White/Caucasion (1) _____Asian/Pacific Islander (2)

_____Hispanic/Latina/Latino/Latinx (3) _____Middle eastern/Mediterranean (4)

_____ Indian-Asian Continent (5) _____ First Persons/Indigenous (6)

_____ Multiracial (7) _____ Not listed: _____(8)

7. How would you describe your sexual orientation?

_____Gay (0) _____Lesbian (1) _____Heterosexual (2) _____Bisexual (3)

_____Polysexual(4) _____Polysexual(5) _____Asexual/Demi (6)

_____ Not listed:_____ (7)

8. How would you describe your religious affiliation?

_____Christianity (0) _____Islam (1) _____Buddhism (2)

_____Judaism (3) _____Hinduism (4) _____Nature-based religion (5)

_____Atheism (6) _____No affiliation (7) _____Not listed:_____(8)

9. How would you describe your political alignment?

_____ Conservative (0) _____ Moderate/Centrist (1) _____Libertarian (2)

_____ Liberal (3) _____ Independent (4) _____ Green Party (5)

_____Not listed:_____(6)

10. How would you describe your relational orientation?

_____ Monogamous (i.e. marriage, partnership, serial monogamy) (0)
_____ Partnered Consensual Non-Monogamy (i.e. polygyny, plural, polygamy, polyamory, polyandry) (1)
_____ Degree of both (i.e.monogamish, swinging, open marriage, open relationship) (2)
_____ Non-partnered Consensual Non-monogamy (i.e. relationship anarchy, solo-polyam) (3)

11. Do you have children? _____No (0) _____Yes(1)-how many? _____

12. What is your current age, today? _____

Appendix III- Vignette

Riley and Jaime are members of a relational dyad that have come to you in the hope of working through some of the challenges they have been facing. Riley and Jaime have been together for two years. They are in their mid-20s and began dating when they attended the same small college. They immediately realized that they had a lot in common. They believe that cultivating hobbies together builds a special bond between them. They enjoy each other's company and especially like to go out to eat and enjoy watching movies together.

A year and a half ago, Riley and Jaime both mutually agreed that it is okay if they have other sexual partners. For about a year, they have been engaging in relationships with other partners. They are finding themselves to be happy with this arrangement and plan to continue to be non-monogamous. Now they both work full-time and have recently moved into an apartment together.

Jaime tends to worry the worst is going to happen and tries to plan ahead for all scenarios. Riley has been struggling to get up in the morning and reports a decrease in motivation. Both partners report feeling less connected to one another and an increase in conflicts and miscommunication. Jaime's parents live locally and have been putting a lot of pressure on them to get married and have children. Riley's parents are divorced and there are a number of cut-offs and estrangements within the extended family. During times of conflict, Jaime tends to want to process emotions and feels unsettled if anything is left unspoken. Riley has a history of trying to avoid conflict by agreeing with the other person and shutting down if

interactions become too emotionally heightened. Given the increase in stress recently, Jaime and Riley are looking for ways to improve their interactions and feel more connected with one another.

Appendix IV- Qualitative Questions

1. Although a therapist may not want to formulate preliminary hypotheses without gathering more information, some therapists do have certain hypotheses that they test as they continue to work with their clients. What are your hypotheses concerning the source of the problem for the clients?

2. What are your initial thoughts about how you would work with the clients to help address the source of their problem? What recommendations would you make?

3. What other information would be most important to know in order for you to create a treatment plan and work with these clients?

(Asked after responses to Questions 1-3 are submitted)

4. Would you change anything about your hypotheses and treatment planning if the relationship described was monogamous?

Appendix V- Examples of Open Coding

Q16. Explore trauma as well as generational and attachment issues.

Q17. Create a memoir of life story. Process generational and trauma histories.

Q18. Past dx, medication,

Q19. No

Q16. I will want to know about how they view their relationship, whether they are still ok and on the same page about having an open relationship, how they want their present relationship to look like and explore the family of origin and its impact on their relationship.

Q17. I would want to know more about the family of origin. Sometimes we inherit and repeat the communication style and coping styles that we have seen our parents use.

Q18. I would want to do a genogram and ask the partners to reflect on how their experiences with their family or origin influences their current problems, understanding of the couple dynamics and roles for each partner.

Q19. Yes I think I would focus more on the family of origin, communication and coping styles than how they view the open relationship and whether it is still a good fit for them.

