AN EXAMINATION OF INTERNALIZED CONSENSUAL NON-MONOGAMY NEGATIVITY AND HELP SEEKING BELIEFS, ATTITUDES, AND INTENTIONS

by

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ABSTRACT

Although consensually non-monogamous (CNM) relationships have grown in prevalence (Haupert et al., 2017; Rubel & Bogaert, 2014), a high degree of stigma surrounding CNM relationships remains (Balzarini et al., 2018; A. C. Moors et al., 2013). Previous research has indicated that stigma surrounding CNM relationships may be internalized (Moors et al., 2021) and internalized stigma has been found to impact help seeking beliefs, attitudes, and intentions in similarly marginalized populations (Lappin, 2019). A multiple linear regression approach was used to examine how three dimensions of internalized CNM stigma predict help seeking beliefs, attitudes, and intentions within a CNM sample with previous experience as an additional variable. Public identification of CNM identity was found to predict attitudes toward seeking help (stigma tolerance) ($F(3, 162)= 4.815$, $p= .044$), R^2 of .082. When previous experience was included as an independent variable, a significant relationship was found between help seeking intentions, the factors of internalized CNM negativity, and previous experience ($F(4,160)=5.63$, $p<.001$, R^2 of .123), though only previous experience was a significant predictor of help seeking intentions ($p<.001$). Additionally, previous experience was significantly related to beliefs about expertness ($p=.044$). Lastly, well-being was negatively correlated with personal discomfort of CNM identity, $r(165)=-.191$, $p=.013$. Findings from this study may help mental health providers understand barriers to accessing mental health services this population faces, the possibility of protective factors within this population, and how to better connect with this community.

I. INTRODUCTION

Consensual non-monogamy is defined as a type of romantic and/or sexual relationship in which all members involved agree to extra-dyadic romantic and/or sexual relationships (Moors & Schechinger, 2014; Schechinger et al., 2018). There has been a recent growth in consensually non-monogamous (CNM) relationships; 4-5% of American adults report practicing CNM in one form or another (Rubel & Bogaert, 2014), and more than one in five adults in the United States reported having engaged in CNM relationships at some point in their lives (Haupert et al., 2017).

Although CNM relationship structures are rising in popularity, there is a high degree of stigmatization (i.e., negative social attitudes, which imply disapproval; *APA Dictionary of Psychology.*, 2007) that surrounds CNM relationships. When compared to their monogamous counterparts, individuals engaged in CNM were rated less favorably and these negative beliefs were reflected in interactions with CNM individuals as well (Conley, Moors, et al., 2013; Rodrigues et al., 2018). CNM individuals consistently report experiences of condemnation and marginalization from both family members and society at large (Henrich & Trawinski, 2016). The stigma surrounding CNM relationships can have widespread consequences in the legal realm as well, including fewer legal protections relating to discrimination, children, shared property, and inheritance (Conley, Moors, et al., 2013; Henrich & Trawinski, 2016). Furthermore, it has been shown that stigma can lead to stress and a variety of subsequent and associated mental and physical health concerns for marginalized individuals (Major & O'Brien, 2005).

The perpetuation and pervasive nature of this stigma can become internalized, in the form of internalized CNM negativity (Moors et al., 2021). Internalized CNM

negativity is associated with a lower degree of relationship satisfaction and has been associated with diminished relationship functioning (Moors et al., 2021). CNM relationships are not widely researched within the counseling field (Brewster et al., 2017), contributing to a lack of understanding amongst clinicians that is harmful to CNM clients (Henrich & Trawinski, 2016; Kisler & Lock, 2019; Schechinger et al., 2018) and could further perpetuate the internalized stigma of CNM individuals. The perpetuation of negative ideas surrounding CNM relationships by counselors could further contribute to negative attitudes and beliefs surrounding mental health services, as several studies have shown internalized stigma decreases an individual's willingness to seek mental health services (Lappin, 2019; Tucker et al., 2013; Vogel et al., 2007). A further investigation into the relationship between internalized consensual non-monogamy negativity (internalized CNM stigma) and beliefs about seeking mental health services is warranted to more fully understand how counselors can best serve this population.

Research Questions and Hypotheses

The researcher used a multiple regression analytic approach to determine how three dimensions of internalized CNM negativity (public identification, social discomfort, and personal discomfort) predict beliefs related to a mental health professionals' ability to help (expertness), clients' intentions to seek help (intention), and clients' attitudes related to help seeking (stigma tolerance). As previous experiences with mental health services may directly impact current attitudes and beliefs as well as future help seeking intentions, previous experience with mental health services was examined as a potential additional independent variable. Well-being was investigated as a moderating variable, to evaluate its effect on help seeking intentions. The researcher hypothesized that well-being would

act as a moderating variable for help seeking intentions, such that a lesser degree of well-being would be associated with higher intentions to seek help.

The researcher conducted a MANOVA analysis after the main regression analyses to examine if there was a significant difference among participants who have previous experience with mental health counseling and those who have not. The researcher then controlled for previous experience as an extraneous independent variable to examine if the effects remained. The researcher examined well-being was as a potential mediating variable.

