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THERAPEUTIC CONSIDERATIONS FOR THE POLYCULE:

A QUALITATIVE EXPLORATION OF CONSENSUAL NON-MONOGAMY

IN COUPLES TREATMENT

by

Tema Watstein

City University of New York

The Graduate Center

A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

2022

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Therapeutic Considerations for the Polycule: A Qualitative Exploration of

Consensual Non-Monogamy in Couples Treatment

by

Tema Watstein

This manuscript has been read and accepted for the Graduate Faculty in Clinical Psychology Doctoral Program at City College in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy

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Abstract

Therapeutic considerations of the polycule: a qualitative exploration of consensual non-monogamy in couples treatment

by

Tema Watstein

Advisor: Elliot Jurist, PhD

Despite the growing visibility of consensual non-monogamy culturally and in the academic domain, treatment of CNM relationships has been understudied from the clinical perspective. This study utilized a sample of 11 clinicians, who discussed their experiences of treating non-monogamous couples through a semi-structured interview. Qualitative thematic analysis led to the emergence of robust themes, which were synthesized into three broader categories: 1. Therapeutic Process, 2. Issues in Treatment, and 3. The Meaning of Non-Monogamy. Therapists discussed their own clinical processes, with emphasis on countertransference, frame, self-disclosure, and considerations for training. Themes also emerged surrounding common issues in treatment, ranging from specifics in the process of opening up and creating relationship agreements, to broader realms of fantasy, desire, and connection. The overlap of trauma history with pursuit of CNM was also salient in a majority of interviews, with a focus on emotion regulation as a crucial component in the resulting therapeutic work. Findings also indicate that an important aspect of couples work for CNM relationships is meaning-making, through which couples articulate and create a shared understanding of CNM and its value specifically in the context of their relationship. While internalized mono-normativity and the resulting minority stress experience were relevant factors particular to this relationship work, many of the findings from this study are generalizable to all couples treatments.

Keywords: consensual non-monogamy (CNM), polyamory, open relationships, couples therapy, relationship therapy, commitment, intimacy

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At its best, monogamy may be the wish to find someone to die with; at its worst it is a cure for the terrors of aliveness.

Adam Phillips, Monogamy

CHAPTER 1: The Cultural Rise of Consensual Non-Monogamy

Introduction

Through the past decade, consensual non-monogamy has begun to leave the sanctuary of the bedroom and has been garnering increasing public attention in the media as well as in the academic domain. Non-monogamy has also entered the clinical sphere, as both individual and couples patients look to treatment to help sort through the complexities of human relationships. To quote the psychoanalyst Adam Phillips (1996), one of the earlier contributors on the subject, “If monogamy is our secular religion, polyamory is the latest heresy.” Kipnis (2004) notes that, “sexual exclusivity [is] the cornerstone of modern coupledom,” a rock at which non-monogamy chips away. So much research regarding human relationships has been founded on assumptions - presumptions - of monogamy, which must be re-examined. As with Whiteness or maleness in research historically, monogamy has been assumed as both the baseline “norm,” against which all deviations can be measured, and a crucial achievement of healthy development. In the first meta-analysis examining just this, (Conley, Moors, Matsick, & Ziegler, 2013) concluded that monogamy is perceived both in research and in today’s society as “foundational

for a healthy, satisfying relationship" (see also Moors, et al., 2013; Easton & Hardy, 2009; Haag, 2012; Kipnis, 2004; Moors & Schechinger, 2014; Perel, 2006; Sheff, 2014; Smith, 1991). As will be explored in this dissertation, the nascent body of empirical research examining the quality of non-monogamous relationships in fact evidences that engaging in non-monogamy indicates nothing "pathological" about one's attachment. Moreover, for those who choose to mutually engage in non-monogamy, these arrangements may contribute positively to relationship quality, and even the growth of trust. Despite its growing visibility, non-monogamy inspires intense reactions, including in therapeutic countertransference. The immense and longstanding stigma against non-monogamy in combination with the overall de-sexualization of the psychoanalytic field have contributed to blind spots and missed opportunities in couples treatments. An uninformed perspective can hinder both a patient's ability to feel safe with a clinician, and a therapist's ability to monitor their associations and biases.

Esther Perel, who herself remains in a long term self-reportedly monogamous partnership, is one of the preeminent voices cautioning therapists that monogamy should not be assumed as the universal fit. In my own increasing work with couples throughout my training, I have experienced otherwise open and exploratory supervisors as judgmental and pathologizing when it comes to non-monogamy. I have also grappled with my own reactions, which have ranged from fear and discomfort to excitement and over-emphasis of the subject. This paper hopes to address some of the questions asked in these early days of clinical non-monogamy research.

The purpose of the present study is to investigate common themes communicated by therapists who have worked with consensually non-monogamous patients in couples treatment.

The data set is comprised of interview transcripts, to be completed by the writer. A grounded theory methodology was utilized so that the participants' responses could be assessed in the unrestricted, spontaneous and authentic manner in which they were offered. While several studies have explored the experience of non-monogamous couples in therapy, none have used a psychoanalytic framework to approach the therapeutic perspective. This study aims to contribute to the burgeoning literature in this domain as a thematic investigation of the issues that arise in these treatments, particularly as they pertain to countertransference. Resulting theory may inform training, supervision and treatment interventions broadly in the field of relationship therapy.

CHAPTER 2: Literature Review

Defining CNM

For the purposes of this paper, consensual non-monogamy will be defined as "a relational arrangement in which partners agree that it is acceptable to have more than one sexual or romantic relationship at the same time" (Conley, Moors, Matsick, & Ziegler, 2013). It is important to note that non-monogamy can present in a number of forms, which can include swinging and open relationships, both of which are centered more around single or recurring sexual encounters, as well as polyamory, in which individuals are permitted to pursue and maintain multiple simultaneous loving or committed relationships. Before defining consensual non-monogamy, the implications of the language around these relationships must be acknowledged. Even the linguistic suggestion of the primary term, "non-monogamy" places the idea of a monogamous pair bond as the gold standard against which other forms of relationship

must be measured, is in itself problematic. Terms like "infidelity" or "cheating" as well as "betrayed partner" also imply a strong negative around the notion of non-dyadic bonding (Weeks, & Stellberg-Filbert, 2013 via Conley, 2015).

Prevalence

Census research (Haupert et al., 2016) suggests that approximately 4-5% of individuals (regardless of sexual orientation or gender) are involved in some version of concurrent sexual relationships, ie. non-monogamy, at any given moment, and that lifetime prevalence is approximately 21% across populations. In this same study, Haupert asserts that, "the percent of the population reporting some experience with CNM remained remarkably stable across many categories, such as age, race, social class, religion, education level, and political affiliation." However, there were some differences across sexual orientation and gender, with men and queer-identified participants being more likely to report engagement with non-monogamy than women or heterosexual subjects. Moors' (2014) review indicates that second to gay men, prevalence is by far highest among bisexual-identified individuals (as per 90% of subjects in Barker's 2005a survey, and 51% and 54% respectively in Weber's, 2002, and Wosick-Correa's, 2010, surveys, via Moors, 2014). The gender difference (with men reporting more engagement in non-monogamy than women) may be the result of the sexual double standard - to be further explored later in this chapter - through which women are judged more harshly than men for promiscuity. Additionally, a social desirability response bias may have been present, as people tend to avoid admitting participation in stigmatized behaviors. Non-monogamy is also dynamic

through the lifespan, and the definition is plastic from person to person as well as couple to couple. People may forget about previous non-monogamous encounters, or may identify differently at various points relationally.

Non-Monogamy: "It works for gay men"

Most literature asserts that contemporary consensual non-monogamy has its roots in the activities of gay communities (Conley et al., 2017). Blumstein & Schwartz (1983) first documented gay men's engagement in consensual sex outside their primary relationship in the early 1980s. There is a significantly greater body of research on gay male non-monogamy, which has generally indicated that gay males are equally satisfied and fulfilled in both monogamous and non-monogamous relationships. At the time of Blumstein's study, the reported engagement rate of approximately 65% of subjects as non-monogamous was remarkably uncontroversial; Moors (2014) hypothesizes that this is perhaps "because dominant groups have less interest in regulating the sexuality of marginalized groups than of other dominant group members." Studies addressing negative bias towards gay male relationships have typically shown that people perceive gay men as "sexually risky" and their relationships as low in quality and satisfaction (Moors, Matsick, Ziegler, Rubin, & Conley, 2013; Peplau, 1993). These stereotypes parallel some of the negative bias prevalent in non-monogamy research as it pertains to heterosexual configurations, which has garnered increasing visibility and attention in the past two decades. Literature has largely dispelled these myths for gay men (Moors, 2014; also Peplau, 1993, and

Peplau & Spalding, 2003), and may soon catch up in other queer and heterosexual realms as well.

Non-Psychoanalytic Perspectives

While the interviews in this study will focus on psychodynamic perspectives, to be covered later in this literature review, social psychology offers a number of reasons underlying the uptick in non-monogamy. One perspective to consider is Kelley and Thibaut's (1978) Interdependence Theory. As Conley (2017) puts it, "Partners stay in a relationship on the basis of the ratio of costs and benefits in the relationship, as well as how mutually involved individuals are in each other's lives." Polyamorous individuals with more than one close relationship have a more diversified relationship portfolio vis-à-vis monogamous individuals who are focusing on only one romantic relationship." From this position, the risk associated with finding or encountering new relationships is considerably higher in monogamy.. Within a monogamous framework, a new relationship entails the dissolution of a previous relationship; however, polyamory shifts this paradigm. Put another way, polyamory is a strategy that helps to manage risk. Steven Mitchell, from a psychoanalytic lens, argues largely the same point. Another theory to consider is Aron & Aron's (1996) self-expansion theory, which suggests that part of a satisfying relationship is one's ability to see their partner as part of themselves, and as a result, expand their own sense of selves and pleasure. Conley (2017) notes that the process of opening up a relationship (as opposed to beginning from a place of non-monogamous agreement) can entail excitement, but that the valence of the excitement is crucial.

Pressures of Marriage

Reibstein and Richards, via Rusbolt (2004) describes polyamory as a reaction to the expectations with which modern couples are afflicted. Many clinicians acknowledge the unreasonable pressures placed on modern coupledom, but few advocate for non-monogamy as a feasible way of managing and dispersing this pressure. Marriage, the primary expression of monogamous commitment, inevitably lets members of a couple down. Of course soaring divorce rates indicate this, but some research indicates that even considering alternative models might be enough to reinvigorate a monogamous couple. Perel, in her 2018 book The State of Affairs, notes that "people make secret deals with themselves – a unilateral decision rather than a decision as a unit." We rationalize "cheating" rather than bringing our desires to our partner, an act of trust, vulnerability, and perhaps even a catalyst for erotic intimacy within the bond. In a 2006 study, Perel found that simply discussing the possibility of non-monogamy may increase sexual desire between two monogamous partners. This clinical observation bolsters the assessment of monogamy as a social structure that may promote reactance. As Tammy Nelson, a non-monogamy expert at Yale, puts it in her 2018 TED talk, "Yes – some are rebelling against divorce–but people are looking for realistic ways to make their vows last – nonconformists aim for a more holistic, malleable definition of the term; [perhaps it's] not non-monogamy but new monogamy."

Rejection of Patriarchy and Social Support

Sheff (2005) and Wolkomir (2015) both emphasize the ways in which non-monogamous subjects (mainly women, but also some men) view their lifestyle as an active rejection of patriarchy. In deconstructing the roles of "femininity" and gender, subjects reported striving for greater "authenticity." Other interviewees noted rejecting the notions of "living for other people" and the power in asserting their own desires. Some also referenced desire as a historically masculine concept, reclaiming sexuality as their own. Interestingly, many subjects also reported that non-monogamy allowed for a spectrum of intense female relationships, not all of which were sexual. Research indicates that a wide range of social support is a major protective factor for mental and physical wellbeing (Reblin, 2008). By widening both the breadth and depth of relationships permissible within the context of committed relationships, women are building more comprehensive networks for themselves. Beginning to bridge the gap into psychoanalytic territory, Chodorow (1978) noted that boys may identify with father at the expense of relatedness, whereas girls' identification is sacrificed *to* relatedness. Benjamin (2012) furthers that "when identificatory love is not satisfied within this context of mutual recognition—as it frequently is not for girls—it later emerges as ideal love, the wish for a vicarious substitute for one's own agency." Through practice of non-monogamy, women may explore themes of agency, as well as a diversification of social support.

Sexual Scripts and Fluidity of Sexual Identity

Another interesting area of exploration within non-monogamy research are applications to sexual scripts. Sexual scripts are socialized ideas of how male and females should behave in sexual and romantic contexts. In a 2013 study by Masters et al. of 44 heterosexually active men and women, analysis discerned three styles of working within sexual scripts: "Conforming, in which personal gender scripts for sexual behavior overlapped with traditional scripts; exception-finding, in which interviewees accepted culture-level gender scripts as a reality, but created exceptions to gender rules for themselves; and transforming, in which participants either attempted to remake culture-level gender scripts, or interpreted their own non-traditional styles as equally normative." Intuitively, non-monogamous relationships fell into both exception-finding and transforming categories. Despite these groupings and the notion that "gendered sexual scripts are hegemonic at the cultural level," (Masters et al., 2013), this work suggests that this may not be the case on the dyadic or individual level. This work again emphasizes that non-monogamy is a very individualistic practice, and that there is not a one-size-all approach.

Yael Malka (2019) for The New York Times, interviewing a series of non-monogamous constellations, remarked that many people felt surprised by a burgeoning aspect of their sexuality of which they had previously been unaware. Malka observed again and again that women in particular felt surprised by their desires when given room to explore. This could pertain to the discovery of previously repressed homosexual fantasies or new fetishes. Allowing for action also allowed for fantasy to blossom. To quote Zelli Kane, a 35-year-old writer and one of the subjects in this article, "You have to be willing to spend more time deconstructing your inner internalized

ick factor, when it comes to being open — your own self-judgment." Interestingly, I have observed this with men as well in my own clinical practice. In one heterosexual-identified polyamorous couple I had been seeing for approximately 6 months, only after getting married did the cis-male-identified husband act on pursuing sexual encounters with other men for the first time in his life. It seemed that both the presumed safety of his marriage as well as the freedom allotted by the couple's agreements around polyamory allowed this man to embrace his bisexuality.

Attachment in Non-Monogamous Partnerships

Consistent with other stereotypes mentioned above which have a positive bias towards monogamy, Roberts & Pistole (2009), Moors et al. (2014), and Conley et al. (2017) note that attachment researchers often equate romantic security with sexual exclusivity. Psychological theoretical perspectives implicitly and explicitly imply that monogamous partnering is ideal. Even popular framing of Erikson's (1982) psychosocial developmental stage in young adulthood, intimacy versus isolation, frequently places emphasis on monogamous pair-bonds. While only 3-7% of mammals are monogamous (Lukas, 2013), pair-bonds are the main unit considered in attachment research. While of course individuals can maintain multiple pair-bonds, in the scheme of attachment literature, pair-bonding refers to "an individual's development of a monogamous relationship with one (and only one) other person" (Hazan, Campa, & Gur-Yaish, 2006: Hazan & Shaver, 1987, via Conley 2017). Recent empirical findings, however, do not support these assumptions. As Moors (2014) notes, "Although (Western) attachment theorists

typically assume that adult attachment is equivalent to monogamous bonding, monogamy may not be strictly necessary for the development of attachment security." In a 2014 study of 1,281 heterosexual and monogamously identified individuals examining one's leanings towards pursuing non-monogamy, Moors et al. found that individuals with an avoidant attachment style hold more positive attitudes towards consensual non-monogamy. Additionally, those with avoidant attachment styles also report greater willingness to participate in various forms of consensual non-monogamy. Bearing in mind that these subjects had never actually participated in non-monogamous relationships, Moors speculates that this may be because avoidant individuals are more willing to engage in a non-monogamous arrangement because it promotes distance from their partners. Anxiously attached individuals maintained more negative attitudes towards consensual non-monogamy but no difference in desire to engage in non-monogamy as compared with securely attached individuals. Referencing Allen & Baucom (2004), Moors notes this may reflect anxious individuals' ambivalent attitudes towards intimacy.

In a linked study of 1,952 heterosexual individuals (in both monogamous and non-monogamous relationships) examining non-monogamous behaviors (as opposed to attitudes), Moors et al. (2014) found that individuals lower in avoidance were more likely to be in a consensually non-monogamous relationship over a monogamous relationship. This same study concluded that anxiety was unrelated to current relationship status. This study replicated results from previous non-monogamy research (Jenks, 1998; Ritchie & Barker, 2006), which indicate that individuals in consensual non-monogamous relationships are primarily securely attached. To participate in an enduring non-monogamous relationship may require higher depth and frequency of communication among partners. As Moors et al. (2014) states, "communication strategies that

are expected within polyamorous relationships also are demonstrably the most effective methods of communication for maintaining positive dyadic relationships. By contrast, these differences could mean that individuals who self-select into specifically polyamorous (rather than open, swinging, or monogamous relationships) make communication about relationships a more significant part of their lives." This theory is also congruent with the finding that monogamous individuals are higher in avoidance than non-monogamous individuals. Work by Conley et al. (2017) indicated no differences between groups of monogamous versus non-monogamous individuals on measures of relationship functioning, which included measures of global satisfaction, commitment and passionate love. In short, engagement in non-monogamy does not foreclose the possibility of satisfaction in a primary relationship. Notably, jealousy was lower and trust was higher for those in the non-monogamous groups. Conley notes this could be because of the permission granted for extradyadic contact, and also hypothesizes that perhaps people who are less jealous gravitate more towards practice of non-monogamy. The communication styles employed by non-monogamous individuals, when they work well - which of course isn't ubiquitously the case - may serve as models for monogamous dyads as well.

