A Study of Consensual Nonmonogamy Stigma in Healthcare

By

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Abstract

Consensual nonmonogamy (CNM) is a relationship type that involves multiple partners, be they sexual, romantic, or intimate, where all those involved are aware of, consent to, and have access to multiple partnerships. Consensual nonmonogamists, those who practice CNM, experience stigma on personal, relational and institutional levels, including in counselling. This review addresses CNM stigma in counselling by exploring how the literature on CNM stigma can inform counsellors' professional practice with consensual nonmonogamist clients.

A narrative literature review of 11 qualitative and mixed methods studies was performed, including a methodological critique. Four main themes emerged: stigma: living in a mononormative world, responses from healthcare providers, client strategies to navigate stigma, and suggestions for clinicians. The results of this review indicate that counsellors and therapists perpetuate mononormativity through stigmatizing practices, such as pathologizing CNM. Based on these results, including suggestions from research participants, a framework for counselling CNM clients is presented, entitled CNM-Affirming Clinician Practices.

Keywords: *consensual nonmonogamy, polyamory, swinging, open relationships, stigma, discrimination, counselling, therapy, healthcare*

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Chapter One: Introduction

Consensual nonmonogamy (CNM) is a relationship type that involves multiple partners, be they sexual, romantic, or intimate, where all those involved are aware of, consent to, and have access to multiple partnerships (Carlström & Andersson, 2019; Haupert et al., 2017). Those who practice CNM often experience stigma in their daily lives in multiple contexts, including social, legal, economic, and institutional (Klesse, 2019; Stults et al., 2022). The prevalence of CNM stigma is significant. For example, 26-43% of people in polyamorous relationships report having experienced it (Mogilski et al., 2023). Sexual minority stigma has been associated with negative impacts on mental, physical, and relational health (Doyle & Molix, 2015; Lick et al., 2013; Meyer, 2003a, b).

This literature review addresses CNM stigma in healthcare contexts, including counselling. This introductory chapter begins with background information on CNM and stigma, including relevant terminology, prevalence, and a brief overview on the topic based on the literature explored. This will be followed by the research problem, question, and significance, as well as counselling applications, the theoretical framework, and my reflections on biases. Finally, this chapter will conclude with an overview of this project.

CNM Prevalence

The data on CNM indicates that 4-5% of the population currently partake in this relationship structure (Fairbrother et al., 2019; Levine et al., 2018; Rubel & Burleigh, 2020). Lifetime prevalence data indicates about 20% of the general population have tried CNM at some point (Fairbrother et al., 2019; Haupert et al., 2017). Boyd's (2017) study on the demographics of polyamorists in Canada reveal that this population is younger, more educated, and has a higher socioeconomic status (SES) than the national norm. In Stephens' (2020) more recent study on

emerging adults' attitudes, identities, and orientations regarding CNM, nearly 48% of participants reported an orientation that is nonmonogamous. Further, there has been a surge in interest in CNM, as evidenced by an exponential increase in internet searches on CNM in recent years (Moors et al., 2017) as well as multiple books, blogs, podcasts, social media groups, and TV shows like "Poly" (Moukarbel, 2022). Whether the increase is representative of a higher level of interest or of a more welcoming culture in which one can claim their CNM status is unknown. What is known is that stigma toward this population abounds and requires attention from the public and clinicians (Tweedy, 2011).

Research Problem

Consensual nonmonogamists face stigma in social, legal, economic, and institutional contexts (Klesse, 2019; Stults et al., 2022). Marriage, filiation, cohabitation, zoning, and custody laws maintain compulsory monogamy, while criminalizing CNM behaviours by labeling them as "adultery" (Emens, 2004). Positivist studies on laypeople's view of CNM reveal that consensual nonmonogamists are often judged as vicious, promiscuous, or perverted (Table et al., 2017), and less trustworthy (Stults et al., 2022). Their relationships can be perceived as less sexually satisfying, less committed, less moral, at a higher risk sexually, and more harmful to children, although these perceptions are not corroborated by evidence (Conley, Moors, et al., 2013; Conley, Ziegler, et al., 2013; Grunt-Mejer & Campbell, 2016; Stults et al., 2022; Rodrigues et al., 2018). Compared with people in CNM relationships, those who are in monogamous relationships are rated higher on traits which are irrelevant to relationship style, such as intelligence, reliability as a dog-walker**,** and taxpayer (Conley, Moors, et al., 2013; Grunt-Mejer & Campbell, 2016).

Qualitative studies rooted in constructivist frameworks reveal polyamorists' experiences of stigma through narrative, phenomenological, and ethnographic lenses. Themes such as discrimination in health, employment, familial, and friend contexts (Rodríguez-Castro et al, 2022); loss of resources; character devaluation and experiencing threatening behaviours (Mahar et al., 2022); and invisibility (Rodríguez-Castro et al, 2022; Sandbakken et al., 2022) reveal parallels to quantitative study findings (Conley, Moors, et al., 2013; Conley, Ziegler, et al., 2013; Grunt-Mejer & Campbell, 2016; Stults et al., 2022; Rodrigues et al., 2018; Table et al., 2017).

Many polyamorous families report unsupportive responses from their families of origin, such as rejection of family members, partners and/or parenting choices, as well as interference in child custody agreements. In some cases, polyamorous family members are cast out completely (Klesse, 2019; Sheff, 2014). The effects of stigmatization on children are especially distressing for polyamorous parents (Klesse, 2019). The challenges that children from polyamorous families face include being in a non-normative family, making friends, bullying, and being forcefully removed from their parents (Klesse, 2019; Sheff, 2010; Sheff, 2014).

In health care contexts, providers lack knowledge about CNM (McCrosky, 2015). CNM women have reported experiencing judgement and inappropriate comments about their sexual behaviour as well as treatment provision refusal. They have also reported requests from their healthcare providers not to return for further care, resulting in searching for other providers or avoiding receiving essential care (McCrosky, 2015). Weber (2002) found that 38% of those who practice CNM hid their relationship style from their mental health care provider due to fear of stigmatization while 10% who disclosed reported a negative reaction from the provider. Health professionals, including counsellors, are undereducated and undertrained in how to treat consensual nonmonogamists. Therefore, this population is not getting the health care it requires

(Haupert et al., 2017). Thus, this review will explore the research question, how can the literature on consensual nonmonogamy stigma inform counsellors' professional practice with consensual nonmonogamists?

Research Justification & Significance

There are several reasons which corroborate the need for CNM stigma research for counsellors. First, the dearth of research on this topic calls for a more robust knowledge base on this population (Klesse, 2019). Research on CNM can increase our understanding, provide evidence when advocating for this population, dispel myths, improve healthcare, and ideally, decrease stigmatization. Research on stigma can increase an understanding of contemporary relational practices and the needs of those with marginalized identities (Katz & Graham, 2020). As there is little research on CNM experiences in general, there is even less on CNM stigma and how it affects consensual nonmonogamists' day to day lives, relationships, therapeutic relationships, and mental health. More rigorous data on these experiences could help counsellors better understand this population and therefore provide better care.

Second, likely as a consequence of the first point, consensual nonmonogamists are poorly understood by both the public and larger institutions such as those that provide health and legal services, leading to inappropriate and inadequate care (Cardoso et al., 2020). There is a perception that CNM is inferior to monogamy, which has led to fewer rights in realms such as marriage, adoption, and parenting, and discrimination in consensual nonmonogamists' everyday lives (Pallotta-Chiarolli, 2020; Tweedy, 2011).

Third, counsellors might not have adequate knowledge and skills for providing care to consensual nonmonogamists (Haupert et al., 2017). As a result, consensual nonmonogamists commonly experience discrimination and prejudice in the counselling room (Vaughan et al.,

2019), perpetuating some of the very issues for which they are seeking counselling. While knowledge of CNM exists, the differences in lifestyles, practices, constellations, culture and experiences vary widely. If counsellors were more aware of these factors, their competence could increase and their biases could decrease, thereby minimizing harm and improving therapy outcomes (Woodbridge, 2022). By offering a clearer picture of CNM experiences shared via consensual nonmonogamists' own narratives, this research could provide the most recent theories and interventions in the literature and offer suggestions for future research in the counselling field. Further, as a result of this work, counsellors could have a better understanding of how to empower CNM clients, normalize their experiences, and engage in advocacy (Sprott et al., 2017).

Fourth, in the beginning stages of CNM research, most studies were limited to the United States. More recently, research spanning multiple countries, such as Sweden, Poland, The Netherlands, Spain, and Norway, has been published, creating an opportunity for a cross-cultural examination of qualitative experiences of CNM stigma (Carlström & Andersson, 2019; Grunt-Meyer & Łyś, 2022; Rodríguez-Castro et al, 2022; Roodsaz, 2022; Sandbakken et al., 2022). Similarities and differences in CNM experiences from different countries can inform a more culturally sensitive and culturally aware approach to serving this population (Grigoropoulos et al., 2023).

Theoretical Frameworks: Minority Stress Theory and Queer Theory

Minority Stress Theory

Minority stress refers to the stress that stigmatized minority group members face that exceeds the level of stress experienced by the broader population (Witherspoon & Theodore, 2021). Minority stress theory, developed by Meyer (2003b), proposes that those with stigmatized

identities, such those in the LGBTQ community, face additional stressors due to being in a minority group. Their heightened stress is associated with an increase in both mental and physical health problems (Meyer, 2003b).

Applying Meyer's (2003b) and Earnshaw and Chaudoir's (2009) interpretations of stigma, Stults and colleagues (2022) propose that there are three forms of CNM stigma: enacted, anticipated (which are both interpersonal), and internalized (which is intrapersonal). Enacted stigma refers to experienced prejudice and discrimination, while anticipated stigma refers to an expectation of experiencing prejudice and discrimination in the future. Internalized stigma denotes an internalization of negative beliefs concerning the stigmatized attributes that consensual nonmonogamists embody (Stults et al., 2022). As minority stress theory predicts, adverse health effects, such as chronic stress (Link & Phelan, 2006), decreased self-esteem, and poorer self-reported health conditions (Lehmiller, 2012) are linked with the stigmatization that consensual nonmonogamists face.

Given minority stress theory's focus on the effects of stigma on mental health, minority stress theory can be considered an appropriate lens through which to explore how the literature on minority stigma (in this case, CNM stigma) can inform counsellors' professional practice. Minority stress theory accounts for minority stress in general, that is, the stress one experiences as a result of being a member of a minority group. It does not, however, account for the unique experiences of stress individuals may experience due to being a part of a specific minority group. Therefore, to account for this limitation, this literature review also employs queer theory as a theoretical lens through which to examine CNM stigma and to inform counsellors' work with consensual nonmonogamists.

Queer Theory

Queer theory emerged in the 1990s, influenced by the gay rights movement and women of colour feminist movement (Hagai & Zurbriggen, 2022). The theory questions social constructs by deconstructing and dismantling binaries that marginalize people who do not fit into such binaries, such as man/woman and heterosexual/homosexual (Browne & Nash, 2016; Meyer et al., 2022). Queer theory focuses on "deviant" cases that do not fit into normative constructions of gender, sex, and sexuality (Browne & Nash, 2016; Hagai & Zurbriggen, 2022). Further, queer theory promotes the idea that sexual identity can manifest in different ways, is unstable, and ever-evolving (Hagai & Zurbriggen, 2022). Queer theory aims to challenge and deconstruct normative narratives by confronting social hierarchies and inequalities. While rooted in LGBTQ2S+ studies and feminism, it is appropriate in any critical context of normative ideas and expectations (Falardeau, 2022). This applies to CNM. "To the extent that queer is defined as a rejection of what is normative, in a mononormative world, polyamory is queer" (Schippers, 2020, p. 71). Queer identities deviate from the normative to an extent that social, legal and/or political systems oppose and condemn them, creating "hierarchies of shame" (p. 557). Privileging monogamous relationships creates unjust social and psychological contexts where nonmonogamous relationships are invisible, unsanctioned, disparaged, or devalued (Hammack et al., 2019). Both societal stigma and the oft-resultant internalized stigma that nonnormative populations such as consensual nonmonogamists face, places this population at risk for health inequities and injustice (Hammack et al., 2019).

Queer theory conceptualizes stigma toward CNM as rooted in and perpetuated by heteronormativity, the view that real love and natural sex can only be achieved through the union of a cisgender woman and a cisgender man, and mononormativity, the idea that true relationships involve a close bond between two adults (Klesse et al., 2022). Both heteronormativity and

mononormativity maintain the idea that monogamy is necessary, obvious, and the only legitimate relationship practice (Sheff, 2020). In this way, relationships and sexual behaviour that resist majority culture norms are considered unnatural and unwanted (Grigoropoulos et al., 2023). In concordance with queer theory, this review is meant to explore and ultimately question heteronormativity and mononormativity (Falardeau, 2022).