Appendix VI- Examples of Coding Categories

-NON-MONOGAMY IS THE PROBLEM
- **SUB: MAKE THEM CHANGE**
- **SUB: NOT VIABLE**
- **SUB: UNSUSTAINABLE**
- **SUB: NOT ON SAME PAGE**
- **SUB: POOR/FORCED CLIENT CHOICES**

-RELATIONSHIP STRUCTURE EQUALITY/CLIENT GUIDED
- **SUB: UNDERSTAND THEIR RELATIONSHIP (CURIOUS STANCE)**
- **SUB: INCLUDE CONSIDER OTHER PARTNERS**

-DISSONANCE IN RESPONSE RE: CNM
- **SUB: TOTAL DISSONANCE**
- **SUB: MISCONCEPTIONS**
- **SUB: DISSONANCE WITH CLIENT**

-DEMOGRAPHICS/CONTEXT
- **SUB: SOCIAL LOCATION**
- **SUB: ENVIRONMENT**
- **SUB: PERSONALITY**
- **SUB: INDIVIDUAL MENTAL HEALTH CONCERNS**
- **SUB: VIOLENCE**

-PRESSURE/EXPECTATIONS
- **SUB: PARENTS/FAMILY**
- **SUB: SOCIETAL**

-STRESS
- **SUB: EXTERNAL**
- **SUB: LIFE STAGE**
- **SUB: INDIVIDUAL**

-BOUNDARIES
- **SUB: WITH OTHER PARTNERS**
- **SUB: WITH FAMILY**
- **SUB: WITH EACH OTHER**

-IMPACT OF HISTORY
- **SUB: INTERGENERATIONAL/FAMILY OF ORIGIN**
- **SUB: RELATIONSHIP**
- **SUB: TRAUMA**

-COPING & CONFLICT RESOLUTION
- **SUB: ATTACHMENT**
- **SUB: HX OF TRYING TO SOLVE PROBLEM**
- **SUB: EMOTIONAL REGULATION/PROCESSING**
- **SUB: INTERACTIONAL PATTERNS**

-CONNECTION/INTIMACY
- **SUB: SEXUAL**
- **SUB: TRUST**
- **SUB: EMOTIONAL CONNECTION**

-QUALITY TIME
- **SUB: SHARED ACTIVITIES**
- **SUB: NEW ACTIVITIES**

-COMPATIBILITY
- **SUB: RELATIONSHIP EXPECTATIONS**
- **SUB: VALUES**
- **SUB: GOALS**
- **SUB: ROLES**
- **SUB: SATISFACTION**

-COMMUNICATION
- **SUB: STYLES**
- **SUB: PATTERNS**
- **SUB: LOVE LANGUAGES**
- **SUB: SKILLS**

Appendix VII- Researcher Journal Excerpt

“October 30, 2022

I think I had an important realization today. I encountered a number of struggles while working on this dissertation and my motivation has waxed and waned throughout. However, more recently I have been finding myself having more motivation than I have in a long time and I think I may have realized why.

I have not known how to talk about this, because of the complicated feelings I have about it…My partner and I are in a mono/polyam relationship. Our relationship is open, however when it comes to our individual experiences and approaches, I consider myself to be “polyam-minded”, but functionally monogamous. In other words, while I naturally approach relationships from a “bottom-up” or build-you-own perspective and I conceptually believe and agree that people can love and have intimate relationships with multiple people, I do not think this relationship structure is the one I would ideally choose for myself. A big part of why I am functionally monogamous is that I identify as asexual/grey-asexual/demisexual. I am also queer romantic of some kind, but suspect there is some degree of demi-romanticism in there too. Additionally, my gender identity is also something I’ve been exploring, since I suppose I connect with the cultural (?)/historical/community aspect of womanhood, but I feel disconnected from a lot of aspects of gender expression and the idea of most things being tied to gender at all.

I am still trying to figure out exactly what to call my sexuality, but what I do know is that I am rarely attracted to people in a romantic way and almost never in a sexual way. I did not feel any sexual attraction in my first relationship and I’m not sure I felt any romantic attraction either. So, my current relationship (the only other relationship I’ve had), where I experience both, is sort of an anomaly in my life (in a good way! haha) and I like to say (as I say about monogamy in general) that I am poly-saturated at one. Therefore, I cannot really imagine wanting to ever pursue romantic or sexual relationships outside of my current partnership, not because I think it’s morally bad or impossible, but simply because it seems very unlikely I personally will have that drive.