Organization

Chapter one will provide an overview of the present study. Chapter two will provide a review of the current literature regarding consensual non-monogamy, including the perception of and stigma surrounding engagement in consensually non-monogamous relationships as well as the subsequent consequences of stigma on well-being. Literature surrounding the relationship between stigma and help seeking will also be explored. At present, there is a lack of research surrounding the relationship between CNM stigma and subsequent help seeking attitudes, beliefs, and intentions, highlighting the need for the present study.

Research questions, planned analyses, and hypotheses will be explored in depth in chapter three. The first regression model examined the three components of internalized CNM stigma (personal discomfort, public identification, and social discomfort) as independent variables, and attitudes related to mental health services (stigma tolerance) as the dependent variable. The second model again examined the three components of internalized CNM stigma (personal discomfort, public identification, and social

discomfort) as independent variables, and beliefs surrounding mental health professional expertness as the dependent variable. As with the two previous models, the third model examined the three components of internalized CNM stigma (personal discomfort, public identification, and social discomfort), as independent variables, and intentions to seek help as the dependent variable.

A MANOVA analysis was then completed to examine if there was a significant difference among participants with previous mental health services experience and those without previous experience. Previous experience was then included as an additional variable in all three models to examine if the relationships remained. Lastly, a Monte Carlo method of assessment was used to examine overall well-being as a potential mediator (Selig & Preacher, 2008).

Chapter four will provide the results of the aforementioned analysis and explanations of the findings and chapter five will provide a discussion of the findings, deeper explanations of the findings, limitations of the study, directions for future research, and implications of the findings as they relate to the counseling profession.

Despite the continued growth of CNM relationships, there is still much that is unknown about how internalized CNM stigma may impact CNM individuals' attitudes, beliefs, and intentions regarding seeking mental health services. Through this study, the researcher investigated the relationship between internalized CNM stigma and help seeking beliefs, attitudes, and intentions using a series of multiple liner regression models. It was hypothesized that individuals who experience higher degrees of internalized CNM stigma would have more negative attitudes regarding help seeking, and that these individuals may have lower intentions to seek help.

II. LITERATURE REVIEW

Despite the longstanding prominence of monogamous relationships in the United States, consensually non-monogamous (CNM) relationships are becoming more common within the population. Approximately 4-5% of American adults reported practicing CNM in one form or another (J. Rubin et al., 2014), and more than one in five adults in the United States have engaged in CNM relationships at some point in their lives (Haupert et al., 2017). More recent research indicates that the prevalence of those engaging in polyamory (one form of CNM) in the United States could be as high as 23% of the US population (Rubel & Burleigh, 2020). Furthermore, there is a growing body of research to indicate that CNM relationships are a viable alternative to monogamous relationships. In fact, past research suggests that individuals engaged in CNM relationships are highly satisfied with and committed to their partners and that their levels of commitment and relationship satisfaction do not differ from their monogamous peers (Balzarini et al., 2019; Conley et al., 2017). Additionally, those engaged in consensually non-monogamous relationships reported more opportunities for new experiences, social interactions, and engagement in a wider variety of activities than those in monogamous relationships (Moors et al., 2017). Furthermore, individuals engaging in CNM relationships report diversified need fulfillment as a main benefit of CNM relationship structures, indicating that by having multiple partners, individuals were able to have a wide variety of their needs met, a facet of CNM relationships often associated with higher relationship satisfaction (Moors et al., 2017).

Despite the increasing prevalence of CNM relationships, there continues to be a high degree of stigmatization surrounding CNM relationships. For example, in past

research examining stigma towards people in CNM relationships, when compared to their monogamous counterparts, individuals engaged in CNM were rated less favorably and they were more apt to be dehumanized (e.g., uniquely human emotion attributes were associated less strongly with CNM partners), regardless of sexual orientation, indicating that CNM individuals were viewed as less human than monogamous individuals (Conley, Moors, et al., 2013; Rodrigues et al., 2018). These negative beliefs and attitudes extend to actions that people take when interacting with individuals in CNM relationships as well, as CNM individuals often perceive their relationship to not be accepted (Balzarini et al., 2018, 2019) and regularly report condemnation and marginalization from family members and society at large (Henrich & Trawinski, 2016). Individuals engaging in CNM relationships face myriad negative consequences that may be associated with experienced stigma, including fewer legal protections relating to discrimination, children, shared property, and inheritance (Conley, Moors, et al., 2013; Henrich & Trawinski, 2016). The stigma experienced by CNM individuals can lead to feelings of stress (i.e., minority stress) and past research has shown that stress affiliated with one's minority status (e.g., being involved in a stigmatized relationship orientation) is associated with a variety of subsequent and associated mental and physical health concerns (Frost et al., 2015; Lick et al., 2013; Major & O'Brien, 2005).