The literature reveals corollary experiences of discrimination and stigma between LGBTQ populations and consensual nonmonogamists. This is not surprising since there is significant overlap between the two as many consensual nonmonogamists identify as LGBTQ (Stults et al., 2022). Queer theory exposes these parallels by highlighting the shared experiences of social, legal, and familial inequities. Examples include living a closeted life, where one cannot reveal their relationship identity or style to the people in their lives as well as the coming out process, where the relationship style is revealed to those outside of the relationship (Rodríguez-Castro et al., 2022; Sandbakken et al., 2022). Many polyamorists report that coming out can lead to the loss of familial and friend relationships, housing, jobs, and even child custody (Moors et al, 2021). While many strides have been made in the gay rights movement, CNM rights lag far behind. Consensual nonmonogamists have yet to achieve equal rights to monogamists. They have no legal protection when it comes to employment, housing, childcare, and marriage (Pérez Navarro, 2017). In summary, queer theory could increase the depth at which one conceptualizes and understands CNM stigma as a specific type of the more general minority stigma acknowledged by minority stress theory. A deeper understanding of minority stigma, and CNM stigma specifically, could inform counsellors' professional practice with consensual nonmonogamists.

Key Terms

Consensual Nonmonogamy (CNM) is a relationship type that involves multiple partners, be they sexual, romantic, or intimate, where all those involved are aware of, consent to, and have access to multiple partnerships (Carlström & Andersson, 2019; Haupert et al., 2017). In these types of relationships, participants advocate for honest communication as well as adherence to previously established agreements regarding involvement with others. When agreements are violated, infidelity occurs (Hangen et al., 2020).

Polyamory, or *poly*, is a relationship style or orientation wherein two or more people engage in relationships that entail a combination of emotional, romantic, and/or sexual intimacy (Carlström & Andersson, 2019). Polyamory is a combination of the Greek word for "many" and the Latin word for "love," literally meaning "many loves" (Rodríguez-Castro et al, 2022; Tweedy, 2011). van Anders (2015) defines it as "the desire for or state of having multiple loving relationships" (p. 168). It is a subset of the umbrella category consensual nonmonogamy (CNM).

Polygyny, polyandry, and polygamy The differentiation of CNM from *polygyny, polyandry, and polygamy* is important to note. Polygyny and polyandry refer to only men or women who have more than one partner, respectively (Carlström & Andersson, 2019). Polygamy refers to plural marriage, regardless of gender (Matsumura, 2021).

In addition to polyamory, other relationship types included in the CNM category are swinging, also known as *the lifestyle,* open relationships, and relationship anarchy. *Swinging* involves couples, who are often married, swapping partners for sexual purposes (Brooks et al., 2022). *Open relationships* tend to focus more on a primary relationship that entails romantic and emotional exclusivity paired with an agreement that each member of the couple has the freedom to explore sexual intimacy outside of the relationship (Hammack et al., 2019). *Relationship anarchy* is a non-hierarchical relationship orientation or style which rejects ranking romantic,

sexual, romantic-sexual or platonic relationships (Nordgren, 2012; De las Heras Gómez, 2018). It is a "philosophy that questions the idea of love as a limited resource that only becomes authentic if it is confined to one person" (De las Heras Gómez, 2018, p. 475). Polyamory, however, often involves sharing intimacy in the emotional, romantic, sexual, and relational facets of life, which can include cohabitating and raising children (Klesse, 2019).

Types of CNM relationships are diverse; for some, practicing CNM may mean having a primary partner with whom they share the majority of their time and resources, while they may have secondary or tertiary partners (Rodríguez-Castro et al., 2022). Others, especially those who practice polyamory, may choose non-hierarchical structures, where partners may share their time, resources, and decision-making power equally (Sheff, 2014). *Polyamory constellations*, or groupings, consist of the following formations: couples; throuples or triads, groupings of three people; vees, where one person is dating two people who do not date each other; and quads, groupings of four. A polyamorous relationship consisting of five or more people is called a *moresome* (Rodríguez-Castro et al., 2022). A *polycule* is a network of people who are associated through polyamorous relationships (Creation, 2019). Some polyamorous relationships may solely involve emotional intimacy without sexual involvement; these are termed *polyaffective* (Sheff, 2014). When a polyamorous constellation is exclusive and does not date outside of itself, this is termed *polyfidelity.* Whatever the structure, CNM provides the opportunity to explore levels of intimacy with multiple people that is not often afforded in monogamy (Manley et al., 2015).

Stigma can be defined as "a confluence of beliefs, attitudes, and behaviours that together function to identify, devalue, and harm people who possess specific undesirable characteristics or engage in deviant patterns of behaviour" (Mahar et al., 2002, p. 1). Stults et al. (2022) define

CNM stigma as "stigma stemming from a person's involvement in a CNM relationship and/or their endorsement of a CNM identity" (p. 2).

Researcher Positionality

As a researcher, it is important to position oneself so that experiences and potential biases can be brought to light, and bracketed (Creswell & Poth, 2018). The topic of CNM stigma is both professional and personal for me. As a student, I have researched polyamory for several projects throughout my master's program. In my counselling practicum placements, I work with CNM individuals, couples, and groupings, and have heard of the challenges they face, including discrimination and prejudice. I also run an online support group for polyamorists, have facilitated workshops, and have been a panelist at community events. Personally, I have been engaging in different iterations of polyamorous relationships, either in theory or in practice, for seventeen years, and have been raising a child in a polyamorous family. I read CNM books, listen to CNM podcasts, and engage in CNM media content. All these experiences have led to my own personal schema of what CNM is, is not, and what it "should" be. My biases relevant to this research project include my own personal journey of CNM in general, the stigma I have encountered from friends, community, the media, and society, as well as the stigma that I have witnessed in my community. I am aware that these experiences influence me to a large extent. Further, interpreting CNM as a healthy, joyous, fulfilling, and worthwhile practice can impede objectivity when I do research.

To distance myself from these experiences and their resultant biases, I put my experiences aside, viewing the research from a fresh perspective. In my searches, I used keywords which oppose my views, such as *CNM* and *lack of stigma* or *no stigma*, or *CNM* and

harmful. Consulting with my supervisor was another strategy I used to help ensure a more objective lens.

Capstone Overview

The remainder of this project consists of 4 additional chapters. Chapter 2 will explicate the methodological process of the literature review. Chapter 3 will encompass the literature review, Chapter 4 will explore counselling implications, and the fifth chapter will draw conclusions and make recommendations based on the findings of the literature review.

Chapter 2: Methodology

Literature Search Process

Originally, the intention of this review was to explore the stigma experiences of the polyamorous population in counselling. The initial search terms included *polyamory, polyamorous, stigmatization, stigma, discrimination, counselling*, and *therapy*. Due to the dearth of research on this topic, the population was expanded to consensual nonmonogamists, and the stigma experiences were expanded to health care contexts, which included counselling, therapy, and medical contexts. In ensuing searches, reflecting this expansion, I included the terms *nonmonogamy*, or *non-monogamy*, or *non-monogamous*, or *consensual nonmonogamy*, *consensual non-monogamy*, or *ethical nonmonogamy*, or *ethical non-monogamy*, and *stigmatization*, or *stigma* or *discrimination* and *counselling* or *therapy* or *mental health* or *health care*.

Literature was collected using multiple databases via the City University Library. Psychology and Behavioral Sciences Collection yielded eight articles, PsycInfo + PsycArticles generated 132, Mental Health and Social Care Collection yielded none, PubMed yielded 40, and SAGE Premier yielded 129 articles. I made a second search attempt in the Mental Health and Social Care Collection, using only the search terms *consensual nonmonogamy* and *stigma* or *discrimination* which yielded 15 articles.

Since there is no database that incorporates an exhaustive collection of published articles, a systematic search was conducted using Google Scholar (Xiao and Watson, 2019), generating a total of 179 results from several databases. Relevant articles were pulled from Springer, Taylor and Francis, and Wiley Online Library databases. The most relevant articles were found via a

snowball effect, where citations in some studies found via the search process were used to expand the sources (i.e., studies) relevant to the research question (Efron & Ravid, 2019).

To decrease potential biases, other searches with words such as *polyamory, consensual nonmonogamy, harmful, problematic,* and *unhealthy* were performed. These searches resulted in articles which referred to the harm that consensual nonmonogamists experience from others as a result of their CNM status. I did not find any studies which referred to the practice of CNM itself causing harm to individuals.

Inclusion and Exclusion Criteria

Inclusion criteria for the initial search were articles that included the initial search terms mentioned above, were peer reviewed, had approval from an ethics board, and were published in the years 2019 to 2023. No limitations were placed on country or language of publication as my intention for this project was to illustrate a cross-cultural perspective. Exclusion criteria for articles were any that were not peer reviewed or had not mentioned receiving ethical approval. Upon reviewing the articles found via the second search, further inclusion and exclusion criteria were applied. Articles irrelevant to the research topic were excluded. Examples of such studies included those on the LGBTQ2S+ population, infidelity, and anal fisting. Poorly written and/or poorly translated studies were excluded.

As a result of the low number of relevant articles remaining once the inclusion and exclusion criteria were applied, and due to the desire to focus primarily on counselling and therapy contexts, two aspects of inclusion criteria were expanded to meet the required number of ten articles. First, the beginning year in the date range of studies was extended from 2019 to 2016, resulting in total range of 2016-2023. Despite this challenge, nine of the eleven articles in this review were published between 2019 and 2023. The two exceptions were published in 2018

(Schechinger et al., 2018) and 2016 (Henrich & Trawinski, 2016). These were included since they involved consensual nonmonogamists' stigma experiences specific to therapy. Second, an ethics board approval was no longer necessary to be included, since three pertinent articles (Grunt-Mejer & Łyś, 2022; Henrich & Trawinski, 2016; Valadez et al., 2020) did not report one. Again, these articles were included due to their exploration of CNM stigma in therapeutic contexts.

Since this review aims to amplify the voices of a minority population and their experience of oppression by the majority, the research paradigm is pragmatist. Eight of the eleven studies were qualitative, while the remaining three were mixed methods. As mentioned, mixed methods studies contain a qualitative component. The objective, detached stance of the quantitative researcher is antithetical to developing the level of trust required to explore sensitive and vulnerable topics such as stigma (Xiong, 2022). Thus, quantitative studies were excluded.

Data Analysis

Bingham's (2023) qualitative analysis process was performed to analyze the data in this review. Bingham's (2023) process, which can be implemented partially or fully, consists of five phases and can be used for deductive analysis, inductive analysis or a combination of both. Deductive analysis involves sorting data into preexisting categories that were generated in previous literature, while inductive analysis involves generating emergent codes and themes as the researcher explores the data (Bingham, 2023). In addition to the five phases, Bingham's (2023) process includes memoing, where one records thoughts and notes throughout the research process. Memoing can provide evidence for the analysis, contributing to trustworthiness (Bingham, 2023). Trustworthiness involves attempting to persuade oneself and others that one's research findings are acceptable, useful and worthy of attention (Nowell et al., 2017).

The three phases of Bingham's (2023) process that I implemented are as follows: *organizing the data, sorting the data into relevant categories*, and *identifying themes and findings*. In the case of this review, I used deductive analysis. First, to organize the data, I created a document which listed all the (relevant to my research question) themes and subthemes generated by the researchers in the 11 studies in this review. Next, I sorted the data into relevant categories. For example, the themes lack of knowledge (Campbell et al., 2023; Carlström & Andersson, 2019), lack of competence (Carlström & Andersson, 2019), insufficient knowledge (Henrich & Trawinski, 2016), lack of education (Swindlehurst et al., 2023), and ignorance (Vaughan, et al., 2019) were sorted into one category. Occasionally, data from a study aligned with a theme that was named in another study, despite not having been named as such in the former study. In cases such as this, I categorized the data accordingly by placing it within the relevant thematic category. In the final phase, *identifying themes and findings*, I chose a theme for each category. In many cases, themes were inspired by a pre-existing theme (from the literature) within that category. For example, for the list earlier in this paragraph, I gleaned the theme, *lack of CNM competence*. Throughout the three stages of data analysis, I implemented memoing, which included reflections and questions on the meaning of the data as well as how the data could answer the research question (Bingham, 2023).

Challenges

Including those mentioned above, other challenges arose during the research process. In the literature, there is no clear nor agreed-upon definition of consensual nonmonogamy, nor of the terms which fall under the CNM umbrella. CNM encompasses a myriad of relationship structures. Researchers tend to conglomerate all or multiple structures, including polyamory, swinging, and open relationships in studies on consensual nonmonogamy. Most of the studies in

the search included a minimum of two types of CNM even when the title indicated the study was on one type of CNM, such as polyamory. Furthermore, academic research on CNM is sparse, therefore, the quality and quantity of studies on CNM and counselling are even more limited.