More than One Couple: Primary vs. Secondary

Preliminary data seems to point to polyamory, which permits both extradyadic sexual and emotional intimacy, as opposed to solely sexual intimacy, as the non-monogamous practice which indicates the greatest positive relational outcomes. Conley (2017) hypothesizes that this may be because of the lack of emotional constriction: "If one of the purposes of sex is emotional

intimacy (e.g., Cacioppo, Bianchi- Demicheli, Frum, Pfaus, & Lewis, 2012; Donnan & Magowan, 2010), perhaps it is more difficult for an individual to be satisfied in one relationship while attempting to suppress emotional and romantic feelings for others with whom that individual is sexual, as is expected in strictly open relationships or swinging." Further, to navigate the complexities of emotional terrain, polyamory necessitates the most subtly distinctive and ongoing communication styles, which may relate to a sense of global closeness within a primary relationship.

Another study by Mitchell et al. from 2014 involved the comparison of primary and secondary relationships, aiming to disprove the perceived stereotype that dyads who engage in non-monogamy do so because they are unsatisfied with their primary relationships and need to seek supplemental satisfaction outside of the "confines" of the dyad. In this online study, comprised of 1,093 polyamorous-identified individuals maintaining simultaneous ongoing relationships, partners reported high levels of need fulfillment and satisfaction in both relationships. This same study concluded that "fulfillment with one partner negatively predicted approximately 1% of the variance in relationship satisfaction with the other partner." Furthermore, no association between need fulfillment with one partner and commitment to the other was found. In sum, these preliminary findings indicate that polyamorous relationships operate as relatively independent of one another.

Bias in Treatment

Even in the hyper-progressive 1970s, researchers expressed concern about the therapeutic community's ability to treat a growing population of "alternative lifestyle clients." Knapp (1975)

found that as many as 17% of therapists admitted they would attempt to convince non-monogamous clients to abandon their lifestyle. Interestingly, this bias was not the result of theoretical orientation, but rather, was correlated with negative views of extramarital sex and therapists' own participation in consensual and non-consensual non-monogamy. More recently, Nauroth, Gollwitzer, Kozuchowski, Bender, and Rothmund (2016) have demonstrated that research experienced as threatening to an individual's identity is perceived as more biased than that which affirms an individual's identity. Conley et al. (2017) applied this premise to non-monogamy directly in a study that concluded that researchers who present data about consensual non-monogamy were perceived as more biased than researchers presenting findings favoring monogamy.

Barker (2010) aptly points out that most research in this nascent domain of non-monogamy has been either "celebratory" or "critical," and that it can be difficult to find unbiased literature. Conley et al. (2017), also studied exactly this phenomenon, and noted that a positive-leaning bias (towards non-monogamy) is often perceived in literature exploring non-monogamy even when it is not present. This is to say that the subject of non-monogamy arouses powerful reactions, and as the body of research on this topic is young, all conclusions must be greeted with some caution and care.

Limitations in Empirical Research

Little has been written about the compounding effect of intersectionality within the non-monogamous minority experience (Haritaworn, Lin and Klesse, 2006). Wiley (2010) powerfully describes this phenomenon, noting that the stigma experienced by bisexuals is felt

"doubly so by non-monogamous bisexuals, triply when they are women, and likely more still if they are women of color." She continues by noting that historically, women of color have been sexualized in dominant culture, represented as not only sexual, but also deviant, demonized, and exoticized. This tremendously disincentivizes women of color from reporting, and maybe even pursuing non-monogamy, as they already endure marginalization day to day. A 2010 analysis by Wiley affirms that "[many] texts...assume an audience of white, middle-class, able-bodied, educated, American people and fail to appreciate systemic intersecting oppressions in a rather simplistic identity-politics agenda." Rambukkana (2010) confirmed similar findings in a review of Canadian literature. In short, while non-monogamy may appear on the surface to be a practice of open and progressive communication, scholarly perspectives are somewhat myopic and utopic.

Psychoanalytic Perspectives

Desexualizing the Field

While it can be easy to associate psychoanalytic treatment with exploration of myriad sexual behaviors, in recent years, the evolution of the field has taken a strikingly normative trajectory. Historically, psychoanalysis has enabled the rethinking of social life from the perspective of sexuality, with libido as a potentially creative energy. Psychoanalysis, in an effort to stay vital, has accommodated the mainstream. As attachment theory, emotion regulation, and relational frameworks have grown in popularity, however, the field has turned its focus away from human sexuality. In fact, psychoanalysis has begun pathologizing "non-normative"

relational models and avoiding sexuality altogether. Elements of this sexual splintering, however, are not so new. Leo Bersani wrote in 1988, “From Freud to Lacan, psychoanalytic therapy has been vastly more conservative than psychoanalytic theory. [Analysts are] remarkably silent – or at best vague and inconclusive -about the relevance of their theoretical subversions to a possible questioning of the couple – especially, but by no means only, the heterosexual couple – as a normative model for psychoanalytic therapy.”

Both in written theory and even in the treatment room, we are all talking less about sex. Although non-monogamy has been on the rise both in terms of practice and visibility, over a decade ago, Fonagy (2008) demonstrated with computer-assisted word frequency analysis of treatment transcripts that there has been a decline of psychoanalytic interest in the concept of psychosexuality. Zamanian (2015) notes the peculiarity of this timing: “This disavowal of sexuality and attendant concepts such as autoeroticism, sadomasochism, bisexual disposition to name but a few, is of utmost curiosity and suspicion given that we have become a culture in perpetual state of war and obsessively consumed with sexuality on the Internet, mass media, and popular culture.” Culturally, we love the drama, but as therapists, we aren’t so encouraging towards our patients in expressing all of their fantasies.

What is a successful couples treatment?

The goals of couples treatment are different from those of individual treatment. Therapists are often too invested in the idea of helping a couple “stay together,” rather than elucidating and working through conflict for the mutual benefit of both parties. From a polyamorous framework, when a relationship ends, it does not necessarily indicate failure.

Inevitably, even when we strive for neutrality, we bring in our own value systems, which may or may not benefit our patients. Charles (2015) highlights several important points about moralism and values:

> Psychoanalysis, in the exposition of preferred, or ostensibly healthier or more mature forms of love, has been complicit in creating a palimpsest in which the multiple realities of loving relationships are obscured by the overlay of value. Although Kernberg (1980), for example, explicitly attempts to refrain from taking a moralistic stand, his rendition of love is forged within the constrained visions of a monogamous culture.

Referencing contemporary evolutionary psychology, Buss (2011) remarks on the "naturalistic fallacy" of assuming that just because something is "natural" or "adaptive" for survival and reproduction it must be good and moral. Saketopolou (2014) notes that sexual disgust, to be further explored as it pertains to countertransference, "tries to accomplish something good, preserving the purity of the self, in a bad way that involves shaming others."

Attachment as Value System and Sexual Subterfuge

As attachment theory has increasingly eclipsed psychosexuality, Zamanian (2015) notes that this can lead to "an impoverishment of the concept of development that in many respects writes meaning, individuality, and personal complexity out of the equation." In our yearning to uphold the wishful simplicity of the dyad, we neglect not only extra-marital players, but intrapsychic intricacies as well. Attachment is of course considered a crucial aspect of

self-preservation, which enables maintenance of regulatory and survival functions. Over-utilizing an attachment framework, however, contributes to the illusion of safety to which our culture has grown increasingly attached. Zamanian (2015) highlights the ways in which attachment theory "is the embodiment of the romantic vision of man." Attachment frameworks also reinforce patriarchal social structures; through our cultural idealization of the mother-child pair-bond, we reinforce idealization of children and parents as loving but asexual. Weinstein (2007) also comments on the limits of attachment theory, asserting that dyadic security can obscure somatic experience. When treatment loses sight of the connection between bodily experience and sexual fantasy, we erase Freud's *Nachtraglichkeit* and Lacan's après coup. In doing so, we deny not only infantile sexuality, but also underpinnings of adult sexuality.

Horney (1928), one of the earlier critics of monogamy, notes the potential toxicity of claiming a monopoly on attachment. Describing the prototypical anxiously attached mother, she notes that recreating the intensity of maternal demand is "not only difficult to enforce but also unjustifiable; [but] further…it represents the fulfillment of narcissistic and sadistic impulses far more than it indicates the wishes of genuine love." As Berlant (2012) further elaborates on this danger, "The infant becomes motivated to sociability by her drive to reclaim an impossible attachment." From an anaclitic foundation, later encouraged in a manner antithetical to individuation, we are discouraged from pursuing relationships that leave room to breathe.

In "Monogamy and its Discontents: Winning the Oedipal War," Charles (2002) asserts that optimally, a child will have positive identifications to and attachments with both parents, which can support tolerable experiences of closeness and distance. A person's adult choice of

love object, she furthers, "depends, to some extent, on one's own inner rhythms and needs for symbiosis versus autonomy." In other words, love objects help maintain a regulatory state, ideally a decent one. These choices are of course reflective of our wishes and lacks.

Charles observes that frequently, one partner may carry a relational piece of the couple, while the other partner may represent a striving or achieving function. This may be linked to prescribed gender norms, which can "delimit both intrapsychic and relational potential," but also may split into a self versus other space, which in turn may lead to false-self relations to self (Dimen, 1991; Goldner, 1991), and sado-masochistic relations with others (Benjamin, 1988). Optimally, early identifications with both parents enable the child to affirm needs for both closeness and distance. Relevance of Oedipal theory will be further addressed later in this chapter.

Desire and Fantasy

Freud (1912) famously wrote, "When they love, they cannot desire; when they desire, they cannot love." A century later, Berlant (2012) asserts, "Without fantasy, there would be no attachment and no love." Desire, fantasy, and love form an intricate matrix. All are necessary components relationally, yet they can thwart one another. For Kernberg (1998), the scaffolding of mononormativity allows for "perversions" such as BDSM to be celebrated as play. Benjamin (2013) furthers that when we over-privilege mutuality, we "anchor polymorphous pleasure in pathology by singularly focusing on particular relational arrangements." Sex and pleasure when sanctioned become sanitized. The generativity of desire relies on "taming" the experience of mutuality, which also allows for less play in the realms of both sex and gender. Barthes (1975)

frames this as the loss of pleasure to a more “dignified model of desire.” But why be so dignified?

Mitchell (1998) feels that conceptual frameworks have shifted away from fantasy and place more importance on “real-life,” concrete relationships. The result is that fantasy is “frowned upon,” and abhorred as a hallmark of immaturity rather than a protective factor in maintaining an erotic life. Loewald (1974) and Kohut (1977), in perhaps a more traditional psychoanalytic vein, suggest that fantasy enriches and enhances reality. Kohut (1977) furthers that in order to sustain and actualize our ideals (in the midst of ambivalence) is an important psychic achievement.

Mitchell (1998) poses an important question for the modern couple: Where does the presumption of safety and knowing come from? From a place of fear, couples assume that they know everything about one another. Winnicott’s (1965) famous phrase, “It is a joy to be hidden but a disaster not to be found” captures the universality of the fear of intimacy. Although he intended the concept to describe children’s desire to be understood by their parents, the phrase equally applies to the tension felt between romantic partners. Unrequited love is painful but safe. In both primary and secondary relationships, to work towards depth of knowledge is the really risky business. In encouraging exploration of fantasy in the therapeutic space, members of a couple might surprise both themselves and one another. Frequently, a couple assumes that they have found one another, but really, they are still missing. The conflict in couples treatment is that partners often value what is absent over what is present, based on the assumption that what we see in our partners is what we get. Each thought and action is predictable. In “taming the

childhood orgy" (Bersani, 1988), perceived threat is minimized, but desire is squelched. Not knowing, of course, is frightening. Realizing how little we know ourselves or our lovers can make attachment a much riskier task.

The Fantasy of Safety

The patient and therapist alike can collude in the process of suppressing fantasy. Bersani (1998) highlights the ways in which powerful experiences of desire can perturb identity and a continuous experience of self. In our relationships, we retreat into the "safe fantasy of the family," motivated to sociability by a "drive to reclaim an impossible attachment" (Baumeister, 1995). Because we never successfully leave our families, we need the regression into the safe haven of marriage. For Freud, *Instinct* comprises both self-preservation and animal urges. Instinct is primarily adaptive in helping the individual maintain a sense of equilibrium and object constancy. Berlant (2012) observes that "desire always finds an object through which it can sustain itself." This is the case even when the self is mis-recognized. In the effort to maintain and sustain self and perceived connection, desire can be confused for stability. As Berlant (2012) furthers, "desire for love can obliterate the wildness of the unconscious, confirm the futurity of a known self, and dissolve the enigmas that marks one's lovers." In an effort to "save" a couple in danger, a therapist may minimize exploration of individuality for the sake of perceived, or contrived, safety. This process bolsters the convention of a 'known quantity,' i.e. a monogamous pair.

Copjek (1999) describes this as a relinquishing of "the private kernel of his being, his *absolute* particularity, in order to enter a social reality in which he [is] comparable to others." To

be monogamous, we conform not just behaviorally, but also psychically. We imagine our sexual identities as stable, able to be regulated, and fidelity then applies not just to the interpersonal partnership but in the relationship of self to self as well. Saketopolou (2014) describes this as facilitating the transformation of intergenerational debts we have inherited from others in the form of enigmatic parental and cultural implants into a relationship to oneself. Charles (2015) notes that, "As conformity becomes confused with consensus, the "other" voice is easier to devalue, causing further rigidity and a lack of viable alternatives." Couples treatment can often encourage an increase in focus, entailing a narrowing of the couple's commitments as partners work to "salvage" a relationship. Perhaps flexibility, in an effort to imbue partnerships with vitality, is the better recommendation. After all, dysregulation, in moderation, can be productive.

Countertransference

Training in confronting various forms of hate in the countertransference when it comes to couples therapy is deeply lacking. Despite its consistent presence, issues of countertransference are typically less addressed in the context of couples treatment than in individual treatment. In experiencing the couple as an entity with an overlapping unconscious, however, countertransference presents powerful challenges which must be dissected and resolved for the sake of the couple. Parallel process, projective identification, and myriad enactments are not rendered moot simply because the process is no longer purely dyadic between therapist and patient. Disgust, jealousy, aggression and overwhelm comprise some of the potential states that may arise for therapists during treatments that adequately address sexual fantasy. While

uncomfortable, these experiences may be transformative, both for the therapist and for the therapy.

A therapist, particularly one with monogamous leanings, may have strong reactions in observing a couple taking pleasure both in a secure relationship and extramarital partnerships. As the empirical literature indicates, most successful non-monogamous couples are securely attached. To be securely attached, however, does not foreclose powerful experiences of insecurity or jealousy. Some couples engage in non-monogamy without conscious awareness of these less savory experiences. Jealousy is a part of any relationship, but is particularly important to acknowledge in non-monogamous arrangements. Much as Kernberg permits perversions in the confines of marriage, insecurity may be treated more kindly in the context of monogamy. Therapists must help render jealousy conscious without imbuing it with pathology. Jealousy must also at times be acknowledged in the countertransference. Perhaps a therapist will feel incredulous, titillated, seduced, or overwhelmed - a particular state to be further explored later in this chapter. A therapist may fear for contamination of their own monogamous values and worry for their own partnerships. Saketopolou (2014) writes that, “Disgust is Janus-faced, as it reflects a dark side of human nature that dehumanizes others at the same time it adaptively tries to preserve something pure, wholesome, and healthful.” Again, through attachment to the increasingly idealized notion of emotion regulation, patients and therapists alike have developed discomfort with more violent and passionate emotions. It seems this discomfort can exist both within the couple and also in the context of the therapeutic alliance.

It is often suggested that affairs, and at times even consensual non-monogamy, are expressions of anger or aggression. Therapists might assume that the “offending party” must be

retaliating in some way, when often, extra-marital relationships serve more as attempt to connect with lost aspects of self (Perel, 2017). In a study by Shalev & Yerushalmi (2009), several therapists reported experiencing discussion of sexual matters as a "form of hostility directed at them" and even felt "abused by their patients." To think that a therapist might chastise a patient for feeling the freedom to speak freely! These complex reactions pose the question: What does a therapist need in order to work with issues of sexuality productively?

Saketopolou (2014) synthesizes some suggestions:

> An analyst's ability to work with the eruptive qualities of sexuality hinges on her capacity to appreciate the significance of the disruptive potential perversity ushers into the ego's coherence. This disruption enlists bodily materiality to perform a particular kind of psychic labor: to turn intergenerational errands (Apprey, 2013) and debts (Faimberg, 2005) that have been installed in us in infancy and which have entered us through the early somatic relationship with our caretakers (Laplanche, 2011) into a relationship to ourselves.

When approached with slightly less risk aversion, these treatments may be very rich for therapists in their own expansion of relational ideals. Saketopoulou (2019) writes about the concept of psychic overwhelm, which "is not inherently self-destructive, but it does incubate precarity and risk." Saketopoulou cautions therapists from assuming that "demonic aspects of sexuality" are self-destructive or expressions of the repetition compulsion.

LaPlanche (1999) emphasizes the duality of sexuality, in that it is comprised of binding and unbinding qualities. Excitation of great intensity, while not without risk, is not necessarily an

expression of trauma. Since 2008, Stein has been arguing that we "rehabilitate" the idea of positive excess when it comes to sexuality. Saketopolou expresses that while overwhelm can appear to have similarities with less benign dysregulation, this state is primarily that one that exists "within an attuned dyad." She furthers, "Overwhelm is an extreme state that can bring about ego shattering, a radical unbinding of the ego that unravels previous translations that may be at an impasse, to make room for new ones." While overwhelm can occur intrapsychically and within a couple, it can also occur in the treatment frame. Where does sexual behavior cross over from the realm of excitation into a place of danger? Much as Emotion Focused Psychotherapy encourages a leaning into affect, perhaps building traction and courting the experience of overwhelm within the treatment could be a useful exploratory enactment. A practiced therapist may better intuit when a couple is truly in a precarious place.

Issues of Boundaries and Consent

Within the couple and within treatment

Part of any couples treatment involves assessing whether or not a couple has established enough baseline safety. Only in the context of adequate trust can play sustainably be cultivated; earlier experiences of safety comprise a solid foundation. Perhaps this safety already existed for both parties prior to entering the relationship, or maybe they need help fostering it as a couple. The therapist must make room for either possibility, as well as the recommendation that a couple is not yet in a secure enough place to take risks, even if opening up the relationship is the primary goal of treatment.