The perpetuation and pervasive nature of this stigma across several domains can become internalized, in the form of internalized CNM negativity (Moors et al., 2021). Internalized CNM negativity is defined as a devaluation of the self and internal conflict regarding engagement in CNM as a result of negative social attitudes and experiences that have been directed toward the self (Moors et al., 2021). Initial research examining

the effects of internalized negativity on people's relationships suggests that internalized CNM negativity can detract from relationships, with more internalized negativity being associated with a lower degree of relationship and diminished relationship functioning among people in CNM relationships (Moors et al., 2021).

The stigma that people in CNM relationships experience is robust (Conley et al., 2013; Moors et al., 2013) and despite the toll stigma may take on an individual's mental health (Mak et al., 2007), people in CNM relationships may be further stigmatized when they attempt to seek help. Indeed, several studies have shown that CNM individuals continue to be stigmatized, even while working with mental health professionals; CNM individuals have reported multiple instances of counselor bias, and subsequent mistreatment from mental health professionals (Henrich & Trawinski, 2016; Schechinger et al., 2018). CNM relationships are not widely researched within the counseling field (Brewster et al., 2017), contributing to a lack of understanding that is harmful to CNM clients (Henrich & Trawinski, 2016; Kisler & Lock, 2019; Schechinger et al., 2018). The lack of understanding of CNM relationships can create reactions from mental health professionals that are misguided in nature (such as bewilderment, a lack of sensitivity, and a focus on stopping CNM behaviors) (Berry & Barker, 2014; Henrich & Trawinski, 2016). CNM clients commonly report experiences of shame and distress as a result of these reactions and these reactions could further perpetuate the minority stress and subsequent internalized stigma experienced by CNM individuals (Henrich & Trawinski, 2016). Additionally, the perpetuation of negative beliefs surrounding CNM relationships by counselors could engender negative attitudes and beliefs surrounding mental health services for people in CNM relationships, as several studies have shown internalized

stigma decreases an individual's willingness to seek mental health services (Lappin, 2019; Tucker et al., 2013; Vogel et al., 2007). A further investigation into the relationship between internalized CNM negativity (internalized CNM stigma) and attitudes, beliefs, and intentions surrounding seeking mental health services is warranted in order to more fully understand how counselors can best serve this population.

Consensual Non-Monogamy

Within the umbrella of consensual non-monogamy, there are three commonly delineated relationship structures- open relationships, polyamory, and swinging (Rubel & Bogaert, 2014). Open relationships are relationships in which partners consent to having sex beyond their dyad, polyamory is the practice, belief, or willingness to engage in consensual non-monogamy in long term and/or loving relationships beyond a dyad, and swinging is engagement in sex outside of the dyad with members of another dyad (Rubel & Bogaert, 2014). Researchers have debated the proper classification of consensual non-monogamy with some classifying it as an identity (Barker, 2005) or a relationship practice (Lano & Parry, 1995), while others consider CNM to be a relationship orientation (Anapol, 2010) or sexual orientation (Klesse, 2014; Tweedy, 2010). Consensual non-monogamy has even been posited to be simply a theory (Emens, 2004).

Regardless of how consensual non-monogamy is defined as a construct, Rubin and colleagues (J. Rubin et al., 2014) posit that healthy romantic relationships may be viewed as falling somewhere along a spectrum of monogamy; with one pole being more monogamous, and the other being more consensually non-monogamous. These authors suggest that by viewing relationships on this spectrum, individuals can bypass the hierarchal associations connected with the various types of romantic relationships, with

strictly sexual relationships being viewed more negatively than relationships involving emotional/romantic attachments (e.g., viewing polyamorous relationships as "good" and swinging as "promiscuous"; (Matsick et al., 2014; J. Rubin et al., 2014). This hierarchy of associations likely results from the belief that an intimate, committed, and loving relationship is a pre-requisite for sexual intimacy (Matsick et al., 2014; Peplau et al., 1977), as supported by the finding that participants disapproved of sexual intimacy without emotional attachment (Matsick et al., 2014). This hierarchal assessment and subsequent judgment of relationships may further contribute to the pervasive negative attitudes surrounding consensual non-monogamy.

Demographics

In a 2011 meta-analysis of CNM research, Sheff and Hammers found that most of the available research portrays the consensually non-monogamous population as largely homogenous, although this may not be an accurate reflection of the CNM community. Within their review of 36 CNM articles, they found that most samples consisted mainly of white, middle to upper middle class, educated professionals (Sheff & Hammers, 2011). However, an analysis comparing demographic information of individuals in monogamous relationships to those in polyamorous relationships found that participants in monogamous relationships were more likely to have a bachelor's degree or higher than those in polyamorous relationships. Furthermore, participants in polyamorous relationships tended to report lower income than those in monogamous relationships (Balzarini et al., 2019), indicating that the demographics of CNM individuals may not be as homogenous as initially assumed. Additional research suggests that members of the LGBQ (lesbian, gay, bisexual, queer/questioning) community have higher rates of

engagement in CNM relationships, compared to their heterosexual counterparts (roughly 75% of the males who reported involvement in CNM relationships identified as gay or bisexual vs 25% who identified as heterosexual; roughly 56% of the female population survey identified as lesbian or bisexual, compared to 44% of women who identified as heterosexual; (Balzarini et al., 2019; Haupert et al., 2017).