Chapter 3: Literature Review

This literature review focuses on the stigma that consensual nonmonogamists face, particularly in the context of counselling. Examining 11 peer-reviewed studies spanning the last eight years, this review will delve into the research question, how can the literature on consensual nonmonogamy stigma inform counsellors' professional practice with consensual nonmonogamists?

This chapter explores the themes that emerged from the data analysis process described earlier. A brief overview of each study is provided throughout this chapter to give the reader foundational information to conceptualize and ultimately understand the themes in this review. After the exploration of themes, this chapter includes a methodological critique of the eleven studies reviewed, followed by ethical considerations.

In total, four main themes and seventeen subthemes arose from this review's data analysis (see Appendix, Table 1). The main themes are as follows: stigma: living in a mononormative world, responses from healthcare providers, client strategies to navigate stigma, and suggestions for clinicians. From the first major theme, stigma: living in a mononormative world, the types of stigma that CNM practitioners experience arose as subthemes. These include institutionalized stigma, internalized stigma, individual stigma, relationship stigma, and anticipated stigma. The second major theme, responses from health care providers, includes the subthemes of negative responses and positive responses. The subtheme negative responses includes the following subthemes: questioning, dismissing, being judgmental, focusing too much or too little on CNM, lack of clinician competence, and pathologization. The theme, positive responses, a subtheme of responses from healthcare providers, includes helpful practices, receiving CNM-inclusive care, and having poly-aware therapists. The third major theme, client

strategies to navigate stigma, includes the subthemes of concealment, disclosure, and seeking CNM-inclusive providers. The fourth and final main theme is suggestions for clinicians, with its subtheme acknowledge, accommodate, ally.

Stigma: Living in a Mononormative World

Heteronormativity denotes a gender binary, with only man and woman, where heterosexual desire is presumed, given power, and enforced by institutions (Valera et al., 2016). Holding hands with heteronormativity, mononormativity denotes an assumption that monogamy, being with solely one person romantically, emotionally, and sexually, is the de facto way of relating (Füllgrabe & Smith, 2023). In other words, when one thinks of romantic relationships, their schema is often a man and a woman who exclusively relate with each other. In dominant North American and Western culture, heteronormativity and mononormativity prevail, as they are associated with moral and natural superiority (Füllgrabe & Smith, 2023; Sandbakken et al., 2022). Anything outside of these are considered indecent and corrupt (i.e., stigmatized, leading to shame and social isolation; Montali et al., 2023). Resistance to mononormativity, such as engaging in CNM, often leads to backlash and opposition (Valadez et al., 2020); mononormativity therefore perpetuates stigma (Day et al., 2011). In the studies reviewed, five types of CNM stigma arose: institutionalized, internalized, individual, relationship, and anticipated. These align with the types of stigma delineated by Meyer's (2003b) minority stress theory and by Stults et al.'s (2022) study on CNM stigma: enacted, internalized, and anticipated stigma. Institutionalized, individual and relationship stigma fall into the category of enacted stigma. This theme explicates the types of stigma that consensual nonmonogamists face and brings attention to their everyday experiences of oppression by heteronormative and mononormative systems.

Institutionalized Stigma

Institutional systems maintain policies that reflect and perpetuate negative attitudes and beliefs toward stigmatized individuals and groups – this is institutionalized stigma (Subu et al., 2021). In seven of the studies in this review, those who practice CNM reported instances of institutional stigma; that is, stigma on a societal scale (Arseneau et al., 2019; Henrich & Trawinski, 2016; Kisler & Lock, 2019; O'Byrne & Haines, 2021; Swindlehurst et al., 2023; Valadez et al., 2020).

Participants in Henrich and Trawinski's (2016) study reported institutional stigma. Henrich and Trawinski (2016) conducted qualitative, phenomenological, and autophenomenological research on the social and therapeutic challenges that polyamorous therapy clients face. In the study, 12 participants representing six different relationship configurations participated in 90-minute semi-structured interviews that asked about participants' lived experiences of polyamory. The participants reported no legal protection regarding property, inheritance, child custody, and hospital visitation – all instances of institutional stigma. Other practical challenges reported include marriage laws, getting family memberships at gyms, and teachers "squirming" (p. 389) when three parents showed up for parent-teacher interviews (Henrich & Trawinski, 2016). As one respondent, a 50-year-old woman, indicated, "The culture … does not accept us [which] takes some joy away from our life together … the most insidious way is the…pervasive subtleties that…keep a kind of exuberance out of our relationship.…It is a big obstacle... Without that really deep acceptance from the culture, we are just not free" (Henrich & Trawinski, 2016; p. 382). This marginalization manifests in covert messaging and institutionalized discrimination, which can then lead to internalized oppression or stigma (Henrich & Trawinski, 2016). The researchers gleaned themes

related to personal identity, social challenges, and therapeutic challenges. The therapeutic challenges included insufficient clinician knowledge on polyamory, client marginalization, and therapist bias. The results of this study must be considered with caution as the participants were from either a polyamorous support group led by one of the authors, the authors' former psychotherapy practice, were the partners of people in these two groups, or were the partners of the authors. Additionally, interviews took place in one of the author's therapy office. These factors indicate potential for bias as well as ethical concerns. The Canadian Psychological Association (CPA), in their ethical code for psychologists, suggest avoiding dual or multiple relationships with therapy clients and research participants (CPA, 2017). They caution that dual relationships can contribute to bias and risk of exploitation (CPA, 2017). The authors acknowledge these ethical concerns, openly discussing their own biases and the potential of participants' responses having been influenced by their dual or multiple relationships with the author(s). Despite these shortcomings, this study contributes to the dearth of research on the therapeutic challenges faced by consensual nonmonogamists, isolating three problems: therapist bias, lack of knowledge, and client marginalization via institutional stigmatization.

Vaughan et al. (2019) also found experiences of institutional stigma in their sample, specifically in healthcare. In focus groups, Vaughan et al. (2019) examined CNM experiences and needs in healthcare. Twenty self-identified or currently practicing CNM adults were recruited through a midwestern polyamory themed organization via in-person announcements on the study at one of the group's meetings. The researchers asked four semi-structured interview questions eliciting responses regarding healthcare needs, how and when participants attempt to get their healthcare needs met, experiences with health care practitioners, factors impacting disclosure of CNM status, and recommendations and needs from health care providers. The

researchers asked participants about the number of partners in their relationship. This is important because it adds nuance often missing in the demographic and relationship structure details of participants' CNM experience in studies. This study also represented diversity in sexual identities in their participant population. Like many of the studies in this review, participants were predominantly white (85%) and middle class (42%). The majority were college educated (90%) and cisgender (90%), leaving minority voices underrepresented. While the study was conducted on CNM as a whole, recruitment was done only through a poly organization, with 85% of participants identifying as poly. Themes which emerged were ignorance of CNM, pressure to educate providers, inadequate preventative health screening, sexual stigma, stigma reactions, stigma avoidance efforts, and CNM-inclusive care, which included open mindedness, acceptance, and meeting healthcare needs and requests (Vaughan, et al., 2019). The researchers did not report the percentages of participants who shared each theme. The findings of this study highlight the challenges experienced by the CNM population of addressing their own healthcare needs, lack of clinician competence, and stigma in healthcare contexts (i.e., institutional stigma), which impact both client health and client trust in the healthcare system. It illuminates the minority stress effects of mononormativity and stigma in healthcare experiences. For example, participants reported attempting to promote their health through collaborative relationships with clinicians, yet these attempts were met with mononormativity and stigma by clinicians. As a result, relationships with clinicians and therefore the potential benefits participants were supposed to receive from their services were compromised. This study points to the need for education, cultural humility, and inclusive practices in clinicians (Vaughan, et al., 2019).

Similarly, Campbell et al. (2023) conducted a mixed methods study on consensual nonmonogamists' sexual health care experiences and found institutional stigma as an experience

reported by their participants. Using snowball sampling on the researchers' personal social media networks (Twitter, Facebook and Instagram), 67 participants were recruited for this study. The sample was predominantly middle class (67%), aged 33-44 (57%), university educated (88%), and poly (48%), and identified as cisgender women (54%), bi/pan (67%), white (90%), and British (57%). This sample was cross-continental, with participants living in the UK (76%), North America (15%), Europe (7.5%), and Australia (1.5%). The researchers used two subscales to measure trust in health care providers and asked open-ended qualitative questions which examined disclosure of CNM status to healthcare professionals, clinician reactions to said disclosure, healthcare provider practices that were done well or needed improvement, and community perceptions. The results of this study found participants describing experiences of being proudly out on one hand to staying closeted on another. They also described clinicians' responses such as lack of knowledge, benign or malignant curiosity, blatant stigma, and withholding of treatment. Like Vaughan et al. (2019), the researchers found that their sample had low trust in clinicians. In terms of limitations, the sample was predominantly white, middle class, and highly educated. Despite having a multicontinental sample, there was no commentary on cultural differences. Additionally, the researchers used their personal social media networks for recruitment, making room for bias and difficulty generalizing. There was no member checking, a process where researchers acquire participants' perspectives on the credibility of the findings, thereby enhancing confidence in the analysis of the data (Creswell & Poth, 2018). When member checking is not present, researcher misinterpretations can be overlooked or perpetuated. Despite these limitations, this study provides examples of institutional stigma perpetuated by providers at healthcare institutions, including sexual healthcare providers, healthcare professionals, general physicians, clinicians, and doctors (Campbell et al., 2023).

In the same vein, O'Byrne and Haines (2021) conducted a qualitative study with the aim to understand CNM and relate these findings to healthcare. Their participants also reported instances of institutional stigma. Participants had to be at least 17 years of age and have both a primary and secondary partner(s). There were 14 participants in total; seven males and seven females, aged 24-50. Five participants identified as swingers, six as in an open relationship, and three did not wish to label their relationship. In semi-structured interviews, the researchers asked about identity, CNM perceptions, relationship and sexual dynamics, and desires. Using an adapted form of grounded theory, they coded and arranged their findings into narrative explications of the data. This is another study that did not ask directly about stigma, yet thematically, stigma from society (i.e., institutional stigma), including healthcare providers, arose. Participants shared that upon disclosure of their CNM status, their healthcare providers perceived them differently. One example was that of a doctor looking at a participant "strangely" (O'Byrne & Haines, 2021, p. 142). Another participant stated, "[Consensual nonmonogamists] are regular people with family, wanting to have some good clean fun. They're usually very well brought up. Couples with good family lives, good careers. They come from good places" (O'Byrne & Haines, 2021, p. 141). These statements identify consensual nonmonogamists' struggle with not being perceived as regular people by healthcare providers, resulting in institutional stigma. While this study contributes to the literature on stigma, it assumed hierarchy, using primary/secondary language for partners, it used only swingers' clubs and sexually transmitted infection (STI) clinics for recruitment, and there were no ineligible participants. These factors promote bias and limit generalizability.

Internalized Stigma

Internalized stigma denotes an internalization of negative beliefs concerning the stigmatized attributes that consensual nonmonogamists embody (Stults et al., 2022). This type of stigma was reported in two of the studies in this review (Henrich & Trawinski, 2016; Valadez et al., 2020). In Henrich & Trawinski's (2016) study, difficulty coming to terms with being nonnormative and what that means was a challenge for participants, including feeling pressure to pursue monogamy over nonmonogamy, denoting internalized stigma.

Valadez and colleagues' (2020) work investigated both stigma and disclosure among those who practice CNM, and found their participants experienced internalized stigma. Their sample consisted of eight people: five were in open relationships, two were swingers, and one was polyamorous. To be included in the study, participants had to identify as being or having been in a CNM relationship. Participants were aged 25-62, with a mean age of 36.50. Participants answered demographic questions, followed by open-ended questions about important events in their CNM relationships and the emotions associated therewith. Supplemental questions were used to help expand answers but did not specifically ask about stigma or disclosure. The demographic information reported was limited to gender, sexual orientation, age, and relationship type. All participants identified as cisgender, limiting gender diversity. Race, ethnicity, education, socioeconomic status, ability, and religion were not reported. Findings indicated that seven out of eight of the respondents considered CNM to be stigmatized. Valadez et al. (2020) reported on the experience of a 25-year-old bisexual female in their qualitative study: she said, "... the voices in my head say, 'oh you're being a slut. You just want an excuse to do that" (p. 154). Societal messages regarding what is normal and what is deviant can lead to internalized narratives that one is inherently bad for not following the accepted relational map. This internalized stigma can have mental health consequences

(Vaughan et al., 2019), and lead to living a closeted life (Arseneau et al., 2019; Campbell et al., 2023; O'Byrne & Haines, 2021; Valadez et al., 2020).