Therapists must attend to the possibility of masochistic passivity, but should also be aware that relinquishing boundaries is not an indicator of pathology. Ghent (1990) writes about surrender, in which "passibility" is a state of radical receptivity, but not an expression of masochism. Frequently, one partner will arrive at the idea first, and the other partner may or may not warm to this exploration. Therapists should listen for undercurrents of coercion, but should also remain open to the possibility that people can change their attitudes. Saketopoulou furthers, "There are marked differences between being susceptible to the other and capitulating to the other's will," and analysts must be attuned to these distinctions. The concept of "enthusiastic consent" is particularly complicated around the nuance that is negotiating boundaries in non-monogamous arrangements.

In an important contribution on the topic of consent, Saketopoulou, (2019) describes the concept of "limit consent," through which "consent involves a more nuanced negotiation of limits and becomes possible when the subject makes herself passible (Lyotard 1988) to an other—a condition that is neither active nor passive." Whereas in affirmative or enthusiastic consent, a subject is fully conscious of anticipated effects, in limit consent, there is more room for unconscious motivation. While this type of consent can certainly serve positive functions in minimizing miscommunications and creating mutually satisfying situations, it is also limited in its predictability. Saketopoulou furthers, "*Limit consent* does not center on (re)producing an experience of satisfaction but instead works to facilitate novelty and surprise. In contrast to its affirmative counterpart, it hinges not on respecting limits but on transgressing them. *Limit consent* runs on nonlinear time, blurs the divide between active and passive, and comes dangerously close to the line of something going wrong."

Limit consent is about play, but is also about interpenetrability, which runs in parallel with a relational therapeutic lens. “Thinking of matters of control in limit consent as dichotomous (one has it or one doesn’t) obscures the kaleidoscope of receptivity/activity, as well as the vulnerability, trust, and asymmetrical responsibility that make limit consent possible in the first place. Dichotomous power is more in the purview of affirmative or informed consent” (Saketopoulou, 2019).

Considering the therapeutic frame and consent: In signing the proverbial contract, patients are implicitly authorizing the analyst to push limits. Furlong (2005) and Gentile (2015) suggest that despite discussion, a patient cannot fully know what their consent entails when they begin treatment. Of course, the analyst is also vulnerable, though in different ways. The carrying of responsibility is asymmetrical, but the role of the therapist also incurs risk. Whether in a sexual or medical situation, the authority (or top) is granted authority by the patient (or bottom), and can be retracted at any time (Saketopoulou, 2019). Moreover, the position of top is typically assumed as the result of an invitation. Saketoupoulou (2019) also offers that the top assumes the responsibility of keeping the bottom safe, which entails taking on an asymmetrical degree of responsibility. “The top makes herself passible to the bottom and to the bottom’s desire and in so doing must wrestle with the evocation of her normative perversity.” Similarly, the therapist must confront her own infantile sexuality and all the ways in which that complicates treatment.

While a therapist may have ideas based on theoretical and experiential knowledge, ultimately, she does not know how a treatment will progress over time (Dailey 2014; Saketopoulou 2011, 2015; Saks and Golshan 2013). While medical treatments are also not fully

predictable, “the informed exercise of choice, and [the ability] to evaluate the options available and the risks attendant upon each” (Saks and Golshan 2013) is more concrete than in the analytic realm. Effectively, “psychoanalytic work may not fall under the purview of informed consent” (Saketopoulou, 2019). In both the practice of therapy and of non-monogamy, rules serve as circumscribing protectors. Of course, the more rules we construct, the more there are to challenge.

Non-Monogamy, Possession, and Oedipal Victors

Neither Oedipal conflict nor its supposed resolution are one dimensional. Like Davies (2003) asserts in her important contribution to Oedipal theory, this paper purports that every child grapples with a deeply divided, disjunctive experience of himself as both the subject and the object of romantic/erotic passion. Effectively, the Oedipus complex is neither won nor lost, but rather, optimally both won and lost (Davies, 2003). Horney (1928) asserted that the primary motivation to pursue monogamy represents a revival of the infantile wish to monopolize the father or mother. Bersani (1988) suggests that monogamy is simply a superficial phase during the Oedipal stage, and that adult attachment to this devouring space. To love inevitably involves identification, but never with only one object (Charles, 2002; Arlow, 1980). Moreover, these multifaceted identifications do not necessarily represent regression to a state of primitive fusion. Harkening back to Freud, Bersani describes the multiplicity of monogamy’s analytically associated functions:

Thus monogamy, for Freud, Phillips and Bollas, turns out to be nearly all things: a

> civilized necessity that represses desire and betrays the promiscuous curiosity of child, a self-sufficient arrangement that, on its own, would never open out into community life and is therefore threatening to civilization, a denial of the mobility inherent in what was only superficially monogamous desire during the Oedipal stage, and a retreat to the comforting immobility of childhood ties and away from multitudinous and wildly scattered 'subjectivities competing for selfhood' in both mature consciousness and social groups.

For Bersani, monogamy represents an individual and societal defense.

It is traditionally understood that from the developmental sphere of oedipal relations comes the “passion and intensity born of an illusion of romantic perfection and deep, mutual idealization” (Charles, 2012). In the post-Oedipal developmental process, one develops the capacity to handle disappointment without the total destruction of desire. Davies (2003) also asserts that in this stage, one can “apprehend that true intimacy requires mutual vulnerability and psychic interpenetration.” Despite the potential for this psychic achievement, the desire for perfection remains on some spectrum of consciousness. As a result, our partners effectively become repositories for disappointments, receptacles for our own projected imperfections. Whether or not the practice of non-monogamy serves as a productive way to cope with this disappointment is in many ways still to be theoretically determined. Secondary partners may assuage some of the experience of “lack,” but they will not replace the ultimate wish to possess and be possessed by the single perfect object.

Davies (2003) also makes important observations about combatting the complex transferences that get activated around Oedipal material. She writes, “The key to unlocking entrenched and exaggerated transferential states resides in the correct interpretation of aggressively eroticized reactions and a nonparticipatory, nongratifying holding of the line against increasingly demanding claims for countertransference participation.”

Some analysts argue that a good parent will be a willing participant in their own symbolic destruction. It is perhaps in the children of caregivers who fail to allow their own replacements that one cannot move beyond the stage of erotic masochism. In some instances, “oedipal child becomes for the parent the perfectly fantasized bisexual complement to the parent's gendered identity, the perfectly fantasized blend of whom the parent would most desire and who the parent would most want to become in an imagined gendered complementarity” (Davies, 2003). Charles (2012) furthers that “certain aspects of the real person are rigorously excluded in the sense of oneness.” The continuing of these merging configurations can continue into adult romance, which lead to an impossible search for the perfect object of completion, and inevitable disappointment at that impossibility.

Davies (2003) poses that in the lack of complete Oedipal resolution, “its derivatives find their way into multiple self-other configurations whose ongoing presence infuses our adult sexual/erotic attachments with their unique and dyad-specific colorations and textures.” From this perspective, whether or not they are erotic in nature, it is best to welcome a tapestry of adult attachments, rather than assuming one will successfully contain all the shards left over from early development.

Functional Triangulation

"The bonds of wedlock are so heavy that it takes two to carry them, sometimes three"

Alexandre Dumas, père, via Perel (2017)

Three is often deemed a crowd, but the utility of a triangle should not be underestimated. When one develops the capacity for psychic space, unconscious aggressive urges to triumph over "the internal parental couple" (Nathans, 2012) will be mollified. Rivalry will decrease in threat, and, "Consequently, there will be a more flexible capacity to integrate a symbolic or actual third because it will not be imbued with such threatening aspects (Nathans, 2012, via McCann, 2017). He furthers, "If the child is able to accept the reality of the parental couple and tolerate being excluded from this dyad, a type of flexible triangulation can result (Britton, 1989) that allows for a form of linked separateness (Balfour, 2005)." De-intensifying the primary love relationship reassures us that we will neither engulf, nor be engulfed.

Kernberg (1991) asserts that mature love is comprised of the interactions of 6 metaphorical persons: the couple, their respective unconscious oedipal rivals, and their respective unconscious oedipal ideals. While Kernberg is a proponent of monogamy as normative if not healthful, he is effectively suggesting that triangulation is a defense, which can alleviate both conscious and unconscious terror of intimacy. Moreover, Kernberg (1991) suggests that it is the responsibility of the analyst to "confront defensive styles, clarify feelings, and interpret, teasing out layers of unconscious contract, and facilitating dialogue to enhance intimacy in couples (Karbelnig, 2017)."

A primary task of therapy is to elucidate defenses such that they can be explored and

mastered. When is triangulation defensive and when is it adaptive? “Defensive love triangles,” writes Karbelnig (2018), “refer to excessive involvement with triangles in the service of defending against dialogue between intimate partners.” Triangulation, as with other defenses, exists on a spectrum. While it can certainly involve sex and lovers, it may also involve platonic bonds with colleagues, friends and family. While issues arising from non-consensual erotic love triangles are perhaps the most overtly problematic, Karbelnig (2017) observes that, “Subtle but perhaps equally problematic love triangles occur whenever a linear relationship overshadows the primary dyadic intimacy.” Citing possible examples, he highlights compulsive work styles and obsessional hobbies as ways of avoiding intimacy with a partner. Management of time and resources in non-monogamous arrangements must be intentional and subject to frequent recalibration. Particularly given the many demands of a “well rounded” modern life, so too must couples not practicing non-monogamy reflect on the various triangles at play in their relationships.

Perhaps most importantly, love triangles can involve relationships with the self, for example, a person engaged in extreme self-criticism or self-adulation. Perel (2017) observes in her practice that often, an affair or consensual non-monogamy serves to reconnect someone with a buried part of themselves. Charles (2015) remarks that the self who loves is fed by the self who is loved. With or without consent, people seek the sensation of jouissance. While the scope of this dissertation does not cover non-consensual non-monogamy (i.e. affairs and infidelity), McCann (2017) observes that a function of an extramarital tryst can be to consciously live out links in a couple’s “shared unconscious organization.” This third party can become a shared object for projection. Therapy serves a similar capacity, in that the therapist can be an object of

love or hate. Therapy, in its intimacy and risk within the context of frame, particularly when paired with rule-based practices of polyamory, is not so far off from a consensual non-monogamous arrangement.

As with all defenses, triangulation is something to be understood rather than eliminated. Karlbenig (2017) points out that myriad issues arise when there is too little room for triangulation. When members of the couple cannot practice rapprochement, there is no space for erotic energy to expand and contract. Too little room increases the likelihood of projective identification. Saketopoulou (2014) notes that, “It may be adaptive to “make” a romantic partner contain our repudiated feelings to help us unconsciously process them because, after all, two heads are better than one.” While it seems there is certainly a risk of spreading the intimacy too thin, whether diluting it with a hobby or a lover, Perel (2017) reminds us that fire does need air.

Treatment Considerations

Cultural humility is increasingly being incorporated into therapy training, but as therapists are encouraged to examine other biases they hold, they must also acknowledge the power they possess as rooted in mononormativity (Pieper & Bauer, 2005) and monogamism (Blumer et al., 2014). Many polyamorous people also challenge the notion of romantic relational hierarchies, and so too must therapists assess power dynamics within the therapy frame. As in any practice working with diverse patients, therapists must work to discern and confront their own discomforts and limitations.

Risk must be acknowledged, but attachment to safety can become the real hazard. As Saketopoulou (2019) describes this phenomenon: “Often our analytic attention is on the patient’s

possibly going too far and becoming overwhelmed, when it might be better placed on attending to both of our resistances, to our not going far enough for overwhelm to arise at all. Our disciplinary preoccupation with safety can at times reach levels of hagiographic idealization."

Weitzman et al. (2009) note that some common concerns among polyamorous patients include "negotiating relationship parameters, agreements, and boundaries; coming-out as polyamorous to children, family, and friends; locating support com- munities and resources; and challenges around separation." He also cautions that therapists must not assume the reason a polyamorous couple is seeking treatment has anything to do with non-monogamy. While a therapist's openness to discussing issues pertaining to non-monogamy should be made clear, perhaps by querying about the couple's agreements around monogamy at the onset of treatment, therapists must not use non-monogamy as a red herring in treatment. The presenting problems of polyamorous couples are just as diverse as those of monogamous couples. This qualitative study hopes to further articulate current limitations in the field and point to future directions for both training and practice.

Summary

In sum, literature indicates that there is nothing inherently pathological about the practice of non-monogamy. Considerations for analytically oriented couples treatment of non-monogamous patients are nascent and need further development. The de-sexualization of psychoanalytic practice as well as increasing trends towards attachment and relational frameworks have further cemented mono-normativity and made it difficult to discuss sexuality and fantasy as vital realms of a healthy couple. Value judgments, powerful countertransference,

and issues around power and privilege may be particularly present in these treatments, and should be preemptively addressed in training.

“Psychoanalytically, monogamy is inconceivable except as something that blocks circuits of desire,” declares Bersani (1998). Blocking desire, of course, serves a function amidst the enmeshment that defines modern partnership, until the circuits somehow reach a point of combustion. No couple will be without extramarital attraction. In working with and through these conflicts, we must accept the mundanity of this fact. As Karen Horney (1928) wrote, “The deeper our understanding of the inevitability of these and other conflicts in every marriage, the more profound will be our conviction that our attitude towards such unchecked personal impressions must be one of complete reserve and the greater will be our ability to control them in reality.” However we choose to work with conflict, whether via action or inaction on desires as they arise, we must push through and not against. Perhaps Freud was reductive in his thinking that everything is motivated by sex, but we are doing ourselves no favors in removing sexuality from treatment as a vehicle for understanding. My hope is that by better considering why non-monogamy arouses such strong reactions, we can help couples create more sustainable relationships. To do this, the therapeutic frame must be a safe enough space for a couple to enter into, even if it is comprised of more than two parties.

CHAPTER 3: Methods

An Introduction to Grounded Theory

Originally developed by Barney Glaser and Anself Strauss, grounded theory was developed in 1967 as methodology originally rooted in sociology. As opposed to a deductive, a priori approach to theory, Strauss & Corbin (1990, 1998) propose that grounded theory needs to be rooted in "data from the field, especially in the actions, interactions, and social processes of people." Studies that employ grounded theory intend to move beyond description and to generate or discover a theory, an abstract analytical schema of a process (Strauss & Corbin, 1998). Participants in a grounded theory study need to have "experienced the process," and effectively "development of the theory might help explain practice or provide a framework for further research" (Creswell, 2007). The subject pool in the current study will be comprised of dynamically oriented and integrative therapists, each of whom will have "experienced the process" of working with non-monogamous couples.

Sampling and Recruitment

Participants were recruited via email listservs (Das Unbehagen [dU], CCNYAlumni, AASECT [American Association of Sexuality Educators, Counselors and Therapists] and NYU Postdoc) or contacted regarding potential participation directly by the present author, who had compiled a list of clinicians with a degree of expertise within the domain of non-monogamy. See Appendix A for the recruitment poster. When prospective participants responded stating that they were interested in participating in this study, a pre-screening survey was sent out via Google

Forms (See Appendix B). On this screening, the prospective participants were asked to respond to the following questions:

1. What is your training background?
2. How would you describe your theoretical orientation?
3. How long have you been practicing?
4. What is your psychotherapeutic experience working with couples?
5. What is your experience working with non-monogamous couples?
    a. Approximately how long have you been engaged in this work and how many patients have you worked with?

Upon completion of the pre-screening questionnaire, prospective participants were sent detailed information about the study: 1. Duration; 2. Research question; 3. Methodology; 4. Lack of financial compensation for participation; and 5. Logistics of interviewing (to be conducted and recorded via Zoom). The first 11 participants who completed the screening form and were eligible (out of a total of 26 who completed the pre-screening questionnaire) were emailed to confirm interest and availability and were subsequently interviewed on Zoom.

Criteria for Inclusion

The criteria for inclusion was as follows: 1) the participant is a psychotherapy provider with any of the following titles: Social Worker, Clinical Psychologist, Psychiatrist, Marriage and Family Therapist, or Mental Health Counselor; 2) the participant has worked with at least two non-monogamous couples for over 4 months each; 3) the participant was willing to be interviewed on the topic of her/his perception of non-monogamy from theoretical and emotional perspectives; 4) participants of all ages were eligible for study participation; 5) the participant

states they are able to recall and speak about at least one psychotherapy case with a non-monogamous couple; 6) the participant met with patients in the United States.

Informed Consent

Participants were emailed immediately following their confirmation of interest in participation with the following list of criteria (Cone and Foster, 2003):

1. A description of the study and its purpose
2. A description of what the participant will be asked to do and how long it will take
3. A description of potential risks and benefits to individual participants
4. A statement that participation is voluntary and that the participant can withdraw at any time without penalty
5. Reassurance that all data will be kept confidential and a description of any circumstances in which the researcher would have to forgo confidentiality
6. The name and phone number of a person the participant may call to get further information about the research
7. The name and phone number of a person (other than the researcher) the participant may call if he or she has any complaints as a result of participating in the study
8. Information regarding whether and what compensation will be provided
9. Explanation that a summary of the results/findings will be available if wanted

Interview Protocol

Interviews lasted approximately 60-90 minutes, and were audio recorded and transcribed for subsequent coding and analysis. Participants were monitored for psychological distress throughout the interview and all participants were provided with mental health referrals at the end of the interview in case they felt the need to consult with a provider at any point. An interview plan and prompts provided the author with a preliminary structure which evolved throughout each interview and over the course of the collective interviews.

The following questions were used as an outline for each interview:

Interview Questions

Interviews, to be conducted and recorded in person or via Zoom:

- Can you describe your theoretical orientation as it pertains to couples treatment?
    a. Do you adhere to any pre-existing frameworks? (For example, EFT/MBT/CBT?)
- In your work with couples, do your patients speak about their practice of consensual non-monogamy? How?
- Do you query about whether or not a couple is non-monogamous, and if so, how and at what point in treatment?
- What is your own understanding of the practice of CNM?
- How has your work with patients informed or changed your understanding?
- What have you learned from your patients about non-monogamy?
- What have you experienced in your countertransference towards CNM patients?

a. Have you noticed any differences in your work with monogamous and non-monogamous patients in this regard?

b. In general?