Despite the apparent homogeneity amongst the CNM community reflected in research, this population may be more diverse than previous studies indicate (J. Rubin et al., 2014). For example, online samples (such as those used in many CNM research studies) tend to skew toward individuals who can complete the online surveys from the privacy of their homes, and toward those who are not limited by filters commonly found on public access computers, such as those in libraries (J. Rubin et al., 2014), thus excluding individuals without the privilege of private internet access. Furthermore, the homogeneity commonly found within CNM samples could be a result of the community-based strategies used to recruit participants and may not be an accurate reflection of all individuals who engage in CNM (J. Rubin et al., 2014). Using data from two large online samples, the researchers discovered that there were no significant differences in terms of likelihood to participate in CNM relationships between individuals of color and White individuals (J. Rubin et al., 2014). Together, the findings from this study indicate that the CNM community may be more diverse than what traditional research methods have been able to capture.

A final consideration regarding demographic data of consensually non-monogamous individuals is the subjective nature of self-reported data. Moors and colleagues note that a couple may allow deviations from monogamy, but still consider

themselves to be monogamous (Matsick et al., 2014). Individuals who do not identify with CNM but allow deviations from monogamy in their relationships may not be reflected within consensually non-monogamous research (Conley, Moors, et al., 2013). Subsequently, little is known about this population of individuals who identify as monogamous while allowing for deviations from monogamy in their relationships.

Consensual Non-Monogamy and Monogamy: A Comparison

It is important to note that cultural and social factors largely determine sexual behavior, including engagement in CNM. Based on data collected from 59 countries, it was found that sexual behavior varies largely amongst regions in the world (Wellings et al., 2006), indicating that the culture in which we reside shapes the relationships, emotions, and desires an individual has (Weeks & Weeks, 2003). Despite the unknown genesis of monogamy within the human race, monogamy has served as the ideal model for romantic and/or sexual relationships within Western culture for many centuries (Ferrer, 2018; Herlihy, 1995; MacDonald, 1995). In Western culture, the dominant relationship pattern is life-long monogamy with one partner, as demonstrated by saturation within the media of "one true love" and "happily ever after" (Ritchie & Barker, 2006). The standardization of monogamy as being the "normal" practice of emotional and sexual commitment has come to be known as *mononormativity* (Pieper & Bauer, 2014).

There has been a noted halo effect (a cognitive bias wherein individuals are rated favorably based on a sole attribute; Thorndike, 1920) surrounding monogamous relationships, with many believing monogamous relationships to be superior (Balzarini et al., 2018; Conley, Ziegler, et al., 2013; Grunt-Mejer & Campbell, 2016; Matsick et al.,

2014). Despite this halo effect, evidence suggests that monogamy does not afford individuals benefits superior to CNM (Conley et al., 2013). Based on data collected from a 2014 meta-analysis, Rubel and Bogaert (2014) concluded that the psychological well-being and quality of relationships for those involved in CNM did not significantly differ when compared to those of their monogamous counterparts. Furthermore, Conley and colleagues indicate that consensual non-monogamy should be viewed as a viable alternative to monogamy, for those who chose to participate (Conley et al., 2013). This notion is supported by a growing body of research that indicates that participation in consensual non-monogamy is associated with higher rates of secure attachment, more sexual openness, increased psychological well-being, and increased rates of intimacy, passion, satisfaction, and commitment (Brooks et al., 2021; Moors et al., 2015). Furthermore, while those in monogamous relationships reported higher degrees of favoring withdrawal as a conflict resolution style, those in CNM relationships appeared to favor positive problem-solving resolution methods (Brooks et al., 2021).

Perception

Although CNM relationships are not found to be more detrimental than monogamous relationships, stigma towards CNM relationships is robust and research has shown that monogamous relationships are consistently viewed more positively than CNM relationships. Research has shown that CNM relationships and the individuals involved have been consistently rated by diverse social groups, including CNM individuals, as less "in love," less relationally satisfied, less sexually satisfied, less socially acceptable, and lonelier than monogamous relationships and the individuals involved (Conley et al., 2013). Furthermore, negative perceptions of CNM individuals extended to relationship-

irrelevant traits as well, with people in CNM relationships being rated as less reliable at daily dog walking and taking daily multivitamins, for example, indicating the stigma surrounding CNM relationships and the individuals involved is both robust and expansive (Conley et al., 2013).

Similarities between CNM and LGBQ Experiences

Although the experiences of individuals identifying as CNM and the experiences of those identifying as LGBQ can vary, it is also likely that there is overlap between these experiences as many CNM individuals report identifying with the larger LGBQ community (Sheff & Hammers, 2011) and over time, the LGBQ community has expanded to welcome CNM individuals as well (Nichols & Shernoff, 2007). There are many documented shared experiences between CNM individuals and members of the LGBQ community, including the social disapproval the respective members face (Weitzman, 2007), identify formation (Klesse, 2014), and legal discrimination faced by members of both communities (Goldfeder & Sheff, 2013; Henrich & Trawinski, 2016; Ray et al., 2011). The negative attitudes held by within society often have direct and real consequences for members of these communities, thus highlighting the importance of investigating the stigma surrounding these relationships (Kirkman et al., 2015).