Individual Stigma

Individual stigma, a finding in Swindlehurst et al. (2023)'s study, denotes negative assumptions at the individual level. In their study, polyamorous individuals receiving healthcare services reported experiences of individual stigma, including sexist assumptions regarding their CNM practice. Examples of assumptions included being perceived as sexually promiscuous and as making less consensual or less empowered choices, at times relative to gender identity (Swindlehurst et al., 2023). One participant shared regarding her choice to engage in CNM, "There is very much the preconceived notion that it must be the 'fault' of the one in possession of a penis and that I must just be hanging on and they can't shake me, not that I am happy to be there and am the chief architect" (Swindlehurst et al., 2023, p. 10). Schechinger et al. (2018) and Vaughan et al., (2019) found similar instances of individual stigma. In Schechinger et al.'s (2018) study, one therapist insisted that "real women want monogamy" (p. 886). A participant in Vaughan et al.'s (2019) study reported a healthcare provider referring to his female CNM partner as "a hoe" (p. 47). Examples from these three studies illustrate the influence of patriarchy, which promotes the narrative that sexual openness is a socially acceptable practice only for those who identify as men, therefore only men would convince or force women to engage in such a practice. Further, both explicit and implicit experiences of judgement and shock from clinicians regarding sexual "promiscuity" were reported, which were characterized by participants as highly stressful (Vaughan et al., 2019).

Relationship Stigma

In the studies conducted by Henrich and Trawinski (2016, described earlier) and Swindlehurst et al. (2023), participants reported clinician assumptions that stigmatized their relationships; clinicians privileged monogamy and devalued CNM. Swindlehurst and colleagues (2023) qualitatively examined consensual nonmonogamists' experiences in mental health, with the aim of improving services. Nineteen people over 18 years of age, fluent in English, who self-identified as CNM and disclosed this to a mental health clinician, were recruited via Facebook groups, the authors' social media, and online forums such as Reddit. Study participants also had to have access to mental healthcare in the United Kingdom. Participants completed an open-ended, online survey that inquired about challenges, supportive practices, and assumptions experienced in therapy as an individual who practices CNM. They were also asked to provide information on what could help to improve the therapeutic experiences of the CNM population. Three main themes arose: stigma, pathologization, and barriers to openness within the therapeutic alliance. Fourteen of the 19 participants reported experiencing both individual and relationship stigma from their therapists. Twelve participants reported direct pathologization of their CNM relationship(s) by their therapists. The most prominent finding was the theme, reported by 15 participants, barriers to openness within the therapeutic alliance. This theme encompassed being fearful of pathologization, experiencing pathologization, and therapists lacking CNM education. Based on their findings, the researchers posited that mononormativity in therapy compounds minority stress and damages the therapeutic alliance. A fractured therapeutic alliance can have negative implications, such as unsuccessful outcomes, early termination, and the categorization of therapy by clients as destructive and unhelpful (Goldfried, 2013; Schechinger et al., 2018). Swindlehurst and colleagues (2023) did not report demographic information and member checks were not used to increase validity. Despite these limitations, this

work contributes to the literature on minority stress, the lack of education that therapists display, stigma, and fear of stigma as a barrier to therapy. The study nevertheless offers provisional guidelines for therapists to avoid negative responses to CNM clients that may damage the therapeutic alliance.

Those reporting relationship stigma emphasized that clinicians are not immune to the strength and force of heteronormativity and mononormativity in society: "I think he assumed nonmonogamy meant lack of care or commitment… Basically all the assumptions that monogamy is better, would be better for me, and must be what I really wanted deep down" (Swindlehurst et al., 2023, p. 11). The evidence from these studies demonstrates that people who practice CNM experienced stigma related to their relationship structure from healthcare providers, despite there being no empirical evidence that monogamy is superior to consensual nonmonogamy (Conley et al., 2013).

Anticipated Stigma

Anticipated stigma refers to the level to which people are concerned about others reacting negatively toward them, such as through devaluation and discrimination, if they disclose their minority status (Mahar et al., 2022). In line with minority stress theory (Meyer, 2003b), anticipated stigma arose as a common experience for participants in five of the studies (O'Byrne & Haines, 2021; Schechinger et al., 2018; Swindlehurst et al., 2023; Valadez et al., 2020, Vaughan et al., 2019). Participants in Swindlehurst et al.'s (2023) study, for example, reported a fear of not being understood or of their therapist assuming CNM is the crux of their problems. Aligning with the participants in Schechinger et al.'s (2018) study, Swindlehurst et al.'s (2023) participants also feared religious and moral judgement, and the associated legal implications, such as having their children removed by authorities.

Responses from Healthcare Providers

Participants from eight of the 11 studies in this review reported direct responses from their healthcare providers related to their CNM status (Arseneau et al., 2019; Campbell et al., 2023; Carlström & Andersson, 2019; Henrich & Trawinski, 2016; O'Byrne & Haines, 2021; Schechinger et al., 2018; Swindlehurst et al., 2023; Vaughan et al., 2019). The healthcare providers listed in these eight studies included therapists, psychologists, mental health practitioners, sexual healthcare providers, healthcare professionals, general physicians, clinicians, and doctors. Negative responses from healthcare practitioners ranged from focussing too much on CNM to an outright refusal of service (Arseneau et al., 2019; Campbell et al., 2023; Carlström & Andersson, 2019; Henrich & Trawinski, 2016; O'Byrne & Haines, 2021; Schechinger et al., 2018; Swindlehurst et al., 2023; Vaughan et al., 2019). Positive responses were reported as well, including receiving CNM-inclusive and CNM-aware care (Vaughan, et al., 2019). Positive responses will be discussed later.

Negative Responses

Negative responses were reported in eight of the 11 studies in this review (Arseneau et al., 2019; Campbell et al., 2023; Carlström & Andersson, 2019; Henrich & Trawinski, 2016; O'Byrne & Haines, 2021; Schechinger et al., 2018; Swindlehurst et al., 2023; Vaughan et al., 2019). Within the subtheme of negative responses, practices present included questioning, dismissing, avoiding and being unresponsive. Therapists were also reported to lack CNM competence and pathologize CNM. This section provides a brief overview of the studies by Schechinger et al. (2018) and Carlström and Andersson (2019) then describes the negative response subthemes.

In a mixed methods study, Schechinger et al. (2018) investigated the therapy experiences of CNM clients. They quantitatively measured CNM therapeutic practices, therapist helpfulness, and premature termination. Participants reported on up to four therapists: their current or most recent, their first, their most helpful, and their worst or most harmful. They specified whether each therapist engaged in 13 different practices, rated the helpfulness of their therapist, and indicated if they terminated therapy early due to CNM stigma. They also answered open-ended questions related to therapist CNM practices that were either very helpful or very unhelpful, such as validating CNM or dismissing CNM, respectively (Schechinger et al., 2018). This study had a robust sample compared to the others in this review. There were 249 participants, with the inclusion criteria of currently engaging in CNM, having discussed their romantic relationship in therapy, and being 18 years or older. Respondents were 82% white, 62% women, 43% bisexual, and 78% polyamorous. The mean age of the sample was 36. This study provided a rationale for all measures and implemented a thorough statistical analysis of the data. The qualitative data yielded four major themes for *very helpful practices*: *affirming, helpful techniques, nonjudgemental*, and *knowledge* and five major themes for *very unhelpful practices*: *judgemental, pathologize, knowledge, dismissive*, and *focus*. It should be noted that only 60% of respondents completed the open-ended questions on what was helpful, and 38% on what was very unhelpful; therefore, the results may be skewed. Compared to other studies in this review, participants more often reported appropriate practices than inappropriate ones. Some examples of appropriate practices included providers being familiar with CNM and being nonjudgmental. The findings indicated that participant screening of therapists led to more exemplary practices from therapists yet also resulted in higher expectations and therefore greater disappointment if expectations were not met. The findings suggest that the most helpful CNM clinicians were those

who were educated in CNM, were affirming, helped clients feel good about their CNM status, were open to discussing CNM relationship issues, and used helpful interventions that align with CNM clients' goals. Participants who experienced more negative responses from their therapists felt worse about their therapy experience (Schechinger et al., 2018). Positive and appropriate responses will be examined in a separate section.

A qualitative study by Carlström and Andersson (2019) explored the experiences and consequences of polyamorists going against heteronormative expectations. Using phenomenology and queer theory, they attempted to understand the meaning and practices of forming relationships of individuals and families with intersecting marginalized identities. Purposeful sampling was employed to recruit participants, yielding a total of 22. Inclusion criteria were having experiences of nonmonogamy and being 18 years of age or older. Exclusion criteria were being involved in polygyny or polyandry as these have been differentiated from polyamory in the literature (Strassberg, 2012). Participants ranged from 20 to 60 years old, with 11 identifying as women, eight as men, and three as non-binary. Most were born in and all lived in Sweden. Ethnicities represented were Nordic, southwest Asian, and central European. All participants were educated with at least a high school diploma and most were employed or studying. In participants' homes, cafes, and at a university, the researchers conducted in-depth, 1–3-hour interviews in Swedish, which were then translated. Participants were asked to define polyamory and nonmonogamy and how they became involved in it. The resultant themes relevant to this literature review were *Silence and Coming Out* and *Being Stopped – Interactions with Professionals* (Carlström & Andersson, 2019). In the former theme, participants described degrees of openness regarding their CNM status, and the resultant ignorance, skepticism, and negative comments they experienced when disclosing in social and institutional contexts. In the

latter theme, participants reported negative responses and a lack of knowledge from therapists (Carlström & Andersson, 2019). Like other studies in this review (Arseneau et al., 2019; Vaughan et al., 2019; Valadez et al., 2020), the researchers did not ask directly about stigma, yet it emerged as a major theme. This study contributes valuable data on interactions with healthcare professionals, specifically, doctors, therapists, and psychologists. It found that consensual nonmonogamists feel obligated to be closeted and experience being interpreted as incomprehensible and immature. These feelings were often perpetuated in therapy. Some limitations in this study are that while it lists gender identity and other relevant demographic information, it does not indicate the sexual orientation nor ability of the participants. When researchers omit certain demographics from their sample, or do not report them, this limits generalizability to those populations. Participants either identified as polyamorous or nonmonogamous, contributing to the academic ambiguousness of the differences amongst CNM identities (Carlström & Andersson, 2019).

Questioning. Respondents in two studies reported that clinicians continuously stopped and questioned their choice to practice CNM (Campbell et al., 2023; Carlström & Andersson, 2019). An example included two psychologists trying to get a study participant to "force out" a reason for their CNM, insisting there had to be something wrong with her, such as sexual exploitation as a child (Carlström & Andersson, 2019, p. 1327). A 40-year-old bisexual polyamorous female, upon disclosing her polyamorous status to her doctor, was asked if she was ok with it. She felt judged, and believed the doctor was asking questions to feed her own curiosity as opposed to providing the care the patient was seeking (Campbell et al., 2023). In another example, a 42-year-old straight poly woman described how her practitioner was titillated, and felt the doctor was asking questions so that the doctor could gossip and laugh about

it to their friends later (Campbell et al., 2023). In these examples, participants highlight the undermining of their choices as well as the sense of being viewed as less than, leading to a deterioration in trust, and therefore the therapeutic alliance.

Dismissing. Consensual nonmonogamists in one study felt they were dismissed by their therapists. Under the umbrella of dismissal, they shared that they were assumed to be monogamous, were pressured to end a relationship or come out, or they were refused service outright (Schechinger et al., 2018). One participant reported their therapist suggested they leave their boyfriend because he was polyamorous while another participant reported their therapist refused to consider CNM an option (Schechinger et al., 2018).

Judging. In five of the studies, clinicians were reported to engage in both covert and overt expressions of discomfort and judgement. These ranged from judgmental body language, such as judging with facial expressions (Campbell et al., 2023; Schechinger et al., 2018) to characterizing CNM as wrong or unnatural (Carlström & Andersson, 2019; Schechinger et al., 2018), to outright shaming (Henrich & Trawinski, 2016; Schechinger et al., 2018). In Vaughan et al.'s (2019) study, Gree, a single, White, cisgender, heterosexual, grey/asexual polyamorous man, reported, "I go to see my regular doctor, and they're like, 'Well maybe if you came up with a more 'stable' environment, maybe these other symptoms [depression] can go away.' And I was like, "No, these don't work like that. Thank you for your judgment. Let's move on." (p. 46). A participant in another study shared of their therapist calling them a "whore" (Schechinger et al., 2018, p. 886). In yet another study, participants reported experiencing distrust and disgust from their healthcare providers (Campbell et al., 2023). Clearly, these types of experiences are the opposite of therapeutic.