I do not want to generalize and say non-monogamy is easier when both partners in a dyad are practicing it through exploring other relationships and/or romantic/sexual encounters, but I think it maybe would be for me. My partner is pansexual and genderfluid and while he is demi-romantic, he thinks about and engages in sex very differently than I do. In our open relationship, he occasionally will hook-up with other people, but he is not interested in other long-term committed romantic or sexual relationships. I feel a good amount of shame and guilt about the fact that this is not easy for me and touches on a lot of personal insecurities, many of which stem from my experiences with peers growing up as an asexual person and also social messages about the experiences of asexuality. For instance, my anxiety gremlins sometimes tell me that an allosexual person will naturally have a better connection with another allosexual person because they can connect with each other on a level I cannot. I also have a hard time separating my own experiences of sexuality from the reality of my partner’s conceptualization and experiences.

Despite a lot of reassurance from my partner and overall satisfaction in my relationship, I must admit that this aspect of our dynamic is still challenging to me…which has made me feel

like a fraud or an imposter many times while doing this research. In fact, during times when tensions were high between my partner and I or during times when he was in a setting where he was likely to engage in a sexual interaction with someone else, I found myself completely unable to connect with this research. This disconnect or even avoidance of this research came from both feelings of anxiety, insecurity, and hurt that have come up as I've been navigating my non-monogamous relationship, as well as the feelings of guilt and shame those feelings generated in regard to what they mean for me as a researcher on this topic, a therapist who works with non-monogamous clients, and an overall advocate for consensual non-monogamy.

Today, I realized…or I should say…a slow realization culminated…that for a long time, my partner and I were the only people I knew personally who were engaged in a non-monogamous relationship. Though I chose this topic years ago (2018), I had only really encountered non-monogamy conceptually or indirectly. Upon starting this dissertation, I myself was in an 8-year, monogamous relationship. My current relationship, which I hadn't been expecting, evolved alongside this dissertation. Due to this, the concept of non-monogamy itself was really tied to my own partner relationship. One of my professors always said, "research is me-search", but I had not expected that to be true with this topic…since it essentially "wasn't" when I started.

Today, however, I was reflecting on an event I went to last night (a Halloween night market), which I attended with my partner, two of my best friends, and my one best friend's wife (another friend of mine) and boyfriend. This made me reflect on how my life has changed in the past few months. Back in 2021, when I transitioned out of family crisis work, and into working for a group private practice, I quickly started to build a caseload that included non-monogamous clients. Over time, even clients who were not specifically coming to therapy for the purposes of exploring non-monogamy began to seem comfortable talking about their non-monogamous relationships, and even clients who had never considered the idea before started asking questions about it and asking for resources to learn more (since I advertised non-monogamy as a speciality area). At first I still felt a big disconnect here…as I was well-versed in non-monogamy academically, conceptually, and in terms of professional training, but I was struggling with it in my personal life. However, as time went on and I also started to make new friends and engage in communities where non-monogamy is more commonplace, I not only became more aware of the conceptually non-monogamous part of myself (by seeing how aligned I felt in these conversations and interactions), but I also started to uncouple (ha!) the concept of non-monogamy with JUST my own relationship, simply from being exposed to more people who were talking about, exploring, or practicing this relationship structure. I experienced more variety in regard to non-monogamy shapes and forms in "real-life" and not just in the pages of books, journals, and workshop slides. Non-monogamy finally felt like a more integrated part of my life and I felt like a very different therapist in this regard when I started my own practice (which I've been doing full-time for about a week or so now!)

I think all of this has helped me feel more motivated to engage in this research because I am asking these research questions for the benefit of myself, my partner, AND my clients, my friends, and everyone/anyone else like them. I have both witnessed and personally experienced the impact exposure and understanding can have and it has reinvigorated my drive to understand the role therapists have been or could be playing in this. Working with my own clients has opened my eyes to just how big of a need area it is to have CNM-inclusive and knowledgeable therapists. I learned this through my own search for a therapist and through being surprised at

just how often CNM comes up in my clinical practice, when given the space. I knew a lot of this from working on this research, but even I was not expecting CNM to come up as often as it does in both my work and my world."