Investigating Stigma

Proposed Mechanisms for Stigmatization Processes

There are several competing ideologies pertaining to the underlying mechanisms of CNM stigmatization. Day and colleagues (2011), suggest that stigma surrounding CNM relationships may be an attempt to defend the ideology and implicit assumption that desirable relational and social outcomes (such as loyalty) can only be accomplished

through monogamous marriage (Day, 2013; Day et al., 2011). It is possible that supporting the idealization of monogamy allows individuals to preserve their beliefs that the larger socio-political system can provide order and stability (Day et al., 2011). Relatedly, Mogliski and colleagues (2020) posit that the aversion to CNM relationships may stem from an association between CNM and sexual promiscuity and a subsequent association between sexual promiscuity and traits that produce interpersonal conflict within the group (such as partner retribution and aggressive competition for mates), harming the social unity of the group (Mogilski et al., 2020).

Another potential mechanism of stigmatization is theorized to be rooted in feminist ideology; specifically, the belief that the prolific nature of monogamy is rooted in standards enforced socially and politically over time that serve to reduce not only the agency and autonomy of women and marginalized sexualities, but also their subsequent ability to gather meaningful support networks, leading to negative health impacts (Klesse, 2014; A. C. Moors, 2019). Similarly, another potential mechanism of stigmatization has drawn from queer theory (Minton, 1997), and suggests that within systems of power, sexual practices and identities are organized into a hierarchal structure which in turn, promotes monogamous and heterosexual practices and stigmatizes identities and practices deviating from monogamy and heterosexuality (Moors & Schechinger, 2014; Rubin & Vance, 1984).

Ritchie and Barker (2006) attempt to address the underlying mechanisms of how mono-normativity is replicated and persists by examining the language used surrounding monogamous and consensually non-monogamous relationships. The two suggest that identities associated with communities are founded on the use of language, and that

consensually non-monogamous relationship structures are marginalized through the perpetuated use of mono-normative language surrounding romantic relationships, jealousy, and loyalty (Ritchie & Barker, 2006). The use of this mono-normative language consistently reminds consensually non-monogamous individuals that they are not members of the majority (Ritchie & Barker, 2006).

The minority stress model developed by Meyer provides a framework for understanding observed differences in health and well-being between members of the majority and minority groups (I. H. Meyer, 2003). It is important to note that with the increase in knowledge and research surrounding LGBQ populations, the language used to describe marginalized groups also evolves and changes. Although this model utilizes the terms "minority" and "majority," we find it is preferable to use the terms "marginalized" and "privileged," respectively. Building on social stress theory, the model posits that decreased social standing due to stigmatization leads to members of marginalized groups having an increased exposure to stressful life events that members of the privileged group do not encounter (such as discrimination), while concurrently facing fewer social resources to cope with these events (Meyer, 2003). These persistent stressors, in turn, may lead to a variety of negative effects on relationships, well-being, and health (Frost et al., 2015; Meyer, 2003).

Regardless of the method of transmission, stigmatization surrounding the CNM community contributes to experiences of minority stress, which has been associated with both negative mental health outcomes (Frost et al., 2015) and an increased utilization of mental health services within the LGB population (Mays & Cochran, 2001). When CNM clients seek help for their experiences related to minority stress or other life concerns,

counselors and other mental health professionals have the power to perpetuate or combat the minority stress and stigmatization faced by this marginalized group (Schechinger et al., 2018). Results from a qualitative analysis of therapeutic work with CNM clients indicated that the possession (or pursuit) of knowledge about CNM practices as well as the use of affirmation (supporting and encouraging clients) and non-judgment in session are exemplarily helpful practices (Schechinger et al., 2018). In summation, a key component of effective therapy work with CNM clients is an understanding of CNM and the associated experiences of minority stress due to stigma.

Internalized Stigma

Meyer (1995) suggested that the stigma surrounding same-sex attraction can be subconsciously internalized—referred to as *internalized homonegativity*— and that members of the LGBQ community who experience stigma and internalize this stigma, may subsequently view these messages as part of their self-image. This notion was further supported by later research, which found that negative feelings toward oneself are directly related to the integration of negative societal messages (stigma) surrounding same-sex attraction. This suggests that internalized homonegativity is not an inherent personal trait, but rather it could be associated with larger sociopolitical biases present in society (Herek et al., 2009; Szymanski & Carr, 2008).

Recent research has found that, similarly to how heterosexism can be internalized, the stigma surrounding engagement in CNM can be internalized as well. Moors and colleagues (2021) posit that by being consistently exposed to the stigma present within American culture, individuals can direct the negative views and attitudes toward themselves, leading to a lesser view of the self and a development of internal conflict

surrounding engagement or desire to engage in CNM. These researchers found a direct relationship between internalized CNM negativity and diminished relationship satisfaction and commitment (Moors et al., 2021).