Focus. In two studies, participants reported that their therapists engaged in either focusing too much or not enough on CNM. For example, one therapist was reported as overly interested in the sexual details of a poly relationship, while another avoided the topic altogether (Schechinger et al., 2018). In Henrich and Trawinski's (2016) study, 5% of participants reported their therapists overfocusing on sex instead of exploring other motivations for polyamory. One participant, Sue, who grew up in a polyamorous family, and was in an 18-year polyamorous marriage, shared, "There is a strong focus on sex. If I am interested in having sex with someone outside my marriage, that is wrong. Get back in the box… [Sex outside of marriage] is viewed as betrayal, infidelity; it is an affair… wrong by definition.… If that judgment [about sex] could be lifted from a therapeutic relationship, that would be a great thing. It would behoove a therapist to look at the motives for why people choose polyamory" (Henrich & Trawinski, 2016, p. 385).

Lack of CNM Competence. A subtheme of the main theme, negative responses, which arose from six of the studies in this review, was that of insufficient knowledge of CNM or a lack thereof (Campbell et al., 2023; Carlström & Andersson, 2019; Henrich & Trawinski, 2016; Schechinger et al., 2018; Swindlehurst et al., 2023; Vaughan et al., 2019). This was framed as ignorance (Vaughan et al., 2019), a lack of education (Swindlehurst et al., 2023), or a lack of competence (Carlström & Andersson, 2019), with therapists being uninformed and unprepared (Henrich & Trawinski, 2016) and refusing to gather information about CNM (Schechinger et al., 2018). These responses were described as irritating, othering, and nefarious (Campbell et al., 2023). One participant noted, "I have seen several therapists, and then it has often been that I talk about my life and relationships, and I feel that there is a very, very little competence about non-monogamous relations" (Carlström & Andersson, 2019, p. 1327). This lack of knowledge was described as profound, resulting in clients having to educate, explain, or justify CNM to their

therapist instead of working on their presenting problem (Schechinger et al., 2018; Swindlehurst et al., 2023). This lack of understanding led to feeling a lack of support, thereby negatively affecting the therapeutic relationship (Swindlehurst et al., 2023).

Pathologization. Another major component in the stigma experiences of consensual nonmonogamists is that of pathologization, a theme which emerged in eight out of the 11 studies in this review (Campbell et al., 2023; Carlström & Andersson, 2019; Grunt-Mejer & Łyś, 2022; Henrich & Trawinski, 2016; Kisler & Lock, 2019; Schechinger et al., 2018; Swindlehurst et al., 2023; Valadez et al., 2020). Examples of pathologization include harmful and inaccurate assumptions and therapist bias (Campbell et al., 2023; Henrich & Trawinski, 2016). Participants shared accounts of therapists and health care providers assuming their problems stemmed from their relationship structure, clients' inability to commit, or that CNM harms relationships (Schechinger et al., 2018). Clinicians' inaccurate and harmful assumptions and their resultant negative reactions were fueled by their inherent bias toward monogamy being considered ultimately correct and natural. A 58-year-old straight male reported, "[The clinician] viewed CNM as inherently psychologically and physically unhealthy, unnecessary risk taking, and one considered it a form of cheating and IPV [intimate partner violence]" (Campbell et al., 2023, p. 6). In another study, a participant said, "I have been with two psychologists who insisted that there had to be something wrong – either it was my childhood, or that I have problems in relation to my mother, or that it would come from sexual exploitation as a child. It was like that. I felt it instantly. This is what they want to force out of me" (Carlström & Andersson, 2019, p. 1327). Without evidence, these clinicians assumed that if one is in a CNM relationship, one must be sick, impulsive, unfaithful, abusive, or abused.

As of the time of writing, there is only one study which directly investigates the attitudes of therapists toward CNM as opposed to the other studies which explore client and patient experiences of their therapists. In Grunt-Meyer and Łyś's (2022) unprecedented work, researchers presented to current and prospective therapists, hypothetical vignettes of couples in four different types of relationships: monogamous, polyamorous, swinging, and cheating. In each vignette, "the couple" was seeking therapy due to either depression and burnout, alcohol abuse, erectile dysfunction, or relational conflict. The vignettes' first and third paragraphs were the same in each condition. The second paragraph described the couple as either monogamous, swinging, cheating, or polyamorous. The third paragraph described the problem, which was either depression and burnout, alcohol abuse, erectile dysfunction or conflicts (Grunt-Mejer & Łyś, 2022).

Participants rated the clients in the vignettes on relationship satisfaction and their morality- and competency-related abilities. Additionally, the therapist participants gave a hypothesis on the source of the couple's problem, suggested possible solutions, and speculated on the possibility of finding a solution therapeutically. Two hundred and seventy-three women, 46 men, and one other, ranging from 19-53 years of age with a mean age of 28, were recruited through the psychology departments of five Polish universities with graduate programs in clinical psychology. A demographic questionnaire determined the gender, age, years of practice, and therapeutic lens of the study subjects, as well as if they had completed an internship (Grunt-Mejer & Łyś, 2022).

In terms of rating clients, the respondents rated the monogamous couples higher than the CNM couples on honesty, trustworthiness, appropriate behaviour, intelligence, coping skills, goal achievement, being interesting, communicating well with each other, being each other's

best friends, being happy with each other, satisfaction with the relationship, and having a chance of solving the problem. The only traits on which CNM couples were rated higher were tolerance and engagement in social issues. In terms of hypotheses regarding the origin of the relational problems in the vignettes, monogamous couples had the highest number of hypotheses that were unrelated to the relationship. In contrast, CNM relationships were cited as the reason for depression and burnout, erectile dysfunction, and the origin of conflict. The only relationship issue that was not most associated with a CNM relationship was alcohol abuse, for which cheating had the highest count. Along with these biased assumptions regarding the origin of the couples' problems, participants were reported to write outright judgements instead of hypotheses. For example, one respondent wrote, "If I am to be honest, when I read this, I wonder where the world is going… both she and he have people they are close to, with whom they maintain romantic and sexual relations… sad" (Grunt-Mejer & Łyś, 2022, p. 68). This outright judgement demonstrates the biased, negative assumptions that therapists can place on their CNM clients, thereby pathologizing CNM and perpetuating stigma.

The results of this study are therefore consistent with the findings of the other studies in this review. Here we have direct feedback from therapists which points to a reality reflected in the qualitative experiences of clients and patients. There are some limitations to this study, however. Since data were collected in Poland, the cultural narratives regarding CNM may not be generalizable to Canada or other countries or cultures. Participants differed in clinical experience, ranging from master's students to clinicians with several years' experience. The study did not specify whether clinicians were trained in CNM specifically but did indicate that the majority of respondents practiced CBT, followed by an equal number of humanistic and psychoanalytic practitioners, then by systemic, solution-focused therapy, and a small number of

Eriksonian, existential and integrative therapists. While there is more to explore to obtain more reliable and generalizable results on this topic, Grunt-Meyer and Łyś (2022) have laid a foundation on which future research on therapist stigma toward CNM can be built.

Positive Responses

While many negative experiences were reported**,** participants in four studies also reported positive experiences related to their CNM status when they had sought healthcare services (Campbell et al., 2023; Henrich & Trawinski, 2016; Schechinger et al., 2018; Vaughan, et al., 2019). Reported positive responses included receiving CNM-inclusive care (Vaughan, et al., 2019), having poly-aware therapists (Henrich & Trawinski, 2016), and helpful practices (Campbell et al., 2023; Schechinger et al., 2018; Vaughan, et al., 2019). CNM-inclusive care involves responding with open-mindedness and acceptance and meeting healthcare needs and requests (Vaughan, et al., 2019). An example of a helpful practice from Campbell et al. (2023) was the clinician responding in a matter-of-fact manner, as long as it comes from knowledge, experience, and acceptance. In Schechinger et al.'s (2018) study, 60% of participants identified the helpful practices in which their therapists engaged. Those who reported helpful practices listed their therapists engaging in the following types of practices: 49% reported affirmation, 43% reported using helpful techniques, 36% reported being non-judgmental, and 17% reported having CNM knowledge. Affirmation involves being supportive of CNM identity (18%). When engaging in affirmation, therapists focussed on the client's needs, goals and values. Additionally, therapists validated CNM, trusted the client's decisions, affirmed kink and queerness, and acknowledged societal stigma. Being non-judgemental includes not over-reacting or pathologizing. Further, a non-judgemental approach involves normalizing and accepting CNM practices, as well as acknowledging one's own biases, and remaining neutral. Helpful techniques

reported were asking helpful questions, providing helpful advice, listening effectively, valuing relationships individually, helping with interpersonal and relational skills, and not fixating on CNM. Participants reported CNM knowledge as a positive experience, with openness to learning, seeking outside education, and providing resources as examples (Schechinger et al., 2018).

Client Strategies to Navigate Stigma

In five of the studies in this review, participants described strategies for navigating stigma (Arseneau et al., 2019; Campbell et al., 2023; O'Byrne & Haines, 2021; Valadez et al., 2020; Vaughan, et al., 2019). These strategies were coded into the subthemes of being closeted, disclosure, and seeking CNM-inclusive providers.

Being Closeted

Akin to the 2SLGBTQIA+ community, consensual nonmonogamists used concealment, or being *closeted*, to protect themselves from stigma (Arseneau et al., 2019; Campbell et al., 2023; O'Byrne & Haines, 2021; Valadez et al., 2020). Arseneau et al. (2019) reported that their participants performed a cost-benefit analysis to determine whether it was worth the risk to disclose or not. If they chose to conceal, they would present as monogamous in social settings, "for various reasons" (Arseneau et al., 2019, p. E1125). The study did not explicate what those reasons were, specifically. Passing, or the ability to outwardly appear as normative, was also reported by Campbell et al. (2023) and O'Byrne and Haines (2021). This required either lying or framing their CNM as cheating (Campbell et al., 2023). When choosing to withhold their CNM status, even if relevant, respondents reported not getting the healthcare services they needed as a result (O'Byrne & Haines, 2021). This was because of their reluctance to disclose to healthcare providers due to anticipated stigma (O'Byrne & Haines, 2021).

Disclosure

There was a spectrum of behaviours associated with the theme of disclosure. In Valadez et al.'s (2020) study, all participants spoke of disclosure and/or concealment as strategies for navigating stigma. Participants in other studies reported always disclosing (O'Byrne & Haines, 2021), disclosing only if they deemed it relevant to the care they were seeking (Arseneau et al., 2019), or only doing so if asked (O'Byrne & Haines, 2021). Reasons for being "proudly out" had personal, practical, and political implications (Campbell et al., 2023). Some chose to disclose in order to advocate for CNM with the intention and hope of demystifying CNM and thereby reducing the associated stigma (Arseneau et al., 2019).

Seeking CNM-inclusive providers

In Vaughan et al.'s (2019) study, participants reported seeking providers who identified themselves as open to sexuality and LGBTQ+ populations, and who did not use explicitly religious language in their promotional materials. The researchers did not indicate the percentage of participants who reported this. Participants also asked other CNM individuals for recommendations (Vaughan, et al., 2019), thereby creating an organic vetting process within the community. Additionally, participants engaged in pre-screening healthcare professionals, such as searching the healthcare professionals' websites for signs of openness to CNM and LGBT+ populations, and for language that was nonreligious (Vaughan, et al., 2019).

Suggestions for Clinicians

Two studies provided direct instructions for clinicians who work with the polyamorous population. The first, conducted by Arseneau et al. (2019), qualitatively researched the unique challenges that polyamorists face when accessing healthcare for pregnancy and birth. Via convenience and snowball sampling in social media poly groups spanning major cities across

Canada, the researchers recruited 24 participants aged 23-48 with a mean age of 34. The researchers conducted semi-structured interviews in-person or on Zoom, in English or in French, with individuals or groups, where partner(s) could be included. Questions on demographics, relationship structure at the time of pregnancy and now, as well as about the pregnancy and birth experience generally, were posed to participants. Additional questions sought to explore disclosure, health care provider experiences, parenting, and the future. The researchers also collected CNM definitions from participants and compiled a glossary of terms. Findings indicated that participants experienced both positive and negative experiences from their clinicians when accessing healthcare. Negative experiences included discrimination associated with their polyamorous status, such as partners not being acknowledged equally. One participant stated, "It's kind of funny because the hospitals have these situations where they're like, 'We're used to 1 man, 1 woman, a baby or 2, maybe 3.' And so they can adapt to that scenario. But … the hospital freaks because they're like, 'Crap, we can't make 3 bracelets for the [parents]!'" (Arseneau et al., 2019, p. E1124). Participants reported selective disclosure as a strategy to minimize stigma. The researchers used member checking of the glossary of terms to increase validity. This study was the only one in this review to focus specifically on the poly experience of pregnancy and birth. It spanned four provinces in Canada, including British Columbia, Ontario, Quebec, and Alberta, making it the most locally relevant study in this review. There was a notable amount of diversity in sexual orientation amongst participants. The orientations most represented were heterosexual (31.8%), bisexual (27.3%), and pansexual (18.2%). It was limited by the otherwise homogeneous sample, with all respondents identifying as cis-gender, 81.8% of participants identifying as White or European and almost half as university educated. Some participants were interviewed alone, while others

with their partners. This could have perpetuated bias, though the researchers acknowledged this (Arseneau et al., 2019). The relationship structure of participants was not reported to preserve anonymity. However, this contributes to the ongoing challenge of types of polyamory being combined, thereby losing important data. Two participants did not complete the demographic questions, yet their responses were included. The final limitation of this study is that it was conducted due to the researchers' personal involvement in poly, leaving more potential for bias. Their solution to this was for all researchers to participate equally, yet they did not mention bracketing (Arseneau et al., 2019).