- Is there a case involving CNM you could describe in detail?

  a. In describing the case, can you keep in mind:

     i. Discernment of treatment goals

     ii. What has made this treatment more or less successful

     iii. Specific challenges of the treatment

     iv. Object relations?

- How have secondary or tertiary relationships factored into treatments?
- Are other members of the polycule ever incorporated into treatment?
- How do you think practice of CNM interacts with changes or improvements of presenting problems in couples treatments?
- Have you worked with any CNM couples currently raising children? If yes, what have you observed, both in terms of the cases and your own reactions?
- Have you been able to tolerate views of relationships in couples you treat that are very different from your own? Could you tell me more about that? (Probe: Could you give a specific example of a time when that happened?)
- How has this work affected your own relationships outside of the therapy room?

  a. Have you experienced any shift in your own romantic proclivities you identify as a consequence of working with non-monogamous clients?

- ○ Is there anything I haven't asked you about that would help me to understand your relationship with CNM patients?
- ○ How might training better prepare therapists to work with couples outside of the "traditional" sexual frame? Are any modalities particularly well-suited for CNM couples?

Description of Participants

The participants in this study included 11 clinicians. Data collection took place between April 2021 and August 2021, with a pilot interview conducted in September of 2020. Table 1 reports the demographic characteristics of the sample, including each clinician's corresponding pseudonym (for confidentiality purposes), theoretical orientation, geographic location, gender, years in practice, and approximate number of CNM couples treated in relationship therapy. The clinicians' time in practice ranged from 4 to 38 years, with a mean of 15.8 years of clinical experience. 5 clinicians identified as female, 3 as male, and 3 as transgender or genderqueer. Clinicians represented New York, California, Texas, and Georgia geographically. Clinicians also reported a range of theoretical orientations, to be further discussed in the Results section, but were predominantly integrative, eclectic, or psychodynamic. Participants also verbally endorsed a range of sexual orientation identities, although this was not specifically queried. All but 3 (N = 8) participants self-identified as personally practicing non-monogamy.

Method of Analysis

As participants were the main sources of knowledge on the subject of this study, grounded theory was the best fit in terms of qualitative methodology. Grounded theory, as developed by Corbin & Strauss (1990) and further by Auerbach & Silverstein (2003) serves as a

discovery-based framework rather than as a test of pre-determined hypotheses. Themes and theory were generated through multiple readings and coding of interview transcripts.

All interviews were first transcribed with Trint software using a format and criteria developed by the primary investigator. Following preliminary transcription, each interview was reviewed to denote pauses and word repetition, with non-verbal communication (such as laughter) noted parenthetically.

Open Coding was used to first group the raw interview response data. Each transcript was reviewed twice by the primary investigator and once by the co-coder, Lily Swistel, and a list of initial themes was compiled. The primary researcher then employed Axial Coding to reflect the prominent themes of the cumulative data, after which both researchers utilized Selective Coding to develop an overarching thematic organization related to theoretical underpinnings. At this stage, the primary researcher utilized the qualitative software Nvivo to build a codebook so that this program could be utilized for the remaining phases of coding.

Building off the foundation of Corbin & Strauss (1990), this study also utilized the constructivist perspective of Charmaz (2006). According to Charmaz (2006) via Creswell (2007), constructivist grounded theory “lies squarely within the interpretive approach to qualitative research with flexible guidelines, a focus on theory developed that depends on the researcher's view, learning about the experience within embedded, hidden networks, situations, and relationships, and making visible hierarchies of power, communication, and opportunity.” This perspective emphasizes “diverse local worlds, multiple realities, and the complexities of particular worlds, views, and actions” (Creswell, 2007).

This constructivist approach also takes into account the role of the researcher more fully, with attention paid to ways in which she “makes decisions about the categories throughout the process, brings questions to the data, and advances personal values, experiences, and priorities.” Effectively, Charmaz pays more care to the limitations of a study as it is being conducted, acknowledging that conclusions drawn via grounded theory, while empirically supported, are to some extent, “suggestive and incomplete.” Particularly given the relatively small body of research that exists regarding therapeutic considerations of non-monogamy from the clinical (rather than client) perspective, this study serves largely as exploratory.

CHAPTER 4: Results

This study's central aim is to understand the landscape of consensual non-monogamy within the context of relationship therapy. It was hypothesized that thematic patterns would emerge in transcripts of a semi-structured interview on this subject with couples therapists, particularly regarding themes of treatment and countertransference. It was also hypothesized that there would be thematic differences between interviews with therapists who do and do not identify themselves as 'experts' in the treatment of non-monogamous couples. While therapists who identified their theoretical orientation as predominantly psychoanalytic did have some recurrent themes that were particular to their interviews (repetition, fantasy, and loss), overall, the majority of emergent themes among interviews overlapped enough such that it did not make sense to interpret the results of 'non-experts' in treatment of CNM relationships as a control group.

Even through the data collection process, recurring themes began to emerge in nearly every interview, including attachment and connection, challenges to treatment, and meaning of non-monogamy. Through the various stages of subsequent transcription and coding, these themes remained and others surfaced. Therapists spoke about complexity of group dynamics and frame, negotiation and contracts, language and meaning, and affect regulation. Even though each therapist presented a single case, the only criteria of which was that the couple involved must be non-monogamous, there was considerable overlap in what stood out when therapists reflected on treatment.

As interviews were transcribed and coded using Nvivo, three main areas of results emerged: (1) Therapeutic Process, (2) Issues in Treatment, and (3) the Meaning of Non-Monogamy. Within each of these three broader areas of focus are many sub-themes. All therapists were interested in process and therapeutic identity, expressing curiosity about how they experience themselves as the treatment provider, and all therapists had overlapping reflections on recurring issues in treatment, ranging from challenges to goals, as well as the way that individual pathology can infiltrate a system. In addition to these areas of focus on theory and frame, therapists and reportedly their patients largely agree that the meaning of non-monogamy must be co-created and articulated in treatment. That process happens on an individual level, interpersonally within the couple, and interactively with the therapist and the couple. What materializes are a set of observations certainly relevant to the treatment of CNM relationships, many of which are generalizable to all couples treatments.

Qualitative Analysis

Therapeutic Process in Treatment of CNM Couples

Theoretical Orientation and Therapists' Understanding of CNM

Among the 11 therapists who participated in this study, 18 theoretical orientations were identified: Anti-Oppressive, Bowen Family Systems, Cognitive Behavioral, Eclectic, Emotion Focused, Existential, Family Systems, Feminist, Gottman Method, Imago, Marriage and Family Therapy, Motivational Interviewing, Music Therapy, Narrative Therapy, Psychodynamic or Psychoanalytic, Relational, Rogerian, and Sex Therapy Focused. All therapists identified

themselves as integrative in their practice, particularly of couples work. As one subject noted, "Couples therapy requires a certain kind of pragmatism or pulls for pragmatism in a way that individual work sometimes doesn't." This somewhat flexible, if not practical, experiential aspect would also play out in how most therapists describe their approach to treatment frame.

All of the subjects reported that their own understanding of the practice of CNM was informed by personal experience, typically but not always via their own practice of CNM. Those who did not self-disclose a personal practice of CNM did note the ways in which serial monogamy can be understood as its own form of non-monogamy. Subjects offered a variety of conceptualizations:

> Dr. C: So I think of CNM as an umbrella term that encompasses a wide variety of relationship structures, including polyamory and other forms of multiple loving relationships. This also includes swinging and other forms of multiple sexual relationships, open relationships and other forms of dyad or triad or quad-centered non-monogamy. It also includes relationship anarchy and other forms of individual or solo polyamory, and other forms of individually centered sorts of non-monogamy. So in terms of who practices CNM, I would say lots and lots of different sorts of people.

Others were more glib:

> Dr. E: It's like asking me, What's my conceptualization of giving a blowjob? Some people like giving them some people don't.

Therapists frequently tied their understanding to their own relationship histories, but again and again noted the ways in which non-monogamous relationships are not so different from monogamous relationships:

> Dr. J: I have been in non-monogamous relationships probably for the last 15 years of my life. I think they're really hard. I think that a lot of times the ways that people do it are pretty bad, but I also think the way that a lot of people do a lot of relationships is pretty bad. So that's not particularly a judgment on CNM relationships. I think most of us don't have very good relationship skills and that lack of relationship skill is going to show whether you're doing something monogamously or not monogamously.

Therapists reported observing some patients who have pathologized themselves for questioning why they “can’t commit” and feel it is helpful to have multiple possibilities opened up. Other patients seem to experience the practice on a continuum and don’t articulate it as central to their relationship identities. In general, most therapists reported they have historically observed some patients engaging in non-monogamy as a way to “escape the problems of their current relationship, (Dr. J)” in a manner that is typically not sustainable before being examined and negotiated. In the same way that Monopride and Polyphobia (Ferrer, 2018) are binary phenomena present in various forms of training and practice, these views are also representative of how patients articulate their concerns about themselves.

Therapists consistently reported that their experience working with CNM couples has not informed or shifted their own understanding of CNM. As two subjects asserted:

> Dr. C**:** I think one of the things that's helped and hurt me with - I have a very strong set of feelings in my personal life about how you make non-monogamy work, so no, my patient work hasn’t shifted my own understanding.
>
> **NM:** I feel like I’d be wrong to say [my work hasn’t shifted my understanding…] But I'm going to say that often I am probably the role model in the room because I do bring aspects of myself into the room.

In sum, therapists' practice of CNM seems to give them confidence in helping couples work through these issues, but may also be constricting in terms of their understanding. One therapist, who did not identify themselves as non-monogamous, noted the lack of presumption or automaticity involved in CNM:

> Dr. F: I would say that my understanding is that in a non-monogamous frame with the kind of negotiation required, there's a way that consents are solicited or agreed upon between two people that can seem somewhat contractual. And it's done because I think there is a kind of presumption and often a correct presumption that there's something in that frame that has a bit of a diffuse boundary in it. And so I think it requires a certain kind of articulation of that boundary and effort to articulate that in order to kind of proceed in a way that both parties feel less likely to feel aggrieved or betrayed.

Countertransference

One of the main aims of this study was to explore various forms of countertransference that might emerge for therapists when working with non-monogamous couples. Ferrer (2018) notes that a binary is often present in discussion and understanding of non-monogamy. As he writes, "Discourse in advocacy of both nonmonogamy and polyamory has consistently included both a vigorous critique of monogamy as patriarchal, capitalist, racist, hypocritical, or sexually and emotionally pernicious (e.g., Anderson, 2012; Jackson & Scott, 2004; Ryan, & Jethá, 2010; V. Robinson, 1997; Rosa, 1994; Schippers, 2016; Stelboum, 2010; Willey, 2006); and the elevation of polyamory as biologically, psychologically, socially, morally, or spiritually natural or advantageous (see Petrella, 2007; Wilkinson, 2010; Willey, 2016)." In short, anecdotally and empirically, it seems that monogamists and polyamorists "look down at each other," and inevitably, this binary seeps into the experience of countertransference. In this data, 11 categories arose: Concern of Oppression, Curiosity, Discomfort, Excitement, Frustration, Identification, Jealousy, Judgment, Overinvestment in Outcome, Paternalism, Protectiveness. The two countertransferences referenced with the highest frequency were excitement (N = 4) and judgment (N = 9), which represent Ferrer's dualistic perspective.

Several therapists noted a difficulty in articulating a boundary between excitement and voyeurism:

> Dr. J: A sort of countertransference feeling is… when people are starting to explore, that is exciting to me. So I think I get, like, kind of like juiced about that. Juiced and jazzed. And so that's really fun to me. And I don't want to be like the prurient therapist, just like "tell me all about it." But at the same time, I do want them to have space to talk about it.

Similarly, jealousy and the pull towards voyeurism pose a challenge as well:

> Dr. E: Well, there is one countertransference piece that is a little uncomfortable to talk about, but I will. And that is that I have envy - I'm conflicted. All these guys are like a young, attractive, and open about how successful they are sexually. And I have to guard against loving to hear their wild stories because they're fun and sexy.

Two gay male-identified participants noted nearly identical expressions of jealousy particularly towards their younger patients, struggling with internalized ageism. Both noted they felt more repressed and oppressed as young men, envious of the ease with which their patients can pursue sex and love. Therapists have the privilege of a window into patients' intimate lives, but when are details therapeutically indicated and when do detailed inquiries become more lascivious? This is one challenge that might be addressed in training.

Similarly, what should a therapist do if they feel excited about the prospect of a relationship opening up, but the patients are not instigating this process? As one therapist described it:

> NM: I mean, I can't call it anything other than bias, but I will sit and look at monogamous relationships and watch them struggle through issues of shame or issues of mismatched desire or, you know, mismatched relationship styles and be like, 'Y'all, there's a solution for this.' But that's not my place, right? So I just don't do it.

Another therapist reported struggling with feelings of sadness towards a patient who was struggling with a lack of touch during the pandemic, separated from their partner, but concerned about the rupture that might be induced by encouraging extra-relational sexual contact.

Judgment as a broader countertransference emerged in diverse forms, although several subjects noted the importance of curiosity in the therapeutic stance, even when grappling with their own critical experiences. One therapist discussed his surprise and judgment towards a person who fell in love with their partners much more quickly than the therapist felt himself capable of developing loving attachments. Several subjects discussed judgment of various restrictions put into place, particularly based on gender-identity:

> Clinician A: What the pisses me off is the, like, she can go have sex with other women, but she can't have any other penises - like the one penis policy.Yeah, it's degrading to like everyone in the situation, whether it's degrading to her, because like as though another penis would distract her from her primary relationship. It's degrading to the now the lesbian relationship that's been created as though that's not real sex and that's not threatening or that's not something, and it's degrading even to the guy of being like, you're so insecure that like she can't have another penis in her life, like - I get so wound up about guys who make sure you don't have all the sex you want as long as with the woman.

Others expressed judgment based on experiences of having to support non-marginalized [i.e. cisgender and heterosexual] polyamorous people through the coming out process, given the compounded minority stress experience of trans individuals and people of color in the CNM community. One subject noted that they initially had judgments towards the idea of relationship anarchy, but did feel able to relax this over time as the work led the therapist to a deeper understanding of what this practice meant to the patients. Several therapists also reported judgment and frustration with the hierarchy in place within primary relationships in treatment, noting feeling protectively towards secondary and tertiary partners. Other biases reported

included difficulty working with patients who identify as asexual, and how to handle 'ethnocentric' partners.

Paternalism also emerged as a form of judgment:

> Dr. E: I mean, the one thing that's come to mind -but I haven't really gotten a clear, pithy way to put it. But it's that I feel kind of grandparent-y towards these adults. And I want to say, "guys calm down and it'll be alright," and it's hard when you're that young and pristine and energetic and horny, and I want to bestow peaceful happiness on them and urge you to do that

Incredulity and skepticism were also facets within the umbrella of paternal countertransference, in reaction to breaches of relationship contracts:

> Dr. F: What comes up, I think, absolutely is the moment in my head where I think to myself with some kind of loud internal volume like, well, what the hell were you expecting? Which I hear is something of a not quite condescension, but a kind of paternalism that I think references back what I was saying before, which is the kind of reference point of the origin of the symptom often being, to me, seemingly in latency [in terms of how rule-focused people are and how surprised they are when rules are broken].

Themes of identification emerged on several fronts. Sometimes, therapists felt both identification and admiration in combination:

> Clinician A: There's a few of them that I really feel like, wow, they're really doing that better than I am. I had one client, a non-binary client who had several relationships and the grace that they carried themselves with through those relationships and the amount of like dedication and strength that it took to be present for all of those people, I think just really wowed me.

Others noted that they tended to feel identified with ‘the cheater,’ or ‘the rule-breaker.’ One thing that was reified in most cases was that despite clear articulation of rules, boundaries are often breached. Other therapists discussed ways in which they would map individuals or couples onto their experiences of their own parents as children. As one put it, “ If my mother wasn't a difficult woman, it probably wouldn't be so countertransferential, and I wouldn’t feel so identified with the patient.”

Therapists expressed discomfort and frustration on a number of fronts. As one noted, “The one that makes me really grind my teeth are couples when they come in and they're trying to use non-monogamy to fix the relationship.” Four therapists discussed discomfort around perceiving patients as racist or oppressive, and a desire to maintain impartiality within treatment as well as remaining on target with the couples’ personal goals. One described a scenario as follows:

> Clinician B: For me, countertransference usually comes up only when the person's experiencing violence or marginalization or being misgendered or a [going through a] lack of acceptance for the person's identity. But it's also just like a reaction to that violence. I think when working with cis, het white able-bodied wealthy couples, a lot comes out because of their lack of awareness and their language choices, and then also just seeing somebody socialized as male who holds a lot of privilege of their like lack of awareness of how harmful the spaces that they're taking or the way that they're engaging. But then also holding space at the partner in the relationship signed up for that and doesn't have an issue with that. And so what I find to be problematic is not problematic to the people in the room and therefore it's not relevant to even be discussed.

As another therapist put it, "Dr. D: I have to move a little bit slower with [these patients] so that I don't interject any kind of my own personal anger towards that kind of behavior." When should countertransference be utilized in the treatment and when should it be managed by the therapist, either personally or processed in supervision? Again, even within so many specific examples within the category of judgment, the binaries of polyamory vs. monogamy, privilege vs. oppression, and enlightenment vs. ignorance seem salient.

Finally, three therapists noted that they feel some strong pull to 'keep a couple together:'

> Dr. D: Occasionally I feel like I want the relationship to work more than they do or like maybe it isn't going to work. And it just my personality is that I just want things to work out, so I have to check myself.

This topic will be addressed further in discussion of Treatment Goals, but there is a delicate line between maintaining faith in a couple as a unit as they forge their own path, and the projection of our own wish as therapists that we might be able to prevent some sort of split or ending.