Furthermore, the stigmatization surrounding CNM (both external and internally) may lead to increased feelings of minority stress. Experiences of minority stress in a sample of polyamorous individuals were associated with higher degrees of psychological distress, including higher reported symptoms of depression and anxiety (Witherspoon & Theodore, 2021). These increased levels of psychological distress associated with minority stress may lead to a subsequent desire to seek mental health services.

Help Seeking and Stigma

Help seeking has been conceptualized as pursuing professional help for concerns related to mental health to cope with mental health concerns (Rickwood et al., 2005). Mental health services can be an important component of maintaining a sense of overall well-being for many individuals; in 2019 nearly one in five American adults had received mental health treatment in the last year (Terlizz & Norris, 2021). However, seeking mental health services is often stigmatized and there is a pervasive belief that those who seek help are weak (Lappin, 2019). This stigma may discourage some individuals from seeking needed services (Lappin, 2019; Tucker et al., 2013) and has been associated with mental health help seeking behaviors (Vogel et al., 2007). Being viewed as one who seeks help (regardless of what the help is needed for) has been found to strongly predict an individual's help seeking intentions and beliefs (Tucker et al., 2013). Furthermore, research has shown that the negative public attitudes surrounding seeking mental health services can be internalized; resulting in a self-stigma that, in turn, reduces an

individual's willingness to seek out mental health care (Vogel et al., 2007).

It is important to note that there is a distinguished difference between the stigma surrounding mental illness and the stigma surrounding seeking help, as the attitudes and beliefs an individual holds surrounding seeking help are stronger predictors of willingness and intention to obtain professional help than the internalized stigma surrounding mental illness itself (Tucker et al., 2013). Furthermore, not only are individuals who internalize the stigma surrounding mental health services less likely to seek help, they are also less likely to disclose previous instances in which they have sought help for mental health concerns, which may, in turn, further perpetuate the stigma and public perception of seeking mental health services (Corrigan, 2004).

LGBQ Help Seeking

It is important to note that although there are distinct and clear differences between the CNM and LGBQ communities, there are a number of shared experiences that overlap between these two communities (Schechinger, et al., 2018). These shared experiences include concerns surrounding disclosure of identity/coming out and discrimination based on identity (Schechinger et al., 2018). Given the overlap in shared experiences as well as the dearth of research utilizing CNM samples, CNM research often draws on a sexual minority framework (such as that used in LGBQ research). Additional research is required to identify specific points of intersection and disconnect between CNM individuals and other populations that may fit beneath the umbrella of marginalized sexual identities.

At present, little is known about the attitudes and beliefs CNM individuals hold surrounding help seeking behaviors, though work done by Schechinger and colleagues

does provide some insight (Schechinger et al., 2018). Research has shown that that LGBQ individuals may seek to avoid the distress of disclosure, not only regarding their sexual orientation, but also in regard to their mental health well-being (Vogel & Wester, 2003). Furthermore, people who had less comfort disclosing their sexual orientation held more negative attitudes surrounding seeking mental health care, to the extent that comfort with disclosure accounted for more than one third of the variance in help-seeking behaviors and was as strong of a predictor of help-seeking as the previous use of mental health care services (Vogel & Wester, 2003). This finding was corroborated in another study that found that concealing sexual orientation directly results in reduced help-seeking behaviors and that comfort with disclosure of sexual orientation was directly associated with an individual's likelihood of seeking help (Corrigan, 2004). Furthermore, it has been shown that people who hold a negative identity surrounding their LGBQ sexual orientation (self-stigma) report diminished help seeking attitudes and intentions and that the more negatively LGBQ individuals viewed themselves for seeking help, the less likely they were to seek help (Lappin, 2019).

However, some research has shown contrasting effects. For example, one study found that when people perceived their sexual orientation identity more negatively, they also felt more stigmatized and were more inclined to seek out help from a mental health professionals (Spengler & Ægisdóttir, 2015). However, it is important to note that the sample used in this study was not inclusive of bisexual individuals, as these participants were not identified nor represented in the sample, and as a result, it may be difficult to draw conclusions regarding this population based on this study alone (Lappin, 2019; Spengler & Ægisdóttir, 2015).

As CNM individuals and individuals identifying with the LGBQ community often experience similar stigmatization, discrimination, and concerns surrounding disclosure, these communities may have similar experiences surrounding the internalization of stigma and subsequent help seeking beliefs, attitudes, and intentions. In the current study, it is hypothesized that people who identify as CNM will experience a similar negative relationship between internalized stigma and negative intentions, attitudes, and beliefs surrounding help seeking.