The other study that provided suggestions for clinicians was conducted by Kisler and Lock (2019), who examined how couple and family therapists can be more culturally competent and therapeutically effective when working with poly clients. This qualitative, phenomenological study employed a twenty-minute online survey which asked an unidentified number of open-ended questions eliciting experiences with polyamory and suggestions for therapists working with this population. Twenty participants aged 22-61, with a mean age of 37.2, were recruited by linking the survey to an online poly forum with over 9,000 members. To be included, one had to identify as polyamorous or be interested in polyamory. Consistent with most studies in this review, participants were predominantly White and highly educated. There was significant geographic heterogeneity, with multiple states in the USA and six countries represented, although those countries were not identified. Respondents were also diverse in age, sex, gender, sexual orientation, and marital status. To be included in the study, participants had to report an interest in polyamory, but they did not have to explicitly state that they had any present or past experience with polyamory. The study's findings indicated that polyamorists experience special challenges. One such challenge is dealing with stigma, such as fearing the reactions of others,

including judgement from friends, family, colleagues, and healthcare providers. One participant reported, “I’m unable to fully disclose my personal life to my co-workers, students, extended family, doctors, or other professionals. In social or professional settings, I always have to justify my presence (i.e. visiting rights at hospital)” (Kisler & Lock, 2019, p. 47). Other subthemes of dealing with stigma included having to explain their relationship structure and dealing with external and internalized antipolyamorous narratives. Furthermore, the findings gleaned suggestions for couple and family therapists, such as seeking education, challenging assumptions, and not pathologizing polyamory (Kisler & Lock, 2019). Participants suggested that therapists familiarize themselves with poly language and practices by reading about polyamory and speaking with polyamorous people. Further suggestions involved not accepting negative stereotypes about the poly population and avoiding mononormativity as a lens through which to conceptualize poly cases. Differences in participant knowledge and experience in polyamory could have potentially skewed the validity of the data. The researchers used only one forum to recruit participants, and did not perform member checks to increase validity. Despite this, three strategies were used to address validity. Researchers declared limiting their interpretation, although they did not give any further information on how that was done, other than that they “relied heavily on participants’ actual words to identify themes” (Kisler & Lock, 2019, p. 47). Presumably, this means the themes are words that were uttered by participants in the study. The second strategy used to increase validity was looking for negative examples in the data to strengthen analysis. The third strategy was using self-reflexivity to address how personal experiences could be influencing the data (Kisler & Lock, 2019). The participant countries outside of the U.S. were not included, leaving out relevant demographic information. Finally,

data were collected exclusively online, thereby limiting respondents to those who are privileged (Kisler & Lock, 2019).

Acknowledge, Accommodate, Ally

Arseneau and colleagues (2019) compiled a list of affirming practices for clinicians and healthcare institutions based on respondents' suggestions. These affirming practices are *Acknowledge, Accommodate* and *Ally* (Arseneau et al., 2019). *Acknowledging* involves exuding openness and remaining nonjudgmental, providing a space for disclosure, not perceiving concealment as deception, and educating oneself in polyamory. Aligning with this, Kisler and Lock's (2019) suggestions for couple and family therapists include showing openness and seeking education. As seen in other studies in this review, incompetence can lead to detrimental outcomes such as clients educating therapists, focussing on irrelevant content in-session, and client dropout (Kisler & Lock, 2019; Henrich & Trawinski, 2016; Schechinger et al., 2018). *Accommodating* refers to both physical and relational contexts, such as creating more space in the clinic for multiple partners, having CNM-inclusive intake forms, and explaining the relevance of the questions asked of clients. *Allying* integrates avoiding assumptions, advocating for clients and their community, and providing client-led care (Arseneau et al., 2019). Similar to Arseneau et al. (2019), Kisler and Lock (2019) also suggest challenging one's own assumptions and biases regarding CNM. Therapists are encouraged to think about the impact of stigma in broad terms. Specifically, therapists are encouraged to reflect on the interpersonal, institutional, and societal impacts of stigma. If therapists are unable to work past biases, they should refer clients elsewhere. Finally, Kisler and Lock demonstrate the importance of not pathologizing polyamory. Regarding this, a participant shared the following, "Don't assume that poly is the problem – just like not all of a gay person's problems are 'gay related' or not all of an ex-

religious person's problems are 'religion related.' The poly part may be all good and problems could be related to all of the usual suspects or none of them. Poly is only part of the picture" (Kisler & Lock, 2019, p. 50). Another said, "We're people. We all have the same relationship issues, but sometimes multiplied by having more partners. All in all, we are individuals who deserve to be treated as being individuals and our issues considered in light of our personal circumstances" (Kisler & Lock, 2019, p. 51).

Data Analysis/Methodology

Eight of the articles reviewed were qualitative, while the remainder were mixed methods studies. First, qualitative studies and the qualitative results of the mixed methods studies will be critiqued, followed by the mixed methods studies more generally.

Qualitative Studies

The majority of the articles reviewed were qualitative (Arseneau et al., 2019; Carlström & Andersson, 2019; Henrich & Trawinski, 2016; Kisler & Lock, 2019; O'Byrne & Haines, 2021; Swindlehurst et al., 2023; Valadez et al., 2020; Vaughan et al., 2019). Qualitative research is appropriate for the topic of stigma as it can be a tool for exploring the depth and breadth of the human experience (Morrow, 2007), and helps to answer "How?" or "What?" not "Why?" (Creswell, 1998). Considering that counselling psychology is rooted in the concept of narratives, qualitative research highlights and illustrates narrative experiences (Morrow, 2007), amplifying the voices of communities (Barbour, 2014). Additionally, qualitative research can aid in the formulation of interventions and contribute to social change, both crucial aspects of counselling (Hoshmand, 1999; Morrow, 2007).

Most of the qualitative studies, or the qualitative portions of the mixed methods studies, utilized Braun and Clarke's (2006) thematic analysis (Arseneau et al., 2019; Campbell et al.,

2023; Carlström & Andersson, 2019; Grunt-Mejer & Łyś, 2022; Schechinger et al., 2018; Swindlehurst et al., 2023; Valadez et al., 2020). This style of analysis comprises six stages: 1. familiarizing oneself with the data, 2. generating initial codes, 3. searching for themes, 4. reviewing themes, 5. defining and naming themes, and 6. producing the report (Braun & Clarke, 2006). Arseneau et al. (2019) appear to have reduced the six stages to three without an explicit rationale. Carlström and Andersson (2019), Swindlehurst et al. (2023) and Valadez et al. (2020) did well to provide a rationale for their choice in using thematic analysis, yet they did not explain the analysis process, whereas Campbell et al. (2023) both explained their rationale and process in a clear and comprehensible manner. Only two of the qualitative studies reported utilizing member checking to increase the validity of their results (Arseneau et al., 2019; Vaughn et al., 2019).

Mixed Methods Studies

Mixed methods combines both qualitative data, which can contribute to a deeper understanding of a phenomenon, and quantitative data, which can be generalized from a sample to a population (Hanson et al., 2005). This combination may produce more rigorous results than either individual data set. Instrument-based measurements with field-based data may strengthen findings overall (Hanson et al., 2005). Three of the eleven studies in this review were mixed methods.

Campbell and colleagues (2023) used snowball sampling for their participant recruitment, resulting in a small, homogeneous sample of 67. Like the majority of the research in this review, their sample was predominantly White, educated, and middle class. While 22.5% of the sample included participants from outside of the UK, the countries represented were Western and predominantly white, resulting in data that may not be generalizable to more ethnically, racially,

and otherwise diverse peoples. Recruitment was done via the researcher's own personal networks and connections via social media. This is problematic as the potential for bias is high.

Schechinger et al. (2018) recruited a large sample of 249 participants. This sample was more diverse, with the majority being bisexual, poly women, but 83% White, with no data collected on education or SES. Like other studies here, they recruited participants who practice under the full spectrum of CNM. As mentioned, the CNM umbrella encompasses multiple styles of relationships. Much nuance and therefore generalizability is lost when combining all types of CNM relationships (Schechinger et al., 2018). Additionally, the researchers modified an existing 13-item scale which originally measured therapist practices with LGB clients. Since this was the first time implementing the scale, it requires further study to establish its validity. Again, this study did not recruit a random sample, therefore limiting generalizability (Schechinger et al., 2018).

A practice in quantitative, and therefore mixed methods, research is to explicitly present a hypothesis to be tested. Two of the mixed methods studies did not do this (Campbell et al., 2023; Schechinger et al., 2018). Only Grunt-Mejer and Łyś (2022) reported they were attempting to explore clinician's attitudes regarding their client's relationships and if the type of relationship the client is in influences therapeutic practices and goals.

Ethical Considerations

According to the Tri-Council Policy Statement (TCPS2) on ethical conduct for research involving humans (Government of Canada, 2022), and the *Canadian Code of Ethics for Psychologists, Fourth Edition* (Canadian Psychological Association [CPA], 2017), researchers are required to meet ethical standards while conducting studies. TCPS2 concepts relevant to the

studies in this review include three different types of consent, confidentiality, ethics board review, decision-making capacity, and researcher conflicts of interest.

Respect for the Dignity of Persons and Peoples

Informed, Voluntary and Ongoing Consent and Decision-Making Capacity. Consent is an integral aspect of the CPA's (2017) first ethical principle, *Respect for the Dignity of Persons and People*, which involves honouring and respecting participants' autonomy. The TCPS2 recommends that researchers engage participants in a voluntary, ongoing, and informed consent process (Government of Canada, 2022). Seven of the eleven articles mentioned they had engaged in an informed consent process with their participants (Arseneau et al., 2019; Campbell et al., 2023; Carlström & Andersson, 2019; Grunt-Mejer & Łyś, 2022; Swindlehurst et al., 2023; Valadez et al., 2020; Vaughan et al., 2019). For example, Carlström & Andersson (2019) provided participants assurance that data was collected for research purposes only. None mentioned ongoing consent, nor decision-making capacity. Only one article mentioned voluntary consent (Henrich & Trawinski, 2016). Consensual nonmonogamists comprise a minority whose opinions and wishes may not be known to, or align with, the majority (CPA, 2017). Consensual nonmonogamists may, for example, wish to obtain the consent of their partner(s) before sharing information about their relationships. None of the studies explicitly mentioned obtaining the consent of participants' partners when participants were sharing about their relationships. Only one study (Arseneau et al., 2019) interviewed participants as well as their partners, thereby getting consent from partners.

Confidentiality. Categorized within the *Respect for the Dignity of Persons and People* (CPA, 2017), confidentiality involves safeguarding information from unauthorized access, which is essential for maintaining trust between researchers and participants (Government of Canada,

2022). Consensual nonmonogamists are a stigmatized and oppressed population. A breach in confidentiality, such as uncovering the identity of study participants to the public, could lead to consequences such as loss of familial, social or employment relationships, not only for the participants, but potentially for their partners and families as well. It is therefore integral for participants' identities to be protected.

Carlström & Andersson (2019) reported including the "highest possible confidentiality" in their study, yet they did not mention how this was done. Arseneau et al. (2019) reported anonymizing participants by identifying them with letters and numbers, Kisler and Lock (2019) reported they stored their data electronically, in a password-protected account accessible only to the research team. Henrich and Trawinski (2016) reported that all their participants were pseudonymized. Campbell et al. (2023), Grunt-Mejer and Łyś (2022), Valadez et al. (2020) and Vaughan et al. (2019) all reported confidentiality practices. O'Byrne & Haines (2021), Schechinger et al. (2018), and Swindlehurst et al., (2023) did not refer to confidentiality in their studies.