Self Disclosure

I was consistently surprised by how self-disclosing most therapists were during these interviews. Of course, the self-selecting aspect of this study must be taken into account in terms of who felt comfortable volunteering to discuss consensual non-monogamy. While certainly not the focus of this study, subjects described their own relationships in great detail, noting their personal evolutions in the practice of non-monogamy. 8 of 11 subjects disclosed that they practice consensual non-monogamy in reference to their own understanding of CNM. Similarly, self-disclosure seemed to come up with striking frequency during treatment.

Non-monogamy can be associated with self-awareness and self-realization (Sheff, 2014) and with self-centeredness (Rambukka, 2015). Just as the subjects of my study self-selected, patients self-select in terms of who they seek out as a therapist. As one subject noted, “Clinician K: People don't come to us because they're monogamous, right? Yeah. So I usually don't even have to self-disclose [that I’m non-monogamous]. People find us *because* we are. We serve our own community.” One subject had published a book on non-monogamy, and another reported that they were very involved in their local kink scene, frequently running into patients at various events. Three therapists noted that a professional priority of theirs was to serve people in their own communities (predominantly queer, trans, and non-monogamous). “I always share my identities, (Clinician B)” reported one trans therapist. “I'm very intentional with everything to do my best to avoid any type of micro- or macro-aggression, so I always list my pronouns.”

Another therapist described ways in which they feel self-disclosure can help forge therapeutic alliance:

NM: I also believe it's clinically appropriate that my clients know I'm non-monogamous. Know I'm kink. Know I'm in a power exchange relationship. Know I'm a trans guy because they can see themselves reflected in certain ways, right? And I also think it goes to build trust in the therapeutic relationship because the folks that we are serving are so often marginalized by health care providers, by behavioral health care providers. I think being so out, it allows for rapport and trust very, very quickly.

Several therapists noted that their personal incentive to disclose was in response to patients who reported having felt stigmatized for their desires by previous therapists. In some sense, it seems that the therapists hope their self-disclosures will help create a containing frame, perhaps even providing a corrective emotional experience. It should be noted that part of my own incentive to pursue this study was because I had worked with a couple who waited several months before disclosing to me that they were non-monogamous. Of course, I could have queried about this directly earlier on in treatment (and will in future couples' treatments), but the issue of self-disclosure remains complicated.

One therapist noted that their two primary areas of specialty were in consensual non-monogamy and in chronic suicidality. I queried this subject about self-disclosure across domains:

Interviewer**:** It seems like a valuable component of your practice that you just disclose your own status as a polyamorous person. I'm curious if you also share your lived experience around suicidality with your clients?

> Dr. C: I’m actually a lot more delicate with it because...if a client says I'm polyamorous, I can say ‘me too,’ and that's the end of the conversation. But if a client says I'm suicidal and I say ‘me too,’ that actually can create issues with trust and create concerns on their side of things and mostly the way that I use my experience, I lived experience with suicidality with clients is I pull from my own experiences to ask assessment questions. So it guides my questioning more than it guides my sharing.

The idea of questioning versus sharing was articulated by the most analytically oriented therapist: “Dr. F: If you're an analyst, I hope you kind of stop and get your patient to think about what they're asking. But I am probably a bit old fashioned that way.” How does a therapist choose how and whether to answer questions as they arise in treatment? What we choose to ask our patients, and what our patients decide feels important to ask us are both areas imbued with meaning and potential, which may be foreclosed by under and over-disclosure alike.

Frame

When couples make a conscious choice to open up their relationships sexually or romantically, there is almost always a nuanced negotiation of limits, during which parameters are defined. Similarly, most therapists work to set the treatment frame. Much as therapists seem to be somewhat more self-disclosing with their non-monogamous patients in the treatments described throughout this study’s interviews, in treatment of non-monogamous relationships, most subjects reported a relatively high level of flexibility when it came to the therapeutic frame.

Therapeutic frame is almost always established in terms of parameters around time (frequency and duration of session), payment, and confidentiality. Often, if a relationship has a level of hierarchy, it's the 'primary' partners coming in for couples therapy, although several subjects brought up exceptions to this norm (for example, secondary partners presenting for couples treatment or solo-polyamorists with various partners). While in more "classically" psychoanalytic treatments, the frame is often adhered to with some rigidity, even analytically-oriented therapists who treat non-monogamous couples noted that, with the exception of only one subject, they were typically willing to bend the frame for their non-monogamous individual and couples patients. Four subjects reported they were willing to have anyone come in at the last minute for a session, provided the patient[s] sign a release. Some of their reasoning was provided as follows:

> Dr. D: I think polyamory has a unique viewpoint on that because you're expected to share partners, right?. So a lot of people feel OK sharing a therapist and we talk upfront about that.
>
> Dr. G: Anyone can come that the patients feel might be helpful. Absolutely. I want to see you in relation to somebody that you're really intimate with.
>
> Clinician B: I always tell them you can always bring anybody you want there, even if it's last minute right before a session….life is so unpredictable, relationships are so unpredictable. So why should therapy be so controlled? Right, that's creating this false idea of how to function in life when our role is to help the person support them in whatever way it is that they feel they're not able to function or whatever language it is that's bringing them to therapy. Yeah. So I really want to show them how flexibility can

> look and feel because maybe they've never had that in their life and it models it as well as meets them where they're at, which is what we're supposed to do.

Much as it seems that many non-monogamous couples appreciate a high level of transparency in terms of who their partner might be having relationships with, some therapists expressed interest in getting to know secondary partners directly:

> Dr. I: Actually there's an individual I'm seeing who appoached me with sexual concerns with a new boyfriend. Just the other day, I asked can the boyfriend join us for 10 minutes in the beginning? I don't like the idea of this faceless name who is telling you to lick his balls.

Several therapists highlighted the potential complexities of bringing in a third:

> Dr. C: I've never had three folks sign up at the same time. And I think if I had had three folks sign up at the same time, that would be very different because then the unit of treatment would be the three people. But even if we started with a unit of treatment of two, and then they want to bring in a third person and make the unit of treatment three, the third person always feels like because they were late to the game, that they aren't being centered. And it's not that they aren't being centered by me, it's that they aren't being centered by the other two people in the room.

One therapist discussed the gratification that came with seeing the couple in multiple iterations, having started as the therapist for one member of the couple, then seeing the patient with his partner. While he acknowledged he felt there were some potential complications, he conceded that he had ultimately 'bent to pressure' and also admitted that he enjoyed feeling so desired and valued by his patient. Again, the same psychoanalytically-oriented therapist who noted that they were less self-disclosing also happened to be one of the firmer holders of the frame, not permitting "special guest appearances" by other partners during treatment.

Most therapists reported they were regularly available for "tune-up sessions" or "quarterly check-ins" as needed following termination of treatment. As one therapist put it:

Dr. C: I am the frame. They can come back any time and I will still be the frame.

Group Dynamics

In couples therapy, as alliances with each member of the couple or the relationship as a whole may shift, a sense of the 'treatment unit' can be especially convoluted and knotty in treatment of non-monogamous couples. Historically, the unit of treatment in couples work has been a dyad. Therapists interviewed reported grappling with when a conflict is a relationship problem versus an individual problem, and emergence of myriad group dynamics given various iterations of the relationship unit presenting to treatment. Several clinicians who identified themselves as using Emotion Focused Therapy as a primary modality in couples treatment noted that this modality did not feel applicable to larger polycules, as it emphasizes a dyadic attachment framework. While traditionally, couples work has adhered to purely dyadic frameworks, with the incorporation of extra-dyadic partners into treatment, paradigm shifts are

inevitable. As one subject articulated, “I've had a few where entire polycules will show up, and I'm very, very clear about the polycule is my client.”

As Benson (2008) writes, “With people as with atoms, more and more complex bondings are possible with larger and larger numbers, and along with the bondings come ever more complex and sophisticated interactions and capabilities.” As such, therapists need to be prepared for this potential intricacy. One therapist described the exponential complexity added when a third partner comes to treatment: “Dr. G: One and one does not make two, it makes three. The two individuals and then you have the relationship dynamics. So with three people, it is like nine dynamics.” One subject remarked that his own experience of being in a long-term foursome taught him “how to surf really complicated dynamics without thinking that we should make it simpler by eliminating the other people.”

In treating polycules, one person articulated ways in which the group can feel like an equalizer:

> Dr. G**:** I think sometimes in monogamous couples, one generally dominates the session more than the other. When I am working with a group of people in the same room, that ability to dominate the session doesn't happen. It's more fluid back and forth where they are dominating and receding and dominating and receding.

In other instances, subjects reported that a part of a whole polycule (often a dyad) would come to treatment for a group issue:

> Clinician B**:** So these two were coming because the whole group together was not how they wanted it to be. So, the two who came weren't in relation to each other, nor did they have any conflicts or any actual issues. It was like, they desperately wanted all dynamics to work…. Everybody in the group would do the homework, but essentially, yeah, they were the ones who came in and did more of the work. So that was also a topic in therapy of like, how does it feel to be working harder than everybody else?

Several therapists noted that it can be difficult to get a picture of who an individual is without experiencing their relational interplay. Of course, even individuals are coming to therapy to solve relational issues much of the time. Who should be included in treatment and how to conceptualize the relational unit is an area in which much expansion in the field is needed. Please note that group dynamics involving raising children will be addressed later in this chapter.

Goals

Overall, the treatment goals discussed by subjects of this study were fairly diffuse. Much of the time, the goal in couples treatment is to figure out how to proceed while minimizing conflict, whether together or apart. Often, this entails how to communicate effectively, how to break cycles of disagreement, and how to regulate, individually and as a unit. Of course, couples come to therapy with their own hopes, but therapists also often have goals for treatment. Ideally, establishing these goals is a collaborative process. Therapists in this study tended to emphasize the difference between the goal of each individual and the goal of a couple or relationship as a whole. Three therapists expressed their desires for each member of the couple to articulate their identities as separate from their partner's.

Most notably, in treatment of non-monogamous relationships, therapists' responses reflected that the main goal is fostering or repairing a sense of safety and connection:

> Dr. J: Although I don't think that was the conscious goal, I think the goal originally was how are we going to maintain our loving connection while I explore this other thing with this with this other man?

Several other specific goals applicable to all relationship treatment were articulated by subjects:

> Clinician B: I want them to feel confident in the decisions that they make and feel supported in the relationship or relationships that they choose to be in.
>
> Dr. C: My goal is to make myself obsolete in my clients' lives.
>
> Dr. F: A personal goal for me is that my patients feel that on some level love and loss belong together.

Overall, couples therapy often serves to help partners accommodate transitions, including modifying a monogamous relationship into a non-monogamous partnership, or vice versa. No matter the transitional direction, maintenance or re-establishment of connection (typically romantic or sexual) comprises much of the therapeutic work. One thing notably absent during the interviews was discussion about whether secondary or tertiary partners have goals, despite so much emphasis on a sense of non-hierarchical thinking.

Considerations for Training

Monogamous couples certainly have well-documented problems, with ample training to address various ways of approaching these issues. Issues pertaining particularly to non-monogamous relationships, however, are very much still nascent in their documentation. Effectively, seemingly hardly any specialized training exists outside of lived experience. While certainly not every CNM couple is in treatment to address issues of which non-monogamy is the core, couples therapists should be prepared to work with patients practicing outside of the normative dyadic sexual and relational framework.

As one therapist noted, “The training is not going to improve until the trainers improve.” When asked what could be added to couples training to better prepare therapists, three subjects advocated for more sex therapy education. Two mentioned a general decline of discussion of sexual fantasy in the field, and expressed a desire for training to encourage exploration in treatment, both via reverie and through direct questions about sex and sexuality.

While several of the participants in this study qualified themselves as ‘specialists’ in the treatment of CNM couple, overall, subjects’ answers represented various perspectives when it came to the idea of specialization.

> Clinician A: I have kind of a chip on my shoulder about training for the purpose of ‘specialization’ because I think we do so much focusing in there, like how can we make these weird people accessible to our clinicians rather than being like, hey, here's some humans. So I think that the component we're missing isn't research, it's normalization.

Do therapists need specialized training to treat minorities? At what point does the process of training pinkwash the individuality of each case? As one analyst contemplated:

> Dr. F: I think that if the goal is to basically identify a special category that needs special approaches, then it's very difficult to then approach those special categories. And I think that if there's a conviction that love multiply manifests and that, you know, to borrow from the Lacanians, "all is but a symptom," therefore it's interesting but symptomatic. Then people are best prepared not to kind of operate from some preconceived problem or pleasure that they have in these things, but actually just do serious work. So I like the kind of depth approach rather than the specialized training approach personally.

Among those who do consider CNM a niche or specialty area of practice, almost all (N = 5 of 6) expressed that the most valuable tool in couples treatment has been peer supervision with other like-minded clinicians. Four subjects noted that their own therapy has been helpful in exploring countertransference. One expressed that supervision has been important in working through complex group dynamics, but two others noted hesitation and anxiety about bringing CNM cases to supervision, for fear of appearing too loose with the frame.

As will be discussed further in "Issues in Treatment," many therapists reported an overlap in patients' pursuit of CNM with some trauma history and resulting difficulties with emotion regulation. For this reason, several subjects (N = 4) articulated that training in modalities that specifically address trauma have served them well in treatment of CNM couples. Whether taking interventions from DBT or utilizing portions of EFT to slow down and articulate enactments in vivo, tools for regulation appear particularly well suited to treatment of CNM patients.

While most subjects with training in EFT noted that they do often integrate this modality into their couples work with CNM patients, three reflected this modality's limitations as a dyadically-oriented perspective on attachment. One subject noted that they experienced EFT training as valuable primarily in "having a much more clear understanding of my own attunement, my own self as therapist in the room and how I can utilize that as a strength." This same therapist spoke to how the EFT training requirement of recording and watching sessions encouraged deliberate practice and effectiveness of interventions. This practice of recording, of course, is generalizable to other modalities as well. While there is not yet any psychodynamically oriented literature on best practices in treatment of CNM (Baumgartner, 2009), Lorien et. al (2018) advocate that in general, clinicians need to focus on the assumption that partners who seek therapy do so for a variety of reasons.

Theory vs. Practice

Analytically oriented therapists had different views on to what extent adhering to a theoretical model during treatment is helpful. One was in favor:

> Dr. E: Well, somebody once said, 'there's nothing as practical as a good theory.' And I think you have to have a theory of what couples therapy needs to be sure that when the shit is flying around the room, you have an idea, OK, what we're doing here is mutual regulation or what we're doing here is interpreting internalized relational configurations….

Another was less attached to the idea of having a theory in mind:

> Dr. F: I like the Bionian idea where he sort of suggests that thinking is the thing that you do when you're not listening…But the minute that you stop listening, you better have something to think about. In other words, you need to know theory, you need to know things…but those things are not actively front of mind, deliberate, or conscious when you're listening, if they are, they get in the way.

One therapist noted the way in which they had experienced non-monogamy as impractical 'in theory,' but felt much more encouraged through observing couples 'in practice.' This anecdote is useful insofar as it also applies to the question of "what works" in treatment. Sometimes we don't know until we are simply in the practice.

Issues in Treatment

In addition to the experience of therapists treating CNM couples, of course there is also the experience of the patients. What is bringing them into treatment? While certainly these interviews cannot provide a comprehensive view of everything non-monogamous couples grapple with in therapy, several core issues emerged which seem common in treatment.

Safety and Connection

As mentioned in Chapter 2, couples who engage successfully in CNM relationships most typically have a secure attachment style. Of course, while these are not always the couples who end up self-selecting for treatment, they may also choose to utilize therapy more than an avoidant couple in an effort to work through difficulty and maintain a secure bond. One subject who identified as polyamorous noted that in peer supervision, "We have started doing some work around our [own] attachment styles already because there's really no other way you can manage envy, jealousy, and sharing of partnerships or of intimacy if you haven't developed some sense of security. (Dr. C)" No matter how securely attached people seemed, attachment wounds emerged as a major theme in couples treatment, with more than half of the subjects pointing to these attachment ruptures as the primary presenting issue in treatment, whether or not a couple was monogamous. Even when a dyad has been together for more than a decade, couples often wind up in treatment primarily because there is a concern about whether or not they can feel safe and connected with one another.

Although literature indicates that successful CNM relationships are typically securely attached, clinicians shared some reasoning for why avoidant or anxiously attached individuals might gravitate towards non-monogamy as well:

> Dr. C: I see some folks with avoidant attachment styles rolling into non-monogamy because it's easier to avoid depth when you're seeing multiple people and you can, you can say I don't have time or you can actually structure a relationship that doesn't need more than that. So it's a really adaptive way of building relationships. And then I also see folks with anxious attachment styles drawn to open relationships, because if there's a worry about not being attuned to or tended to, one of the ways to manage that, that's again, pretty adaptive, is to date more people and have more folks available to attune.

Achieving a sense of safety is often the first stage couples aim to reach in treatment. As one therapist notes, “after that’s settled, they can start fighting about what they need to prioritize next. (Clinician B)” In the realm of safety and connection, therapists also highlighted “feeling prioritized in the relationship (Dr. H),” “trust within the relationship for the couple to communicate feelings and experiences (Dr. K),” and assuaging “fear of retaliation” as frequent topics in treatment. Generally, there are multiple attachment wounds to be traced in each person’s history. One therapist aptly notes that in changing the external structure of a system (whether a family or polycule) by incorporating more people, invariably, the primary relationship also changes, and these shifts may be bumpy, as different wounds are reactivated. One subject described the inevitable conflict that all individuals experience in relationships, monogamous and non-monogamous alike:

> Dr. E: So on the one hand, we all seek security and safety. And on the other hand, we all want to go to the edge that shatters our solid, stolid, predictable, familiar, comfortable, secure self to the unknown, to the unexpected, to the unimaginable. And you can't get there unless you really let go of safety. And so it feels like it's an eternal tension between security and familiarity and eroticism and ecstasy.

Couples who choose non-monogamy are leaning into added uncertainty, but also creating a scenario in which there may be more expansiveness for novelty. The subject goes on to note, "And the healthiest solution is to be able to move back and forth smoothly as humans always get hurt." Old injuries may become inflamed, and new hurts will inevitably emerge.