Present Study

Previous research highlights the myriad negative impacts of stigma that marginalized populations, such as CNM individuals, often face. This stigma can impact individuals' internalized perceptions of their identity, leading to an internalization of stigma. Despite the well documented negative consequences associated with internalized stigma as it relates to the LGBQ community (and the subsequent impact on help-seeking beliefs, attitudes, and intentions), little is known about the internalized stigma surrounding the CNM community and the resulting impact on help-seeking attitudes, beliefs, and intentions. The present study served to address the need for an investigation of the relationship between internalized CNM stigma and help-seeking beliefs, attitudes, and intentions. The researcher investigated help seeking beliefs and attitudes related to help seeking through the utilization of the Beliefs About Psychological Services measure (Ægisdóttir & Gerstein, 2009). An adapted version of The Reactions to Homosexuality Scale (Moors et al., 2021; Ross & Rosser, 1996) was used to assess internalized CNM negativity. Well-being was assessed using the General Well-Being Schedule (Dupuy, 1977) and was examined as a mediating variable. Previous experience was assessed using

a yes or no question ("Have you had previously sought mental health services?"). All measures were administered via online survey.

It was hypothesized that a negative relationship between internalized CNM negativity and positive beliefs and attitudes surrounding help seeking would exist. More specifically, individuals who experience higher degrees of internalized CNM negativity were hypothesized to hold less positive beliefs and report more negative attitudes toward seeking help. Additionally, a negative relationship between internalized CNM negativity and positive mental health seeking intentions was hypothesized to exist. Lastly, the researcher hypothesized that well-being would act as a mediating variable for the relationship between internalized CNM negativity and help seeking attitudes, intentions, and beliefs.

III. METHODS

The myriad negative impacts of stigma that CNM individuals often face have been well documented (Conley, Moors, et al., 2013, p. 201; Henrich & Trawinski, 2016; Major & O'Brien, 2005). Despite the negative consequences associated with internalized or self-stigma relating to CNM relationships, little is known about the impacts of internalized stigma surrounding CNM relationships on help-seeking intentions, attitudes, and behaviors. This study served to investigate the relationship between internalized CNM negativity and help seeking beliefs, attitudes, and intentions. Previous research highlights the varied and extensive impacts of stigma that members of marginalized populations (such as CNM individuals) often experience. Although negative consequences associated with internalized stigma as it relates to the LGBQ community (and subsequent impact on help-seeking beliefs, attitudes, and intentions) are well researched, little is known about the internalized stigma experienced by members of the CNM community and the resulting impact on help-seeking attitudes, beliefs, and intentions. The present study served to investigate the relationship between internalized CNM stigma and help-seeking beliefs, attitudes, and intentions.

Research Questions and Hypothesis

The researcher investigated the relationship between three dimensions of internalized CNM negativity (public identification (comfort identifying as CNM publically), personal discomfort (comfort with engaging in CNM), and social discomfort (comfort in CNM friendly settings)) and beliefs, attitudes, and intentions related to help seeking through a multiple regression analytic approach. The researcher conducted a series of multiple regression models to determine how three dimensions of internalized

CNM negativity predict beliefs related to a mental health professionals' ability to help (expertness), intentions to seek help (intention), and attitudes related to help seeking (stigma tolerance).

As previous experiences with mental health services may directly impact current attitudes and beliefs as well as future intentions, previous experience with mental health services was examined as an additional independent variable to examine if the relationship between CNM negativity and help seeking attitudes, beliefs, and intentions changed. The first multiple regression model examined how three dimensions of internalized CNM negativity (public identification, social discomfort, and personal discomfort) predict help seeking intentions (as measured by the BAPS; Ægisdóttir & Gerstein, 2009). The researcher hypothesized that all three dimensions of internalized CNM negativity (public identification, social discomfort, and personal discomfort) would negatively predict help seeking intentions. The second regression model examined how the three dimensions of internalized CNM negativity predict negative beliefs and stigma surrounding mental health services (stigma tolerance, as measured by the BAPS; Ægisdóttir & Gerstein, 2009). The researcher hypothesized that all three dimensions of internalized CNM negativity would negatively predict stigma tolerance pertaining to mental health services. The third regression model explored how the three dimensions of internalized CNM negativity predict beliefs about the helpfulness of mental health services (expertness, as measured by the BAPS: Ægisdóttir & Gerstein, 2009). The researcher predicted that all three dimensions of CNM negativity would negatively predict beliefs about helpfulness of mental health services as well. A MANOVA analysis was then conducted to examine if there is any significant difference among participants

who have previous experience with mental health counseling and those who have not. All three models were then run again with previous experience as an additional variable to examine if the relationships remained. The researcher hypothesized that all relationships would remain when controlling for previous experience. The researcher also hypothesized that well-being would act as a mediating variable for the relationship between internalized CNM negativity and help seeking intentions. Through this study, the researcher sought to address the following questions:

RQ1: How does internalized CNM stigma predict help seeking intentions?