Responsible Caring

Ethics Board Review. The CPA (2017) indicates that seeking adequate ethical reviews is an integral part of the principle, *responsible caring*. Research on stigma has the potential to cause pain, discomfort, or harm to participants (Swindlehurst et al., 2023). An ethics board can provide feedback to researchers regarding whether the study meets ethical standards, thereby minimizing harm when exploring sensitive topics with vulnerable populations (CPA, 2017). In the *Compliance with Ethical Standards* section at the end of their study, Carlström and Andersson (2019) indicated that they received ethical approval and followed the ethical guidelines of the Swedish Research Council. Seven other studies received approval from their

respective ethics board (Arseneau et al., 2019; Campbell et al., 2023; Kisler & Lock, 2019; O'Byrne & Haines, 2021; Schechinger et al., 2018; Swindlehurst et al., 2023; Vaughan et al., 2019). The remaining three studies did not report an ethics board approval (Grunt-Mejer & Łyś, 2022; Henrich & Trawinski, 2016; Valadez et al., 2020).

Integrity in Relationships

Conflict of Interest. According to the TCPS2, conflicts of interest can threaten the integrity of research findings as well as the protection of participants (Government of Canada, 2022). A common conflict of interest that can and did arise in CNM research is dual or multiple relationships. Seven of the eleven studies declared no conflict of interest (Arseneau et al., 2019; Campbell et al., 2023; Carlström & Andersson, 2019; Grunt-Mejer & Łyś, 2022; Henrich & Trawinski, 2016; Swindlehurst et al., 2023; Vaughan et al., 2019); the remaining four did not (Kisler & Lock, 2019; O'Byrne & Haines, 2021; Schechinger et al., 2018; Valadez et al., 2020). While Henrich and Trawinski (2016) claimed no conflicts of interest, they recruited participants from their own therapy clientele and romantic partnerships. Considering this, the results of their study merit scrutiny in terms of ethics.

Conclusion

Taken as a whole, the current literature as it stands indicates that consensual nonmonogamists experience multiple types of stigma from counsellors, resulting in a fracturing of the therapeutic alliance, as well as minority stress effects. The consistent theme emerging from this review is that when therapists engage in steps to better themselves as affirming CNM therapists, clients may experience therapeutic benefits. These steps will be explored in the following section.

Chapter 4: Application to Clinical Practice

Applying results from scientific studies to clinical practice is an essential part of being an adept clinician. Therapists are required to seek, understand, and employ evidence-based interventions in their practice (CPA, 2017). This section will offer an overview of integrating the findings of this literature review into clinical practice. Aspiring therapists and counsellors, as well as those who are already practicing, can use the information in this review to clinically support their CNM clients. To holistically support consensual nonmonogamists, therapists must recognize and acknowledge the multiple dimensions of the effects of stigma. Awareness of research, personal biases, innovative interventions, and cultural implications are essential to providing the highest quality mental health care to this population. Based on the results of this review, which included suggestions for practitioners by consensual nonmonogamists, I created a framework for clinicians who work with, or who would like to work with consensual nonmonogamists. The framework (in the Recommendations section below) is entitled CNM-Affirming Clinician Practices. After the framework, this chapter will conclude with a discussion of the cultural implications of the findings.

Recommendations: CNM-Affirming Clinician Practices: A Framework

Based on the results of this review, I created the following framework for therapists who work with or would like to work with consensual nonmonogamists. Inspired by the *Consensual Nonomogamy Fact Sheet* by Moors et al., (2021), which includes recommendations for CNM clinicians, this framework aims to provide guidance regarding basic counselling practices such as providing ethical and competent care, communication with clients, intake, assessment, and treatment. Each part of the framework is based on suggestions from study participants themselves or from the researchers of the 11 studies in this review. Below are the four parts of

the framework, which comprises five strategies. The first two strategies are education and reflexivity. Communication and intake are third, followed by assessment and treatment. The final strategy is advocacy.

CNM Education

As suggested in the studies by Arseneau et al. (2019) and Kisler and Lock (2019), the first step counsellors can take in providing competent care for the CNM population is educating themselves. This education involves consuming seminal and current scientific literature on CNM, literature and media created by consensual nonmonogamists from their experiential point of view (e.g., Veaux & Rickert, 2014), and literature written by CNM-competent therapists (e.g., Fern, 2020; Vaughan & Burns, 2022) (Kisler & Lock, 2019). Further, regularly participating in accredited training in treating this population (e.g., Sexual Health Alliance, n.d.) is required to obtain and retain the level of competence necessary to ethically provide counselling services to consensual nonmonogamists (CPA, 2017). Regarding CNM stigma, practitioners can familiarize themselves more with the types of stigma briefly described in this review, so they can recognize, validate, and treat the associated challenges that accompany stigma experiences.

CNM Reflexivity

Further to education, counsellors are encouraged to engage in an ongoing practice of reflexivity, checking for personal biases (Arseneau et al., 2019; Kisler & Lock, 2019; Schechinger et al., 2018). Whether you practice monogamy or some form of nonmonogamy, be aware of how your conscious and subconscious belief patterns can affect your view of consensual nonmonogamists. Share these biases with peers and supervisors to help deconstruct their basis and influence on your clinical practice. If you do not have sufficient training and/or

have difficulty bracketing your own experiences and biases, refer CNM clients out to competent clinicians (Kisler & Lock, 2019).

CNM Communication and Intake

The literature in this review suggests that counsellors and other healthcare practitioners use CNM-inclusive language in their communication (Arseneau et al., 2019; Swindlehurst et al., 2023) such as on their website, in their marketing literature, and in their booking software. If you have sufficient education and training and are therefore competent as a counsellor who can treat consensual nonmonogamists, indicate your specialization, or that you are "CNM-friendly" (Swindlehurst et al., 2023, p. 15) directly in your marketing materials. For booking options, use the terms *partner sessions* or *relationship sessions* instead of, or addition to, *couples sessions*. Furthermore, one can add CNM-inclusive questions on intake forms, such as asking about relationship type and using the term *partner(s)* until further clarification from clients is provided on their preferred terms (Arseneau et al., 2019; Swindlehurst et al., 2023). Additionally, creating physical space for multiple partners in the clinic waiting room and therapy rooms is suggested (Arseneau et al., 2019).

CNM Assessment and Treatment

While assessing and treating, be open and nonjudgmental, avoid assumptions, challenge biases, take a non-pathologizing approach, and consider the impact of stigma on personal, interpersonal, institutional, and societal levels (Arseneau et al., 2019; Kisler & Lock, 2019). Do not assume that clients are seeking therapy regarding their CNM status unless they explicitly state so, and do not assume their problems are due to their CNM status. Apply theories such as queer theory and minority stress theory to conceptualize clients' struggles that pertain to their CNM status. For example, the clinician could ask questions that allow them to assess the degree

to which the client may be experiencing minority stress related to their CNM status or practices (Witherspoon & Theodore, 2021). An example question would be to ask if the client has experienced any of the following due to their CNM practices: job demotion or denial of a promotion, losing custody of a child, or being stereotyped by a mental health provider (Witherspoon & Theodore, 2021)

CNM Advocacy

Counsellors are encouraged to educate their personal and professional circles about the stigma consensual nonmonogamists face (Arseneau et al., 2019). Another way to engage in advocacy includes participating in activism, such as attending protests and writing to members of the government, encouraging them to reform policy to expand land, marriage, and family rights to consensual nonmonogamists.

Cultural Implications

Viewing and applying research data through a cultural lens is an integral part of ethical clinical practice. This review attempted to collect studies from different cultures to broaden the spectrum of views and experiences of consensual nonmonogamists. The results indicated that stigma exists and is perpetuated in the therapy room and in larger societal contexts. How clients would prefer to acknowledge, explore, and handle this stigma can vary widely and must be a consideration when applying interventions. Furthermore, the results of this literature review show that the practice of consensual nonmonogamy is a broad culture within itself, with multiple subcultures therein. Moreover, there are cultures which are underrepresented in the literature, whose experiences of CNM have not been expressed, especially people of colour, the disabled, gender minorities, neurodivergent people, and those who are of lower socioeconomic status

(SES). It is essential, therefore, for clinicians to tailor interventions to the individual and not make assumptions regarding how clients define their CNM relationships and practices.

Chapter 5: Conclusions and Recommendations

Conclusions

This review explored how the literature on consensual nonmonogamy stigma inform counsellors' professional practice with consensual nonmonogamists. The findings established that consensual nonmonogamists experience mononormativity in healthcare contexts, resulting in CNM stigma. Multiple types of stigma arose: institutionalized stigma (Arseneau et al., 2019; Henrich & Trawinski, 2016; Kisler & Lock, 2019; O'Byrne & Haines, 2021; Swindlehurst et al., 2023; Valadez et al., 2020) and internalized stigma were reported (Henrich & Trawinski, 2016; Arseneau et al., 2019; Campbell et al., 2023; O'Byrne & Haines, 2021; Valadez et al., 2020Vaughn et al., 2019). Furthermore, participants reported stigma which targeted their relationships (Grunt-Mejer & Łyś, 2022; Henrich & Trawinski, 2016; Swindlehurst et al., 2023) as well as them as individuals (Carlström & Andersson, 2019; Schechinger et al., 2018; Swindlehurst et al., 2023; Vaughan et al., 2019). Participants also reported anticipated stigma (O'Byrne & Haines, 2021; Schechinger et al., 2018; Swindlehurst et al., 2023; Valadez et al., 2020, Vaughan et al., 2019).

Participants reported both negative and positive responses from their healthcare providers regarding their CNM status. Negative responses included focussing too much on CNM, questioning, dismissing, avoiding, being unresponsive, lacking CNM competence, pathologizing CNM, and refusing service (Campbell et al., 2023; Carlström & Andersson, 2019; Henrich & Trawinski, 2016; Schechinger et al., 2018; Swindlehurst et al., 2023; Vaughan et al., 2019). Negative responses compounded minority stress and damaged the therapeutic alliance, which were associated with negative implications for clients, such as negative emotional and behavioural reactions, unsuccessful therapy outcomes, fear of not being understood, fear of

pathologization, internalized mononormativity and stigma, early termination, and the negativizing of therapy as destructive and unhelpful (Campbell et al., 2023; Schechinger et al., 2018; Swindlehurst, 2023; Vaughan, et al., 2019). Positive responses included receiving CNM-inclusive and CNM-aware care and healthcare providers responding in a matter-of-fact manner, using affirmation and helpful techniques, being non-judgmental, and having CNM knowledge (Campbell et al., 2023; Henrich & Trawinski, 2016; Schechinger et al., 2018; Vaughan, et al., 2019).

Participants described their strategies for navigating stigma, which included disclosure, concealment and seeking CNM-inclusive providers (Arseneau et al., 2019; Campbell et al., 2023; O'Byrne & Haines, 2021; Valadez et al., 2020; Vaughan, et al., 2019). Specific suggestions for clinicians were provided by participants in two studies (Arseneau et al., 2019; Kisler & Lock, 2019). Among the most important suggestions were those related to *acknowledging* and *accommodating* the unique circumstances and make-up of clients who practice CNM, as well as *allying* with clients through advocacy (Arseneau et al., 2019). Participants suggested that therapists *seek education* about CNM in order to *challenge* their *assumptions and biases.* In this way, therapists could then *show openness* and *not pathologize CNM* (Kisler & Lock, 2019).

These findings can be applied to inform the quality of care counsellors provide to consensual nonmonogamists in three ways. The first is increasing counsellor awareness of CNM stigma. Counsellors can learn of the existence of mononormativity, CNM stigma, and the types of stigma that consensual nonmonogamists face. They can also be aware of the negative and positive responses that study participants have reported receiving from healthcare practitioners. The second is decreasing counsellor stigma toward consensual nonmonogamists. When counsellors are aware of CNM stigma and its effects, they can begin to engage in practices, such

as education and reflexivity, that decrease the perpetuation of CNM stigma. The third is providing CNM-inclusive and CNM-aware interventions to clinicians for working with consensual nonmonogamists, as described previously. These include interventions that do not perpetuate counsellor stigma, as well as interventions that can help clients navigate stigma outside of the counselling room.

Recommendations

Clinical/Therapeutic Research

The framework suggested based on this review is preliminary and has not been tested. Therefore, future research could explore the efficacy of the framework and suggested interventions therein. This would involve, for example, testing the level of training necessary to achieve competence as a CNM therapist, testing the participant-suggested therapist practices for effectiveness in reducing symptoms of minority stress, and studying stigma attitudes in policy makers.

CNM Research

Since research on CNM is in the developmental stage, research gaps abound. The first gap involves underrepresented populations. The most common demographic in CNM studies is White, middle class, educated, heterosexual, and cisgender (Arseneau et al., 2019; Campbell et al., 2023; Vaughan, et al., 2019). Future studies could recruit and focus on participants who fall outside of the majority, which can aid in a more complete understanding of participant experiences (Brewer et al., 2022). While there was some geographic, language, and cultural diversity in this review's study samples (Arseneau et al., 2019; Campbell et al., 2023; Carlström & Andersson, 2019; Grunt-Mejer & Łyś, 2022), the majority of the participants were from

Western countries, either in North America or Europe. Recruitment of consensual nonmonogamists in non-Western countries would strengthen the research.