When people in relationship give one another an opportunity to explore, they also lose the illusion that they will know everything about one another and share every moment together. Connection is a powerful motivator; several subjects differentiated between platonic, romantic, and sexual connection, noting that a perceived lack of connection can exist in any of those domains. In an effort to maintain or repair connection, one partner may be willing to open the relationship before they want to. As a result, dysregulation may ensue.

Trauma

Most subjects (N = 8) discussed the presence of trauma in treatment. Several therapists (N = 3) reported they had observed a high frequency of Borderline Personality Disorder in the CNM population, a pathology often linked with complex trauma histories. As one therapist describes a theory for why this might be, "So, you know, if you're feeling this intense need for connection with someone, well, it doesn't just have to be your one partner, it could be more than one partner. So I mean, I think it's kind of a brilliant way to manage BPD - by having multiple relationships to meet your needs. (Clinician B)" Another therapist noted ways in which feedback from multiple partners is particularly helpful to individuals with BPD in fostering an observing ego:

> Dr. D: [People with BPD] do struggle with connection and they struggle with communication, so oftentimes [CNM] works because If you're involved with more than one person, then you have more people who are witnessing the behaviors and giving you the feedback. …If you have two partners and they're both saying, 'Hey, you know, sometimes I kind of feel manipulated by you' or, 'Your responses are kind of aggressive or abusive, like you're name calling when you get upset or you're you're just threatening to leave the relationship,' right? And then you have two or more people who are all giving you the same feedback. Well, that's really important. Then they come back to treatment and say, 'Oh, OK, it's everyone saying this about me. It's not just my one partner, it's all of my partners.'

Therapists referenced trauma around gender, sexuality, and religion. Particularly because many people in the CNM community identify as queer (and one might argue that participation in a non-traditional sexual frame is a form of queerness in itself), all CNM patients suffer the minority experience. As one subjects remarks, "[Patients are] all coming in with attachment wounds because [as queer people] the world is not built for us, right?"

In addition to demographic traumas, therapists also spoke extensively about childhood trauma, including contentious divorces, early loss, unstable or unavailable parents, and abuse. In addition to the possibility that individuals may feel they have so many needs that they need to get met across multiple partnerships, these traumas also may lead to risk aversion and a fear of loss so intense that investing in one partner feels too risky.

Using treatment to foster an understanding of a partner's trauma history may provide dynamic insight for the other. A therapist shared an example of how this could be helpful:

> Clinician B**:** So if I'm working with people who are in a poly dynamic and one of them is always wanting to know where the other person is, and then we find out that they suddenly lost a parent and nobody knew where they were, and the parent would have survived if somebody knew where they were because they could have called 911, then it creates a better understanding as to why this person always wants to know where their partner is. It's not about control, it's about reliving the trauma or fear that this person could suddenly be in a situation where if no one was called, they wouldn't have died.

The word "Triggered" came up 25 times in this study's transcripted interviews. While the word may be somewhat overused in the classroom or on social media, it can also be understood as a common form of cognitive distortion that arises based on trauma history. One therapist expressed, "not every trauma therapist is going to understand being triggered by jealousy or a very specific dynamics that can only come up during polyamorous relationships." Of course jealousy may arise in monogamous relationships as well, but in a healthy non-monogamous relationship, it is almost inevitable.

Invariably, the unconscious also comes out to play. One therapist notes the way in which individuals "force" their partners to be who they expect them to be, rather than the rescuer they might have imagined:

> Dr. E: We all internalize templates about our parents. We all have wounds that we suffered at their hands. And we come to relationships unconsciously prepared to reenact those traumas because we can't do anything else…And so lots of schemas or internalized object representations or whatever you want to call it, get activated in intimate relationships and cause trouble and disappointment.

In discussing trauma, one therapist also made an observation around sexually compulsive scenarios as attempts at a solution to trauma:

> Dr. I: [This patient] thinks that if only he could find the perfect erotic partner, everything would be OK. I said to him, 'You're trying to solve a trauma problem with the sex solution. And it's not going to solve the problem.'

Everyone wishes to resolve their traumas, for some, CNM is an attempt at exactly this. At times, though, CNM may present a local maximum trap, particularly when the fear of loss outweighs the capacity of intimacy. In other words, by no means can the non-monogamy solution solve every trauma problem.

Affect and Emotions

Regulation

Variation in capacity to regulate is an issue in all therapy with both individuals and couples. Unsurprisingly, more than half the subjects in this study discussed ways in which differences in regulation cause conflict in a couple, and also discussed how regulation might play out in the consulting room as well. Some therapists shared anecdotes during which patients sat at home rocking and crying while their partners were out on dates, despite their strong assertion that they wished to engage in non-monogamy. In these instances, three therapists noted tools and strategies from Dialectical Behavior Therapy as particularly effective in helping the dysregulated patient manage their emotions.

Several therapists also discussed issues that arise when one member in a relationship depends on the other for regulation, for example “I can't be calm if my partner is upset with me” or “I can't be happy if my partner is not around.” Particularly when this partner may have a history of engaging in problem behaviors such as substance use or self-harm, two therapists reported that internalizing differentiation as healthy must be a primary aim of treatment. Another therapist noted difficulty treating intensely dysregulated individuals in couples therapy, describing a tendency to want to “rearrange the dynamics” of the relationship in order to “make the more vulnerable-appearing person feel better” (Dr. D). Again, this clinician remarked on individuation and differentiation as crucial anchors for treatment of the dyad. This therapist also noted they have a policy that each member of a couple must simultaneously be in individual treatment while in couples therapy.

Jealousy

Jealousy may arise in monogamous relationships, but will almost certainly emerge in non-monogamous relationships. Deri (2015) asserts that jealousy is a mechanism of control within relationships when exclusivity is perceived as threatened, and that polyamory's commitment to "face and transform jealousy" is on some level superior to the more common monogamous handling of jealousy as an inevitable negative emotion. Despite the inevitability of jealousy, however, approximately half of the therapists (N = 5) asserted that they feel their patients subterfuged their experiences of negative affect, jealousy in particular. Therapists observed patients utilizing a range of defenses, including avoidance, denial, reaction formation, and intellectualization. As one therapist articulated, "Instead of saying what they really felt, they said what they wanted to feel, what they thought they should feel. And both were somewhat in denial about their jealousy and wanted to deny it in order to preserve the freedom of sleeping around." All of these therapists reported that they experience a couple's capacity to discuss jealousy as akin to their capacity to work on, manage, and improve it. The complexity of language surrounding CNM will be further discussed later in this chapter. In general, however, putting words to negative affect is a key component of treatment.

Communication

Negotiation and Contracts

What can and cannot be spoken is always a therapeutic issue. What a couple expects of one another is something that is always a process of ongoing discussion and arbitration. As couples decide how much they wish to say to their partners in therapy, they are also deciding the extent they want to censor. Consensual non-monogamy is rife with agreements and negotiations, contracts so specific that they could easily be read aloud during litigation.

More than half the subjects discussed this process of negotiation, which one could argue is present in all couples therapy. Three therapists used the term “relationship agreements,” with a treatment goal of articulating a couple’s boundaries and rules around non-monogamy.

As one therapist described their therapeutic process:

> Clinician B: What are those parameters? We are really sitting down and writing it out with each of them or talking it out - What does that look like? Even down to like, is there kissing? What type of sex is allowed?

When the rules are so specific, notes one therapist, does it not produce an emotional mismatch, creating a situation antithetical to the novelty that non-monogamy is supposed to enable? Rules are often imbued with a magic corrective wish, but of course, there are limitations. As one subject describes it:

> Dr. E: They’re having trouble fixing things, and they often think that what they need to do is come up with some new rule: I don't do it in our bed. I won't do it in the city. I won’t do it more than once. And if you follow that rule, then there won't be a problem. And of course, that's not true at all, because those rules don't prevent bad things from happening.

Rules enable the illusion of safety in CNM relationships, much in the same way monogamy enables a parallel illusion for those in sexually exclusive partnerships.

Opening Up

Couples often come to therapy for assistance in transitioning out of monogamy into an open relationship or polyamory. Therapists noted that patients will run into challenges with regulation particularly this process of opening up, and also discussed other themes that emerge in this beginning stage of sexual non-exclusivity. It is important to note that introducing and maintaining multiple partnerships can shift power dynamics, and that this may arise even with the introduction of the idea of an open relationship (Zimmerman, 2012, via Lorien, 2016).

More than half of the therapists interviewed talked about hierarchy (N = 6). One therapist noted that they discuss the limitations of maintaining hierarchy with couples as they make this transition:

> Dr. C: So we talked about some of the disadvantages to having their relationship take priority and how there would be people who wouldn't be interested in dating them because of that. And they were both like, Yeah, that's fine. Like, that was not a concern. She seemed more curious about the sexual side of things. He seemed more curious about the emotional [side].

In terms of which polyamorous relationships enter treatment, one subject described hierarchy as a socioeconomic privilege, noting that, “The folks who can afford me are hierarchical, right? If you are going to pay one hundred and seventy five dollars every week, [you are probably in a primary partnership.”

Several therapists mentioned that they have observed secondary partners feel increasingly entitled over time as relationships open up and primary partners find ongoing metamours. In some instances, couples enter treatment only when the “asks” of the secondary partners may be at risk of disturbing the hierarchy of the primary couple. In other words, as relationships transition from a dyadic place to a more expansive realm, therapists may struggle to hold only the couple in front of them in mind as the relational entity. One therapist noted some judgmental countertransference when a couple in the process of opening up kept referring to themselves as polyamorous, but really adhered more to an open marriage model. They were uncertain under what circumstances this sort of technicality should be marked, if ever.

Two therapists noted cases in which they felt couples came to counseling with the manifest goal of opening up and the latent goal of ending the relationship.

> Dr. J: Not to sort of devalue that she did not have feelings for this for this other man that she had met, but like, it was sort of one of her various strategies that she's tried to use along the way to figure out how to actually separate from this relationship that felt very stultifying.

One subject described a therapeutic stance of asking the couple to keep their relationship sexually exclusive initially when beginning therapy, particularly in cases when the goal is to re-kindle a sexual connection. Two therapists also referenced cases in which they felt that one member of a couple had “given in” to the idea of CNM too quickly, concerned that the relationship might disintegrate if it takes too long to “get on board.”

In the process of opening up, two therapists also described gender discrepencies in opposite sex relationships. Typically, it is easier for a woman to secure extra-marital sex with a man than for a man with a woman. Several therapists cited insecurity around genitalia. For instance, two therapists referenced cases in which men felt they could manage their insecurity if their wives slept with other women, but not with other men. As one therapist described it:

> Clinician A: What the pisses me off is the, like, she can go have sex with other women, but she can't have any other penises - like the one penis policy. It's degrading to like everyone in the situation, whether it's degrading to her, as though another penis would distract her from her primary relationship. It's degrading to the nowlesbian relationship that's been created as though that's not real sex and that's not threatening.

In making the choice to open up, however, couples often cite a sexual need that cannot be fulfilled by their partner, whether physiologically or emotionally. Interestingly, at the start of treatment, as non-monogamy is being discussed and negotiated, several therapists reported observing an increase in dyadic sexual desire prior to the actual pursuit of extra-relational sex. For instance, according to two therapists, sexual arousal appeared heightened, if not revived, after disclosing a crush or deciding to open up, even before the couple had acted on this intention. Implied is a question about to what extent fantasy is arousing in itself.

Raising Children

Interestingly, no subjects brought up children in their case presentations, and no one spoke about treatment issues concerning children before the question was asked directly. When asked about clinical experiences with CNM people raising children, however, a number of reflections emerged. Two therapists noted that CNM people raising children still argue about

child rearing in comparable ways to monogamous parents. One therapist articulated that in addition to the benefit of sharing labor, there is also increased complexity in having a multiplicity of opinions about parenting styles. One mentioned anecdotally that while they could not think of issues around children that arise in treatment, they feel they have more poly friends who experience raising children with multiple partners as somewhat utopic, dividing tasks over more than two people. Of course, it is important to note that generally patients come to therapy to address specific issues and are likely in periods of higher conflict, hence why few therapists described such utopic family environments. One therapist noted a patient who “kept the children out of therapy” (Dr. E) perhaps because it was “too hot to the touch,” and also attributed this exclusion to the fact that the core of the therapy was about the mother exploring non-monogamy, partially in an attempt to move away from an exclusively maternal identity.

Other issues that arose with non-monogamous families raising children were the degree of openness around the subject with kids, depending on the childrens’ ages as well as the depth and frequency of connection with other partners. For example, if a polycule of three is raising a child, the child will likely experience all three adults to be in parental roles; however, if parents have regular metamours but are dyadically primary, these extra-marital relationships might be presented to the children as platonic rather than sexual or romantic. Several therapists also discussed the complexity of splits, both in terms of custody agreements and in terms of childrens’ bonds with one another. If two polycules are involved and the children bond, if the systems then separate, the children may effectively feel they are losing a sibling connection.

Several subjects (N = 4) noted that their patients expressed anxiety about the possibility of the Department of Children and Families (DCF) getting involved via a school or community member, given that non-monogamy is not a protected class. These therapists also expressed that they feel there is an element of advocacy for which they feel responsible in their work, and two noted doing preemptive work with educators in childrens' communities.

One therapist discussed their observations about the way in which biology affects the extent to which parents feel entitlement surrounding decisions that impact children:

> Dr. G: Biology has a heavy imprint. So there are three different groups that I have worked with that have children involved. Where I find it is most successful, as in everybody focuses on the children versus the individual investment in the children is where the biology is intermingled. So where a woman might have multiple babies with different fathers in that group. Everybody is invested in the whole group because the children belong to the whole group. There is no 'those are my biological children'. And unfortunately, what I have seen in some of the other situations where there are biological pairings, there are subsets of families within the larger set.

There may be three or more people in a partnership, but each child can have only two fully biological parents. Those parents may feel more entitled to decision making.

Minority Stress Experience

Given that people who openly practice CNM are in the minority, they invariably experience some degree of minority stress. Little has been written about the compounding effect of intersectionality within the non-monogamous minority experience, and some subjects made observations on this topic:

> Dr. C: My clients of color, specifically my black and Latinx clients, are more interested in swinging and open relationships right now. But I think that's because there are some challenges with white supremacy within the polyamory community in particular. I think I've worked with many black clients who would prefer to be in a polyamorous community but feel fetishized or tokenized or like they aren't able to meet the people they want to date in that way.

Another subject brought up the concept of “internalized monogamy” (Clinician B), akin to internalized homophobia or racism. Several subjects referenced cisgender privilege and the asynchrony that plays out when one partner in a relationship is trans. Even when both or all partners opt in to non-monogamy, there are still central aspects of each individual’s minority experience that the other[s] may not understand. This issue may play out in treatment as well. As one therapist describes:

> Clinician A: I think that in the same way that like I feel competent working with someone who's gay or straight or pan or bi or non-binary or trans or...whatever, I can work with most people. Since I'm some of those things, I'm not all of those things. But that doesn't mean I can't understand.

This same therapist also noted ways in which they feel being non-monogamous themselves helps them in all couples therapy:

> Clinician A: You know, I think that whenever you're a minority in whatever group, you have to be used to the way the other half does it. And so I think as a non-monogamous person, I'm a lot more capable of working with a monogamous person than a monogamous person is working with non-monogamy.

No matter how we identify, our lives and identities can only overlap with our patients' in limited ways. How does the therapist expand their capacity for understanding all aspects of a patient's experience? Again, this brings the issue of training to the forefront. How might monogamous-identified individuals better equip themselves to treat CNM relationships?

The above subject's response highlights the ways in which while overlapping identities can contribute to a helpful baseline of understanding, there are always unknowns and differences to be articulated and explored. Forging trust in the therapeutic alliance when the therapist is like the patient in some ways and unlike the patient in others ways is a crucial task of all therapy.

For some, CNM is a lifestyle individuals feel they can choose; for others, practicing CNM feels integral to their identities. In making an active choice to be part of a minority community, certain pressures may result. As one subject described this possibility:

> Dr. F: You know, like the kind of inchoate feelings of vulnerability or wounds that because you're part of something…when you're part of a movement, even a movement of two, there's a certain pressure to kind of maintain it.

One documented marker of success for long-term non-monogamous relationships is the capacity to go in and out of a state of sexual exclusivity. As such, this can be challenging for people who feel a certain pressure to maintain the minority lifestyle in which they have agreed to participate. Issues of politics and desire become intertwined in ways that can be complicated to unravel.

Meaning of Non-Monogamy

What does it mean when a couple decides to pursue non-monogamy? Answering this question on an individual and dyadic level appears to comprise an important component of work with this population. Returning to the potential binary that Ferrer (2018) highlights, "as with most existential options, monogamy and polyamory can cast 'light' and 'shadow'—that is, both relational styles can be engaged with mindfulness, integrity, and respect, but also unconsciously, deceitfully, or out of insecurities, conditionings, and internalized ideologies (e.g., Anapol, 2010; Ferrer, 2007, 2017a; Masters, 2007)." Both articulating and understanding the meaning of non-monogamy are crucial to the practice of CNM and the treatment of CNM couples.

Meaning fails when we make categorical assumptions. As one subject articulates:

> Dr. F: I think that the necessary consequence of engaging in work clinically is that the categories kind of fall to the wayside and the idiosyncratic meanings of these things to the people as well as kind of like the determinants and then that kind of draw them to these things, at least to my mind, become more interesting in trying to understand the kind of category as an epiphenomenon, you know? So I don't spend a lot of time thinking about, for example, monogamist or non-monogamous couples in diagnostic categories.

As another therapist articulated:

> **Clinician B:** It's equivalent of saying like, what does it mean to be a woman or what does it mean to be black in terms of …people are not a monolith and so consensual non-monogamy is so unique to the individuals who are in that dynamic that anybody who shares with me that they're consensually non-monogamous, I first need to ask them, "What does that mean to you?"

Both why a couple chooses to engage in CNM - the determinants - and what the couples make of their decision are all important facets to explore. Much in the way couples therapy addresses the meaning underlying an affair when a couple grapples with infidelity, therapists must negotiate not only the pragmatics of non-monogamy but the underlying significance. Even when couples are in open relationships, pursuing only ‘casual sex’ rather than love connections (as in polyamory), meaning must be elucidated and processed. Several therapists noted their surprise that patients find such a variety of meanings in sex. In addition to physical gratification, sex is fundamentally about connection. On therapists described this from both personal experience and practice:

> Dr. E: Another thing that I have come to learn both from my own life and from my patients is that - sex as sex is interesting, important and a real thing, but that sex is like the white meat chicken of relatedness. You know, it can take on all kinds of meanings, flavors and varieties, and someone says, I'm horny. I hear this person has some kind of emotional need. It's not really related to sexuality that they're trying to work out through sexuality.

Values

People develop a relationship not only with their partners, but also with the relational structures after which they are modeling themselves. One therapist described the way in which working with CNM relationships evolved their perception of where values fit into treatment:

> Dr. C: I've gotten a little more into values work over the years because I think finding out why clients want to be non-monogamous is more helpful than I initially thought. Like, what is it that draws a person to this lifestyle in particular? Like why *this* structure? …And I found that the folks that are most successful in non-monogamy, they have a relationship with the humans, but they also have a relationship with the concept of being non-monogamous.

CNM entails the constructing of a new, non-normative path, and as a result, values need to be more clearly articulated than they might be in a monogamous relationship. As one subject described it, "A lot of times if we're experiencing conflict, it's because there is a conflict against the core values. And so if we can kind of put that out in a more concrete way for people to look at and reference and create relationship agreements around? We can kind of create a little bit of a path. (Dr. K)" Several subjects (N = 4) reported that they experience CNM individuals as valuing platonic relationships as much as romantic or sexual relationships.

Historically, people have bought into the idea of monogamy as a value system. As one subject described, "I value polyamory as a lifestyle. This is something that monogamous, married folks know a lot about. They stay in part because they value the marriage, the institution, not just because they value the other person. (Dr. C)" Therapeutic environments that provide space for CNM to exist as value system, particularly one that is co-created by the couple with the therapist's guidance, appear to be an important component of treatment for designer relationships.

Language

Nearly every subject (N = 10) discussed the ways in which language is used in discussion of CNM. Language serves as a way that people are able to codify values and structure, and serves the function of both clarifying and hiding affect. Subjects noted the way that as in all therapies, language can serve as a defense - whether via intellectualizing or distancing or even as reaction formation. As one subject noted the ways in which language was used to disguise emotions rather than communicate them, "They would say, 'I don't care, it's OK when what they really mean is I do care, but I want to not care." One therapist described language as the initial presenting problem in treatment:

> Dr. E: At first, for a while, they came to me as a couple for help negotiating their non-monogamy and really had to be taught the meaning of the word jealousy…They needed to be taught that they were using language to disguise their feelings rather than communicate.

Jealousy will be discussed further in the next section, but subjects noted the ways in which couples struggled to directly communicate negative affect, sometimes using jargon specific to CNM as a way to avoid the affective experience. Three subjects spontaneously recalled times when patients said "It's fine" or "I don't care," noting the patients' need to undo or subterfuge a negative experience.

In line with the need to negate the possibility of negativity, one subject referred to an incident during which a prospective patient asked if they consider themselves "sex-positive," a question to which they had a viscerally negative response. The subject stated that their sense was that when patients seek this type of affirmation, they are perhaps needing the therapist to "claim some sort of membership in their exciting lifestyle. (Dr. F)" This subject noted that in this sense,

they felt the language associated with CNM might serve to "easily hystericize" sex and also undo the specificity of meaning for each individual.

Other subjects reflected on the language of CNM as a cultural phenomenon particular in the United States:

> Dr. F: Yeah, I guess I would say that in other places, like I have a lot of friends and colleagues in France, the idea of being in a consensual or ethically non-monogamous couple would seem like an exercise in a linguistic kind of humor, rather than something to be taken seriously, in that like it would reflect to them a kind of naive construction of love or relationship that requires all that language.

In cultures where concepts of infidelity are handled less puritanically, as in France, perhaps all the effort funneled into actively justifying and making sense out of non-monogamy appears juvenile. Additionally, therapists noted ways in which this discourse can suck the eroticism out of a supposedly romantic situation:

> Dr. E: I can tell you personally, sometimes there's a certain measure of exasperation, you know, because they can start to sound lawyerly at a point. In a way that at least to my ear, as an old kind of romantic, I find really un-erotic. And it's striking to me kind of the language exists to set a frame for the possibility of eroticism.

Therapists (N=3) also noted ways in which they have found it helpful to adapt their own use of language in treatment, particularly in standardizing an intake process. One therapist noted appreciated for the flexibility on electronic health records in an effort to be more queer and poly-afforming. Another noted the way in which linguistically standardizing their intake forms served as a "shield," interestingly employing the same defense referenced regarding patients.

One therapist defended the ways in which CNM individuals utilize language, not as a defense, but rather as a form of expressive affirmation:

> Clinician B: I think that of those who feel affirmed in the language that exists or that they've shared or identified or created, then that is their identity. Just like folks like me who don't really have a label and I'm OK with that. I don't need people to - like if the word was petunia, I'm a petunia. Like, I don't need everybody to know about this, about my whole dynamic, because I'm nourished and happy in it, and that's all that should matter if you care about me, not anything else that it entails.

Following the diplomacy of constructing rules around non-monogamy, one therapist notes the ways in which the chosen language may keep couples less performative: "Dr. F: Monogamous couples don't ever, ever think about their vows after they've said them. It's a ritual; it's a performance. In the non-monogamous negotiations, it's not performed." Perhaps the intentionality leads to a greater sense of authenticity. Similarly, another therapist discussed the ways in which the specificity of language regarding CNM helps de-catastrophize otherwise "nuclear" situations:

> Dr. C: When I work with monogamous partnerships, a lot of times I hear nuclear language, right? Betrayal. Affair. The other woman. Complete lost of trust. Divorce. Like I hear like these really big language choices that have lots of cultural weight behind them. And my CNM clients are often using slang from CNM life or making up their own terms. Metamour doesn't have the same cranky sound to it the way mistress does. And so I appreciate that from a narrative therapy perspective.

In the context of CNM, much as with monogamy itself, it seems that language both limits and expands our capacity for expressivity and understanding.

Faith

Subjects also noted experiences of faith in several veins. One therapist described his surprise at the faith couples place in the systems they co-create:

> Dr. F: What's interesting to me about people who are non-monogamous is a kind of faith in a system. Almost religiously so…Yes, you negotiate exactly how it works out. But then you kind of believe. What it constitutes, the ethical trust, the bond between people –is riddled with paradox. Like you can't promise someone that if you are sleeping with someone else, you are not going to develop romantic feelings. You just can't.

Another subject noted the ways in which they felt surprised by the faith couples instilled in their own linguistic creations:

> Dr. E: Your words are as aspirationally correct and therefore not necessarily true as anything else that we commit to. But yeah, it's a faith in language that's kind of wild to me, and it's a kind of superficial language, actually. Right, superficial in the sense is not connected to a deep feeling.

Again, language used around non-monogamy is perceived by the therapist as a defense. Finally, therapists also noted that in couples treatment of all types, it feels important to develop and maintain a faith in the couple, and "in the couple's wisdom to find their own way. (Dr. E)" While the therapist may be an important guide in treatment, ultimately, the couple must serve as its own expert.

CHAPTER 5: Discussion

Summary of Findings

The purpose of the present study was to investigate common themes communicated by therapists who treat couples in consensually non-monogamous relationships and to explore how therapists navigate issues that are particularly salient to this patient demographic. Data was generated via 11 semi-structured interviews with therapists, all of whom have treated CNM couples, some of whom identified as experts in the treatment of CNM relationships. The interviews were transcribed and analyzed using Nvivo. It was hypothesized that thematic patterns would emerge in transcripts of these issues, particularly regarding themes of treatment and countertransference. Ultimately, three main thematic areas emerged: Therapeutic Process, Issues in Treatment, and the Meaning of Non-Monogamy, which did encompass themes of treatment and countertransference as significant subthemes.

While it was also hypothesized that there would be thematic differences between interviews with therapists who do and do not identify themselves as ‘experts’ in the treatment of non-monogamous couples, these differences were not as significant as hypothesized. However, certain themes present only in the interviews of analytically oriented therapists will be further discussed in this chapter, namely desire, fantasy, and loss. Additionally, themes of betrayal and infidelity, i.e. non-consensual non-monogamy, will also be addressed.

The primary aim of this study is to contribute to the burgeoning literature on treatment of CNM couples, taking an integrative theoretical perspective by interviewing diverse treatment providers. It is the goal that these in-depth conversations about couples treatment, which included detailed case presentations, might illuminate constructs that are most salient in treatment of CNM couples and help offer direction in both ongoing couples treatment and in training of couples therapists.

Fantasy

Fantasy and Loss

While the differences between psychoanalytically oriented therapists and therapists with a more affirming stance were not sizeable enough to discern an effective control group, those themes specific to psychoanalysts do merit further discussion. In polyamory, ostensibly, many people are able to "live their dreams" without compromising their partnerships. As such, it is somewhat surprising that themes of Fantasy and Loss were discussed exclusively by psychoanalytically-identified clinicians. Themes of Desire were also focused in these interviews, and discussed by one additional more eclectically-identified therapist (N = 4).

Ferrer (2018) notes that from the 'polynormative' perspective, polyamory serves as a superior model, "an antidote to the problems intrinsic to compulsory and serial monogamy." This assumption leaves little room for improvement, and effectively, little room for fantasy. Fantasy appeared linked to both the themes of Loss and of Desire, almost as a hinge for those two ideas. "To choose one option is necessarily to exclude the other," writes Illouz (2019). Our culture somehow imbues us with a sense that we can, and are entitled, to 'have it all.' But if someone

refuses to exclude the other, they do still suffer a loss - the theoretical loss of loss. As one analyst remarked regarding Fantasy and Loss:

> Dr. F: Giving something up sounds like an important thing to do in a relationship, right? And for some people, I think probably people who have less experience with non-monogamy but who fantasize about it, I think the fantasy is that you can have a primary relationship, that provides some sort of core emotional experience and also not have to give up as much… And maybe that's the thing, like where the fantasy of how you protect yourself against feeling like you've lost something important or that you will lose something important comes in seems to function in a kind of unique way in non-monogamous relationships.

Another analyst noted that in some ways, the idea of ‘casual sex’ is in itself a fantasy:

> Dr. E: Any sex that is truly ‘recreational’ in that [supposedly] it's devoid of fantasy – deep, deep, deep, deep, deep meaning and templates – even if it's somebody you've never met before and don't even know their name or see their face, there's still a lot of deep relational process happening in that encounter.

When people tell themselves that sex is purely recreational, they are defending against the possibility of connection, and more effectively, against the possibility of loss. Non-monogamy as a whole serves a potential defensive function in reminding an individual that they are still connected to people other than their singular partner, whom they might lose. To feel fully permeated by the experience of loss is for some akin to a feeling of castration. Many people underestimate their capacity to carry and move through devastation.

Fantasy and Desire

Lacan famously wrote, “Man’s desire is a desire for the other” (1964). Another important way that people utilize fantasy is as a defense against the lack in the Other. The human condition is constituted by the fluctuating operations of fantasy and desire (Gardiner, 2014), and fantasies emerge “in response to one’s fundamental differentiation between ‘Self’ and ‘Other.’” One way in which psychoanalysts articulate the utility of treatment is as an alteration in a patient’s primary modes of defense, which in turn, may alter their experiences of jouissance. Fantasy provides a schema for us so that objects can function as desire (Žižek, 1997). In other words, the search for alternative lifestyles represents a protest against the shackles of capitalism. With fantasy, we can fill our voids with an image of happiness. For Žižek, fantasy is not an exercise in fulfillment, or contentment, but rather, it provides a scene for a “privileged yet arbitrary object that embodies the force of desire” (Butler, 2015). The goal is not to realize the fantasy or experience satisfaction, but rather to generate more desire and keep our desire in motion.

“Desire, strictly speaking, has no object. In its essence, desire is a constant search for something else, and there is no specifiable object that is capable of satisfying it… it does not seek satisfaction, but rather its own continuation” (Fink, 1999). How we are forced to sit with “lack” and defend against this abyss reveals our desires. Fantasy provides a solution to this longing, temporarily answering a question to which the answer is always shifting. Again, we return to the balance between attraction and repulsion at the crux of jouissance - our fantasies keep us at an ever-shifting and sustainable distance from the Other.

In the realm of fantasy, we have the possibility of a corrective experience that allows us to re-negotiate our relationships with the Other. As therapists, we interpret symptoms and hope our patients may be able to construct and reconstruct their mercurial fundamental fantasies. All

of the contractual negotiations among CNM couples seem one way of sterilizing this overwhelming and relatively futile process. The words in these contracts serve as a signifying chain, but are somewhat inconsequential.These contracts seek to wrap a bow on something which is about process and not about content. From a Lacanian perspective, "desire is learned through the appropriation of the Other's desire." Because this can never be fully known, we largely flail. What we desire is only truly to sustain desire, and in fact, we unconsciously endeavor to postpone satisfaction. In effect, we are confronted with the dilemma of how to manage conflict in treatment. So often, we aim to resolve rather than confront.

Betrayal and Infidelity, Merging and Differentiation

What is the "Other" beyond a substitute for the non-self? When our partner becomes too merged with us, we are more prone to seek the Other. This can happen in monogamous and non-monogamous relationships alike. Particularly within the framework of relationships in our capitalist society, when people experience their partners as becoming so wholly familiar, engrained not only as lover, but also as coparent, co-financial planner, confidant, etc., over time, the question of how one negotiates what constitutes their Self as separate from the Other grows increasingly complicated with time.

As one analyst described the necessarily illusory nature of eroticism:

Dr. E: One of the deepest truths I've learned is that sexuality is a fugitive. That is whatever you think - you've got it nailed down - It escapes and goes somewhere else and you can't really settle it. Because it thrives on surprise, alien, otherness, mystery and not knowing. And knowing and

familiarity are the enemy of intense intelligence. So it's the otherness that we lack that creates desire.

In all of the negotiation around non-monogamy, however, people seem to be defending against exactly the otherness for which they are yearning. Safety appears to be a faith-reliant construct in both monogamous and non-monogamous relationships.

One of the main reasons couples seek therapy is to work through infidelities. Something largely unaddressed in the literature is the overlap between non-monogamy and betrayal. Even when a couple is non-sexually exclusive, with the exception of relationship anarchy, people still find creative ways to betray one another at every turn. Understanding the meaning of betrayal and the meaning made of disloyalty by the aggrieved partner is as important in CNM relationships as in monogamous relationships.

According to one therapist, CNM is often pursued by people who "strongly believe in autonomy and individuality and differentiation." This same therapist described a case in which a woman suggested CNM in her relationship, from the therapist's perspective, primarily as a "first effort at managing individuation. (Dr. J)" They furthered, "So she keeps making these gestures towards more autonomy, more separation. And so his strategy was to be like, OK, let me see if I can recreate this sort of symbiotic merging with another partner. Hence why he fell in love with someone else in the next two months."

Perhaps one of the core goals of couples therapy is to help partners realize that they do not share one mind, and to maintain curiosity about both of their individual psychic landscapes, as well as the quasi-intersubjective third of the relationship. Understanding and even leaning into difference, rather than "trying to get on the same page," may help couples with connection and intimacy. A frequent query in negotiating boundaries around CNM is how much a couple should

share with one another about extra-relational pursuits. Couples often describe compersion and arousal regarding their partner's reports, wanting to hear about experiences in great detail. Total honesty, however, also exemplifies a fantasy of merging, to which infidelity is the salve.
In any relationship structure, no matter how much "freedom" is agreed upon, one may lose their sense of self and act out in retaliatory or defensive ways. In other words, the unconscious finds a path.

We keep secrets from our therapists, our partners, and from ourselves. One analyst noted the ways in which he experiences CNM agreements as emotionally incongruent:

> Dr. F: I think that there's something, you know, between loyalty and cheating. There's something about what happens when the line is being blurred as a line that was decided on by, again, the sort of contractual language that produces, I think, a bit of an emotional mismatch.

This same analyst notes anecdotally that in some cultures, it is far more acceptable to have an affair than to talk about it. The flame of desire is sometimes ensconced in necessary privacy. To have your partner's consent and support is to suck the air out of a transgressive experience of aliveness. CNM removes the eroticism of the potential danger of being caught, and devalues the way in which a lack of consent from a partner is central to the meaning of many extra-relational experiences.

One therapist stated that he explains choices around infidelity to his patients as a series of tradeoffs:

> Dr. I: I've taken the attitude of, What are your playing cards here? Life is a series of tradeoffs. I can't tell you what to do, right? And it might be like anything else. I'd like to

sleep till 10:00 a.m. on Saturdays, but we've got a five-year-old and a three-year-old, and someone's gotta be up to make breakfast.

In helping people reach their own conclusions, the therapist is making space for a patient to work through their ambivalence. One therapist described a potential framework for CNM: "While you're feeling this trust violation, you're saying to your partner, if you would just tell me this is what you want to do and if you tell me upfront, it would be OK." CNM normalizes and perhaps sanitizes a handful of forms of traditional infidelity. People feel more in control when they are able to maintain the illusion that they can predict the future. The same is true in the therapeutic relationship, which is rooted in the capacity for rupture and repair. Much as in the therapeutic alliance, romantic ruptures should not be eliminated, but rather, understood and worked through.

While more poly-affirming therapists encouraged their patients to simply indulge their fetishes from a non-critical lens, psychoanalytic therapists noted the prevalence of repetition in sexual proclivity rather as an attempt to work through trauma, the meaning of which should be explored. The ideas that an issue can be resolved by a repetitive act or by avoiding a repetitive act are both problematic. As one analyst shared, "So if his partner can't ejaculate in his butt, he has to go out and find it somewhere else. Well, that's ridiculous, right? I mean, to me that the idea that you've got a problem that has to be solved by repeated sexual behavior needs to be unpacked to figure out. What are the relational configurations of that solution? There is some solution to it rather than having the problem."