Another gap involves the differentiation of CNM types and their subtypes. Future studies could focus on one specific type individually, such as polyamory, swinging, or open relationships (O'Byrne & Haines, 2021; Valadez et al., 2020). Further to differentiating the major types, studies could explore the differences within each individual CNM type, such as hierarchical/nonhierarchical, romantic/sexual, number of partners, types of agreements and boundaries, and consensually nonmonogamous families, to name a few. There were no studies that included relationship anarchy, therefore, studies are needed on this population to understand their experiences of stigma and to inform therapists on how best to support such clients.

Stronger methodological approaches would strengthen the research on CNM (O'Byrne & Haines, 2021; Swindlehurst et al., 2023; Valadez et al., 2020). For example, stricter exclusion criteria, such as excluding those who are "curious about" CNM (Kisler & Lock, 2019, p. 46) would make studies more generalizable. Recruitment strategies were often limited to convenience sampling, making results subject to selection bias (Arseneau et al., 2019; O'Byrne & Haines, 2021). Therefore, future studies could engage in strategies that recruit a more robust, heterogenous sample. Future studies could also employ member checking and triangulation to strengthen the data and therefore the conclusions drawn (Creswell & Poth, 2018).

Research on counsellor's beliefs, knowledge, education and experience with consensual nonmonogamists will be integral to understanding whether they are able to provide inclusive and competent care (Vaughan et al., 2019). Finally, research on counselling interventions for CNM clients is greatly needed. Studies could, for example, explore quality of care for consensual

monogamists and interventions that can alleviate client fears regarding attending therapy (Swindlehurst et al., 2023).

Education & Policy

Educational institutions that provide graduate education in counselling steward policy regarding the educational content that is provided the students who attend. As of this writing, one university in Canada, Adler University in Vancouver, provides a course on CNM (Adler University, n.d.). Entitled *Introduction to Consensual Nonmonogamy*, the course is described as an introduction to various forms of CNM, as well the conceptualization, assessment and treatment of consensual nonmonogamists. Challenging biases, providing allied care and effective marketing communication are also offered as part of the course. When compared to the framework proposed in this review, the course meets all requirements, with one exception – *CNM Advocacy*. Since the course lens is listed as systemic, advocacy may well be included in the course, just not in the course description. Regardless, it is a promising initial model which could be tested, adjusted if necessary, and added to graduate programs in counselling across the country and beyond, with the potential of creating a more affirming world for consensual nonomonogamists.

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Appendix

Table 1: Summary of Themes

Theme	Subthemes
1. Stigma: Living in a mononormative world	1.1 Institutionalized stigma 1.2 Internalized stigma 1.3 Individual stigma 1.4 Relationship stigma 1.5 Anticipated stigma
2. Responses from Healthcare Providers	2.1 Negative responses 2.1.1 Questioning 2.1.2 Dismissing 2.1.3 Judging 2.1.4 Focus 2.2. Lack of CNM competence 2.3 Pathologization 3. Positive Responses
3. Client strategies to navigate stigma	3.1 Being closeted 3.2 Disclosure 3.3 Seeking CNM-inclusive providers
4. Suggestions for clinicians	4.1 Acknowledge, accommodate, ally

Table 2: Summary of Research Articles

Authors	Title	Year	Research Method	Themes	Country	Notes
Arseneau, E., Landry, S., & Darling, E. K.	**The polyamorous childbearing and birth experiences study (POLYBABES): A qualitative study of the health care experiences of polyamorous families during pregnancy and birth**	2019	Constructivist, qualitative Braun and Clarke's thematic analysis	1. Presenting poly 2. Living in a mononormative world 3. Overcoming barriers/Suggestions for healthcare providers and health care institutions 3. 1 Acknowledge (e.g., partner's presence, partner's roles) 3.1.1 Show openness and remain nonjudgmental 3.1.2 Provide space for patients or clients to disclose; do not perceive lack of disclosure as deception 3.1.3 Self-educate 3. 2 Accommodate (e.g., physical space, hospital bracelets, intake forms, questions to clients) 3.2.1 Explain the medical relevance of the questions you ask 3.2.2 Create, modify or adapt intake forms 3.3. Ally (e.g., avoid assumptions; advocate for your patients or clients and their families) 3.3.1Show openness and remain 3.3.2 Nonjudgmental 3.3.3 Provide client-led care	Canada	PubMed Central Mentions mental health, Canadian study that spans 4 provinces Only relevant themes included Types of clinicians: Healthcare providers, midwives, OBs, doctors, family doctors
Campbell, C., Scoats, R., & Wignall, L.	**Oh! How modern! And… Are you ok with that?": Consensually non-monogamous people's experiences when accessing sexual health care**	2023	Mixed Methods Braun and Clarke's reflexive thematic analysis, inductive	1. Consensual non-monogamists' approaches 1.1 Passing 1.2. Proudly out 2. Clinician's responses 2.1. Lack of knowledge 2.2 Matter of fact 2.3 Harmful assumptions	UK	Taylor & Francis Includes participants from UK (76%), North America (15%), Europe (7.5%), Australia (1.5%) Types of clinicians: sexual healthcare providers, healthcare professionals, general physicians, clinicians, doctors
Carlström, C., Andersson, C.	**Living outside protocol: Polyamorous orientations, bodies, and queer temporalities.**	2019	Qualitative Braun and Clarke's thematic analysis Phenomenology, queer theory	1. Silence and Coming Out 2. Being Stopped: Interactions with Professionals	Sweden	Springer Only relevant themes included Types of clinicians: Therapists, psychologists, doctors
Grunt-Mejer, K., & Łyś, A.	**They must be sick: consensual nonmonogamy through the eyes of psychotherapists**	2022	Mixed Methods Qualitative Braun and Clarke's thematic analysis Quantitative ANOVA	Qualitative: A. Relationship-related 1. Problems related to the form of the relationship 2. Lack of passion and sex satisfaction 3. Problems with extramarital partners 4. Communication skills 5. Temporary problems in relationship 6. Relationship needs unsatisfied 7. Pathological dynamics in couple 8. Dissatisfaction with the relationship 9. Moral dilemmas regarding extramarital liaisons or fantasies 10. Problems related to procreation and sexual health B. Not related to the relationship 1. External problems 2. Psychological individual problems 3. Health problems 4. Diagnosis instead of indication of the problem's source	Poland	Taylor & Francis Types of clinicians: Current and prospective therapists (i.e., graduate students in clinical psychology and postgraduate students in sexology)

				Hypotheses about the origin of depressive symptoms Unrelated to the relationship – mono highest count Related to the relationship - poly had the highest count Hypotheses about the origin of alcohol abuse Unrelated to the relationship - mono highest count Related to the relationship – cheating highest count, much higher than rest Hypotheses about the origin of ED Unrelated to the relationship - mono highest count Related to the relationship – swinging highest Hypotheses about the origin of fights Unrelated to the relationship - mono highest count Related to the relationship – swinging and poly highest (swinging marginally higher) 1. Polyamory as the source of people's problems in therapy (pathologizing)		
Henrich, R., & Trawinski, C.	**Social and therapeutic challenges facing polyamorous clients**	2016	Qualitative Phenomenological	1. Social Challenges 1.1 Internalized marginalization 1.2 Institutionalized marginalization 1.3 Disclosure 2. Therapeutic Challenges 2.1 Insufficient knowledge 2.2 Client marginalization 2.3 Therapist bias	USA	Taylor & Francis Types of clinicians: therapists
S. Kisler, T., & Lock, L.	**Honoring the voices of polyamorous clients: Recommendations for couple and family therapists**	2019	Qualitative Phenomenological and pragmatic	1. Special challenges 1.1 Dealing with stigma 1.2 Navigating polyamory 2. Suggestions for couple and family therapists 2.1 Seek education 2.2 Challenge your assumptions 2.3 Do not pathologize polyamory	USA	Taylor & Francis 6 respondents from outside of USA Types of clinicians: Therapists
O'Byrne, P., & Haines, M.	**A qualitative exploratory study of consensual non-monogamy: Sexual scripts, stratifications and charmed circles**	2021	Qualitative Postconstructivist	1. Perceptions of CNM Reluctance to disclose to healthcare providers: -always disclose -only doing so if asked -fear of judgement -withhold, even if relevant	Canada	ProQuest Types of clinicians: Mentions healthcare stigma, not specifically therapists
Schechinger, H. A., Sakaluk, J. K., & Moors, A. C.	**Harmful and helpful therapy practices with consensually non-monogamous clients: Toward an inclusive framework**	2018	Mixed Methods Qualitative Braun and Clarke's thematic analysis Quantitative R Confirmatory factor analysis Structure equation modeling	Very Unhelpful Practices 1. Judgmental 1.1. Generally judgemental 1.2 CNM is wrong or not ideal 1.3 Emphasized religion/traditional values 1.4 nonverbal judgement/discomfort 1.5 felt unsafe discussing CNM 1.6 Queer critical (e.g. kink, bisexuality) 1.7 Criticized/shamed for being CNM 2. Pathologize 2.1 CNM is the cause or result of another problem 2.2 CNM harms relationships 2.3 CNM is not good for women 3. Knowledge 3.1 Lacked/refused to gather information about CNM 3.2 Not listening/grasping CNM concerns 3.3 Expected client to educate therapist 4. Dismissive 4.1 Pressure to end a relationship or come out 4.2 Dismissed CNM 4.3 Assumed monogamy	USA and Canada	PsycArticles, APA Types of clinicians: therapists

				4.4. Refused service 5. Focus 5.1 Focused on CNM too much 5.2 Avoided CNM Very Helpful practices 1. Affirming 1.1 Supported CNM identity/decision 1.2 Prioritized client's needs/goals/values 1.3 Acknowledged CNM as valid 1.4 Validated/trusted clients' decisions 1.5 Queer/kink affirming 1.6 Acknowledged societal stigma 2. Helpful techniques 2.1 Asked helpful questions 2.2 Provided helpful advice 2.3 Helped to improve/navigate relationships 2.4 Listened effectively 2.5 Valued relationships individually 2.6 Helped explore/manage emotions 2.7 Didn't avoid or fixate on CNM 3. Nonjudgmental 3.1 Normalized/didn't overreact 3.2 Was accepting 3.3 Acknowledged bias 3.4 Didn't pathologize/blame CNM for problems 3.5 Remained neutral 4. Knowledge 4.1 Had basic knowledge of CNM 4.2 Open to learn 4.3 Sought outside information 4.4 Provided CNM resources		
Swindlehurst, S., Sweet, J., & Hoelterhoff, M.	**Room for Growth: A qualitative study into the therapeutic experiences of consensually non-monogamous clients in the United Kingdom**.	2023	Qualitative Braun and Clarke's reflexive thematic analysis, inductive	1. Pathologisation 2. Stigma 2.1. Individual Stigma: Promiscuity and Sexism 2.2. Relationship Stigma: Mononormativity 3. Potential barriers to openness within the therapeutic alliance 3.1. Fear from the Client 3.2. Reactions from Practitioners 3.3. Lack of Education	UK	Mental Health & Social Care Collection Types of clinicians: therapists, "mental health practitioners"
Valadez, A. M., Rohde, J., Tessler, J., & Beals, K.	**Perceived stigmatization and disclosure among individuals in consensually nonmonogamous relationships**	2020	Qualitative Grounding Approach to determine broad themes Inductive latent thematic approach (Braun & Clarke, 2006)	1. CNM as a Stigmatized Identity 1.1 perceived stigmatization 1.2 emotions/thoughts/concerns about stigma 1.3 personal experiences of stigmatization 2. Disclosure and Concealment 2.1 extent of disclosure 2.2 reason for disclosure 2.3 reason for concealment 2.4 emotions/thoughts/concerns about disclosure 2.5 stigma and disclosure 3. Outing 3.1 experiences with being outed 3.2 emotions/thoughts/concerns about outing	USA	Wiley Online Library Relevant information on limiting disclosure Types of clinicians: One mention of a psychologist
Vaughan et al.	**Healthcare experiences and needs of consensually non-monogamous people: Results from a focus group study**	2019	Qualitative Focus group Braun and Clarke's (2006) thematic analysis	1. Ignorance of CNM 1.1 Pressure to educate providers 1.2 Inadequate screening 2. Sexual stigma 2.2 Stigma reactions 3. Stigma avoidance efforts/seeking CNM-inclusive providers 4. Experiences of CNM-inclusive care 4.1 Open-mindedness and acceptance 4.2 Meeting healthcare needs/requests	USA	PsycInfo + PsycArticles PubMed Types of clinicians: "healthcare providers," gynecologist, doctors, "healthcare staff, cardiothoracic surgeon