There is often a neatness around CNM in terms of the specificity of what people are seeking - specific but limited encounters, indulgence of only certain perversions. Whether or not via sexual infidelity, couples will always find a way to let one another down. There will always be betrayal. There will always be surprises and confusion, because predictability is lifeless, and

people need to find ways to experience themselves as alive. Partners seek CNM because they crave novelty, yet they also yearn for stabilization. If an experience was not destabilizing, however, it would be devoid of eroticism. In some ways, treatment of CNM patients is asking for installation of a gyroscopic stabilizer of a ship that will be sent into storm after storm.

Limitations of the Study

This study was designed and intended to look at a number of therapists' work in depth, and must be viewed primarily as exploratory. The small sample size of 11 participants is this study's primary limitation, and to what extent themes of treatment are generalizable to a larger population of CNM couples - and monogamous couples - remains unknown. The themes centered around therapeutic process and issues in treatment are perhaps more applicable to all couples, and the themes around meaning of non-monogamy certainly offer a starting place to begin defining the range of factors that contribute to a person's choice to pursue non-monogamy. A larger sample size, perhaps one that included more analytically-identified therapists, might have enabled observation of group differences, supporting the second hypothesis that differences in themes across treatment might emerge depending on orientation. The therapists who participated were more geographically diverse than anticipated, as interviews took place on Zoom and not in person in New York, and did represent several areas of diversity (age, gender, sexual orientation, theoretical orientation); however, heterosexual-identified therapists were underrepresented, as were monogamously-identified therapists, as compared with the general population of therapists.

The recruitment method of this study also functions as a limitation. The sample was self-selected, comprised of therapists who had enough flexibility in their schedules to volunteer

their time, and enough interest in the subject of non-monogamy such that they were willing to make themselves available. As a result, there was perhaps an over-affirming bias in favor of the CNM lifestyle among the participants, such that other views were not represented. Perspectives of therapists who treat non-monogamous couples but also struggle with a more critical stance on it could have been a valuable addition, both in terms of diversity of opinions, and understanding limitations being enacted in ongoing treatment.

It is effectively a strength and limitation of this study that the data was limited to therapists' perceptions. While contributing to the literature, as nearly all prior studies have recruited CNM patients to talk about treatment rather than therapists, of course the therapists' perception of the course of treatment cannot be corroborated by the patients. Additionally, because each therapist was asked to present only one case in depth, it is possible they selected cases in which things went particularly smoothly. Even though therapists were told all material would be de-identified and that it would be useful to discuss challenges in treatment, most therapists tended to present cases where they represented the course of treatment as relatively smooth. Effectively, some challenges in treatment may have been muted.

Implications for Clinical Practice

Each theme that emerged in coding can serve as a potential motif for therapists to hold in mind as they train in couples work of all kinds. Awareness of the possible challenges particular to CNM cases, manifest and latent, and some familiarity with the linguistic norms around sexual non-exclusivity could help thereapists enter into treatment with a more mature theoretical

framework. Utilizing an intentional exploration of meaning and values to help couples articulate why they want to participate in CNM could also help scaffold treatment.

Clinicians expressed strong opinions regarding their motivations for self-disclosure, with more than half of the therapists reporting a style of active self-disclosure with their CNM patients. While a number of therapists reported they felt this made their patients feel a base level of safety or acceptance, therapists should consider what exploration these self-disclosures might foreclose. Particularly regarding a dynamic that has so much to do with differentiation versus merging, a therapist's own orientation, whether it represents Sameness or Otherness, may detract from a person's capacity to reflect on the meaning of CNM to them individually.

The connection between minority stress and mental health is well established (Flenar, Tucker, & Williams, 2017; Kuyper & Vanwesenbeeck, 2011; Meyer, 2015), although it has been somewhat normalized within queer communities. One subject described a case in which they saw a couple who had previously been to a therapist that intensely pathologized CNM , a practice in which the couple had been engaging for nearly a decade. This experience harmed the couple's self-perception, and development of the therapeutic alliance in the new treatment felt particularly arduous as a carryover effect. Clinicians need to be aware of their own biases, both in the positive and negative directions. Some therapists noted the pull towards voyeurism when their patience shared "salacious" details.

Therapists must contemplate to what end their own self-disclosures surrounding queerness or personal sexual/romantic practices may both help forge therapeutic alliance and narrow the possibility for patients to construct their own meaning. While it is important to bring

awareness to the minority stress experience, there may be a danger in over-affirming stances in limiting the exploration of motivation and for pursuit of CNM. Ultimately, each individual or couple must forge and articulate their own value system. Therapists may want to make an effort to clarify a couple's relationship structure at the beginning of treatment so that it does not emerge as a surprise in a middle stage of treatment, as it did with the couple I treated that inspired this study. Depending on their therapeutic stance, one may want to ask a somewhat standardized set of questions or make sure that goal is achieved organically.

An over-affirming stance may also lead clinicians to downplay potential pathology in their patients. Questions of comorbidity should also be further attended to in this population. Noting the (qualitative) prevalence of BPD and complex trauma histories therapists observed in their CNM patients, taking extensive histories and creating adequate space for ambivalence or exploration of elements of CNM as potentially defensive should be held in mind. Regarding the emotion dysregulation discrepancies that often appear in couples work, particularly when there are trauma histories in the mix, it seems a diverse arsenal of therapeutic tools may aid clinicians in couples treatment. Several clinicians noted the ways in which DBT skills were helpful to patients. Mindfulness and mentalization-based interventions may also serve this population well. Therapists also noted the importance of encouraging patients to pursue their own simultaneous individual treatments, and this should always be considered as a useful recommendation in couples work.

Several therapists also noted their backgrounds in sex therapy. Given the desexualization of the field described earlier in this paper and noted by some subjects, therapists should be mindful about the ways in which they are willing to bring sexuality into treatment. Particularly in

couples work, therapists certainly need to develop comfort in talking about sex, and some education in sex therapy may help therapists suggest concrete interventions regarding sexual intimacy.

This study raises questions about to what extent a therapist should "specialize" in a certain population or issue. For some therapists, including those who reported asking a standard set of questions to each patient at the start of treatment, there is a sense that each patient receives the same treatment, which is antithetical to the more dynamic, Bonian notion that one may enter into treatment "without memory or desire." Therapists who are public experts in their communities and are visible in both academic and social contexts (for example, therapists who frequent kink parties or CNM mixers) also need to be mindful about the effect this may have on their patients, creating room to explore any reactions that may arise. It is possible that these therapists may end up in a role of the "all knowing expert," who may be able to offer fantasied perfect solutions, when in fact, they are of course, people just like their patients.

Surprisingly little was discussed overtly about gender in these interviews. Illouz (2016) writes, "For women casual sex creates a conflict between relationality and the autonomization of the body, while for men casual sex is the opportunity to accumulate sexual capital and status." Particularly for opposite-sex relationships, room must be made to discuss gender discrepencies, which can lead to asynchronies both in terms of physical and emotional safety. While CNM couples, like monogamous couples, come to therapy when they are having an issue, overall, therapists ought to capitalize on the communicative strengths of CNM couples, while taking care not to outsource too much of the emotional labor to the woman (or women) in the room.

Suggestions for Future Research

Despite the relatively small sample size of 11 participants, this study's rich in-depth interviews generated many themes salient to the couples treatment of CNM relationships. A larger sample size of clinicians would help discern to what extent these themes are generalizable, both in treatment of CNM couples and monogamous couples. This study confirms that therapists need to bring awareness to their own biases, and also leads to further questions about to what extent "specialization" helps or hinders treatment. Future research could better help articulate the utility and risks of self-disclosure, and also investigate the effects of marketing oneself as an expert, both in clinical practice, and also as a visibly CNM person in the community.

The case studies in particular offer a tapestry of potential data to explore. It would also be interesting to interview members of the couples in treatment and compare experiences of the therapy from both sides of the couch. It could be useful to investigate to what extent therapists and patients agree that a treatment is effective, and explore overlaps and discrepancies in perceptions of rupture and repair. Future studies could also explore the experiences of treating CNM individuals in therapy, noting differences in the themes of treatment that emerge.

Future studies would be well served by paying more attention to gender discrepancies. Illouz (2016) writes, "Heterosexuality is a more privileged terrain from which to study this question than homosexuality for a number of reasons. In its present form, heterosexuality is based on gender differences, which more often than not function as gender inequalities; heterosexuality in turn organizes these inequalities in an emotional system that places the burden

of success or failure in relationships on people's psyche, mostly women's." Non-monogamy has been much more thoroughly documented in the queer community, particularly in gay male populations, but the ways in which CNM plays out in opposite sex relatonships has been less specifically documented. Dynamics around rearing were discussed only minimally in these interviews, and the subject merits its own research.

It is noteworthy that men and women often employ different psychological defenses (Petragalia, 2009). Overall, the primary defense at the crux of CNM treatments is often intellectualization. What other defenses arise most frequently in treatment, and how they differ depending on gender, is also worthy of investigation. It could also be useful to explore the extent to which people utilize sex defensively, perhaps as a means of escape or differentiation, dissociation, or narcissistic wish fulfillment, to name a few possibiliites.

The findings of this study expand what the existing body of literature addressesses in terms of the minority stress experience. While the therapists who participated in this study were fairly diverse in terms of age and theoretical orientation, overall, the patients described were somewhat more homogenous. Although some were sexually diverse, most were white and relatively affluent, young professionals in their mid to late-30s. Socioeconomic diversity is particularly understudied in the realm of CNM, and of course, those who are able to attend treatment are those with time and money. Future research could better distinguish the struggles particularly of less wealthy individuals. Moreover, how do various forms of intersectionality contribute to how individuals experience jealousy, hierarchy, and loss?

It was notable that some therapists did identify patterns in terms of how CNM can pull on personality traits and attachment styles. Future studies could further investigate these correlations, particularly in terms of diagnostic overlap and comorbidities.

Literature indicates that CNM couples communicate more effectively than monogamous couples (Moors et al., 2014). As such, future research could investigate specifically what this communication looks like, and how these skills might be generalizable to other couples as well. Overall, many of the interventions employed effectively by clinicians were by no means solely applicable to CNM couples. Further research in this domain could certainly help refine therapeutic interventions that could be applicable to all couples.

Conclusions and Concluding Questions

"*Consumer culture that has become the unconscious drive structuring sexuality."*
(Illouz, The End of Love, 2019)

According to Anthony Giddens (1991), one of the pioneering sociologists in the realm of emotional modernity, the price people pay for the capacity to be simultaneously autonomous and intimate is a state of "ontological insecurity," or as Eva Illouz (2019) rephrases it, permanent anxiety. How do people develop the capacity to tolerate and work through ambiguity and discomfort in relationships when they feel their relationships should supply limitless freedom and pleasures? As therapists, do we want our patients to recreate our ideas of what we think a successful relationship looks like, or do we want to explore the myriad shapes a relationship can take? In an age of identity-affirmation, how do we train ourselves to tolerate discomfort in treatment and in relationships? Inevitably, there is pain in monogamy and in non-monogamy. Therapy is about enabling change, but it is not our job to tell patients how to change

This study is intended and can be only viewed as exploratory. While non-monogamous individuals are heterogenous in their reasons for pursuing CNM agreements, there are some important themes that tend to emerge in couples treatment with which therapists should familiarize themselves.

Iasenza (2010) notes that queer theory and relational psychoanalysis have influenced each other in significant ways. These include the designation of "queer" superceding the essential identity categories of lesbian, gay, bisexual, and transgender. Is there something inherently queer about non-monogamy? In its clear rules and regulations, CNM sometimes removes the paradoxes and ambivalence, the "impasses, surprises, confusion" from sex and romance. Removing these elements is in a way antithetical to queerness. Therapists often give into a pull towards pragmatism in couples work. While CNM is by no means always pursued from a defensive position, it is worth noting that all defenses are attempts at adaptation, and all defenses have meaning.

As with all phenomena, the existence of monogamy pulls for a binary. Barker (2012) argues against the positioning of either monogamy or polyamory as intrinsically superior to the other, yet as Ferrer (2018) notes, it is difficult to maintain a dynamic continuum. Assertions that CNM relationships are superior imply that people can fully articulate and realize their fantasies. Where is the unconscious in that process? We long for superabundant vitality, but this is not something we can consciously orchestrate. CNM is indicative of our wish to be rescued, whether by a person, a treatment, or by a lifestyle. Tummala-Narra (2016) notes that, "It behooves psychoanalytic practitioners to seriously and consistently engage with cultural competence and all practitioners to engage with conceptualizations of social identity that attend to conscious and

unconscious processes." Therapists ought not forget about the unconscious element of the process.

All contracts are aspirational, negotiable, and performative, just like the therapeutic frame. Perhaps when patients respond well to affirming therapists, what is actually therapeutic is not the therapist's knowledge or personal practice of CNM, but rather a sense that solutions are available - that a world imbued with less suffering may exist. In times of constriction, a therapist can try to hold expansiveness and hope, keeping a patient's mind alive and accessible. Language around identity gives patients room to symbolize efficiently, but when used too concretely, can lead to a stifling of creativity and expression. Treating CNM as a stand-alone clinical issue is reifying and stereotyping the practice. This siloing wipes CNM clean of idiosyncrasy and the specificity of meaning. A psychoanalytic perspective generally emphasizes the way in which all relationships are imbued with distortion, fantasy, disavowals and repetitions. A stance of curiosity in all relationships – monogamous, non-monogamous, and therapeutic – seems important to foster aliveness.

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Tables

Pseudonym	Theoretical Orientation	Geographic Location	Gender	Number of CNM Couples	Years in Practice
Clinician A, LMFT, Certified Sex Therapist	Bowen Family Systems, Feminist Theory	Austin, TX	Female	30+	9
Clinician B, LMFT & LPCC	Eclectic, person-centered, anti-oppressive	San Diego, CA	Gender Nonbinary	300+	8
Dr. C, PsyD	Eclectic: narrative, CBT, DBT, psychodynamic	Alameda, CA	Female	~25-30	14
Dr. D, PsyD, MFT, Sex Therapy	Experiential and Narrative	Monroe, CT	Female	~100	10
Dr. E, PhD	Relational psychoanalytic	New York, NY	Male	3-4 couples, many individuals	38
Dr. F, PhD, Psychoanalyst	Psychoanalytic	New York, NY	Male	~10	12
Dr. G, PsyD	Integrative, Emergence theory, Somatic theories, CBT	Wurstboro, NY	Female	~200	12

Dr. H, PhD	Attachment-oriented and relational psychodynamic. EFT-trained	Brooklyn, NY	Female	~10	4
Dr. I, PsyD, AASECT certified Sex Therapy Supervisor	Psychodynamic	New York, NY	Male	200+	30
Dr. J, PsyD	Psychodynamic	Brooklyn, NY	Transgender	3+ (but more individuals)	13
Clinician K, LPC, Certified Sex Therapist, EFT Certified	Emotion Focused Therapy via an anti-oppressive lens	Atlanta, GA	Transgender	Unknown. Works exclusively with CNM relationships	24

Table 1:Participant Pseudonym, Demographic Identifiers Based on Pre-screening Questionnaire

Appendix

A. Recruitment Posting

ARE YOU A THERAPIST WITH EXPERIENCE TREATING CONSENSUALLY NON-MONOGAMOUS COUPLES?

If so, you may be eligible to participate in a qualitative study. Sharing your experience could help inform future treatment of this population.

THIS STUDY IS COMPLETELY VOLUNTARY AND CONFIDENTIAL. YOU WILL BE COMPENSATED FOR YOUR PARTICIPATION WITH ENTRY INTO A RAFFLE FOR A VISA GIFTCARD.

For more information contact
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B. Prescreening Survey

CNM Couples Therapy Study Pre-Screener

All information will be kept strictly confidential

* Required

1. Email *

2. First and Last Name

3. Location (City/State)

4. What is your training background?

5. How long have you been in practice?

6. Briefly, how would you describe your theoretical orientation?

____

7. What is your psychotherapeutic experience working with couples?

____

8. What is your experience working with non-monogamous couples?

____

9. Approximately how long have you been engaged in this work and how many patients have you worked with?

____

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C. Interview Questions

- Can you describe your theoretical orientation as it pertains to couples treatment?
    a. Do you adhere to any pre-existing frameworks? (For example, EFT/MBT/CBT?)

- In your work with couples, do your patients speak about their practice of consensual non-monogamy? How?
- Do you query about whether or not a couple is non-monogamous, and if so, how and at what point in treatment?
- What is your own understanding of the practice of CNM?
- How has your work with patients informed or changed your understanding?
- What have you learned from your patients about non-monogamy?
- What have you experienced in your countertransference towards CNM patients?
    a. Have you noticed any differences in your work with monogamous and non-monogamous patients in this regard?
    b. In general?
- Is there a case involving CNM you could describe in detail?
    a. In describing the case, can you keep in mind:
        i. Discernment of treatment goals
        ii. What has made this treatment more or less successful
        iii. Specific challenges of the treatment
        iv. Object relations
- How have secondary or tertiary relationships factored into treatments?
- Are other members of the polycule ever incorporated into treatment?
- How do you think practice of CNM interacts with changes or improvements of presenting problems in couples treatments?

- Have you worked with any CNM couples currently raising children? If yes, what have you observed, both in terms of the cases and your own reactions?
- Have you been able to tolerate views of relationships in couples you treat that are very different from your own? Could you tell me more about that? (Probe: Could you give a specific example of a time when that happened?)
- How has this work affected your own relationships outside of the therapy room?
    a. Have you experienced any shift in your own romantic proclivities you identify as a consequence of working with non-monogamous clients?
- Is there anything I haven't asked you about that would help me to understand your relationship with CNM patients?
- Can you tell me about your experiences in supervision or as a supervisor?
- How might training better prepare therapists to work with couples outside of the "traditional" sexual frame? Are any modalities particularly well-suited for CNM couples?