Based on existent literature, the researcher hypothesized that a negative relationship between CNM negativity and help seeking intentions would exist. A negative relationship between internalized stigma and help seeking intentions has been found in the LGBQ community (Lappin, 2019). As the LGBQ community and CNM community often report similar experiences pertaining to stigmatization, it was hypothesized that a similar relationship between these two constructs would be present in the CNM community as well. The regression model included three dimensions of CNM stigma (as measured by an adapted version of The Reactions to Homosexuality Scale (Moors et al., 2021; Ross & Rosser, 1996) as independent variables to determine the predictive nature of the relationship between these variables and help seeking intentions. Previous experiences with mental health services were then included as an additional independent variable to examine if the effects remained. Well-being (as measured by the General Well-Being Schedule; Dupuy, 1977) was examined as a potential mediating variable. The researcher hypothesized that all three dimensions of internalized CNM negativity (public identification, social discomfort, and personal discomfort) would negatively predict help

seeking intentions.

RQ2: How does internalized CNM stigma predict attitudes (stigma tolerance) surrounding seeking mental health services?

Based on existent literature, the researcher hypothesized that a negative relationship between internalized CNM negativity and stigma tolerance related to help seeking would exist. A negative relationship between internalized stigma and positive help seeking attitudes has been found in the LGBQ community (Lappin, 2019). As the LGBQ community is similar in terms of demographics and experience to the CNM community (many members of the CNM community are also members of the LGBQ community and these communities report similar experiences regarding marginalization and stigmatization), it was hypothesized that a similar relationship between these two constructs will be present in the CNM community as well. At present, there is no existing literature investigating help seeking in the CNM community and this study was novel in that regard. A multiple regression analytic approach was taken, with three dimensions of internalized CNM negativity (personal discomfort, social discomfort, and public identification), included as independent variables and stigma tolerance included as the dependent variable to explore the predictive nature of the relationship between internalized CNM negativity and attitudes toward seeking mental health services. Previous experiences with mental health services were then included as an additional independent variable to examine if the effects remained. Well-being was again examined as a potential mediating variable. The researcher hypothesized that all three dimensions of internalized CNM negativity would negatively predict stigma tolerance pertaining to mental health services.

RQ3: How does internalized CNM stigma predict beliefs surrounding expertness of mental health services?

Based on existent literature, the researcher hypothesized that a negative relationship between internalized CNM negativity and perceived expertness of mental health professionals would exist. In a sample of 249 CNM participants in the U.S. and Canada, less than 40% of participants described recent therapists as quite knowledgeable of CNM communities and resources (Schechinger et al., 2018). Based on findings from this study, it was hypothesized that CNM individuals may not perceive mental health professionals as being knowledgeable experts of their concerns and would subsequently have lower beliefs related to mental health professional expertness. A multiple regression analytic approach was taken, with three dimensions of internalized CNM negativity, well-being, included as independent variables and expertness included as the dependent variable to explore the predictive nature of the relationship between internalized CNM negativity and beliefs about mental health professional expertness. Previous experiences with mental health services were then included as an additional independent variable to examine if the effects remained. Well-being was again examined as a potential mediating variable. The researcher predicted that all three dimensions of CNM negativity would negatively predict beliefs about helpfulness of mental health services as well.

RQ4: Does well-being mediate the relationship between internalized CNM negativity and help seeking intentions, beliefs, and attitudes?

Based on existent literature, the researcher hypothesized that a negative relationship between internalized CNM negativity and mental health-well being would exist. Internalized stigma, such as internalized CNM negativity, has been associated with

negative mental health outcomes in other marginalized populations (Major & O'Brien, 2005). As negative mental health outcomes have been found in populations with similar experiences of marginalization, and may impact help seeking attitudes, beliefs, and intentions, it was hypothesized a mediating relationship between these two constructs would exist in the CNM community. A mediation analysis using the Monte Carlo method (Selig & Preacher, 2008) was employed to examine a potential mediating relationship.

Procedures

Power Analysis and Sample Size

A power analysis was conducted using G Power software to determine the minimum sample size required for statistic confidence in any detected relationships (Faul et al., 2009). It was determined that a minimum sample size of 138 individuals would be required to detect a medium effect size (f^2=0.15) with 95% confidence.

The sample was recruited through the social media websites Twitter, Reddit, and Facebook, utilizing IRB approved posts made in groups specifically for consensually non-monogamous individuals. As the CNM community is often marginalized, members frequently report concerns surrounding public disclosure of their identity and CNM status, therefore groups designed specifically for CNM members were used to directly reach this population. These groups afford privacy to members (members must be approved before being permitted to join the group) and allow individuals to freely disclose their CNM identity with minimal discomfort. The researcher contacted all groups identified as potential sources for recruitment and received permission to recruit.

Eligible participants include individuals over the age of 18 with English language fluency, and who self-identify as being consensually non-monogamous. Individuals who

do not meet all the above criteria were not eligible to participate and were subsequently excluded from data analysis. Participants who failed two or more of four total attention checks were also excluded from data analysis.

Data Collection Procedures

All data was collected online via Qualtrics, at each participant's choice of location and time. After reading the informed consent letter and consenting to participate by selecting the consent option on the Qualtrics survey, participants completed basic demographic questions pertaining to age, race/ethnicity, gender, sex, employment status, income, education level, English language fluency, sexual orientation, and previous experience with mental health services (see appendix A). All participants then completed an adapted version of the Beliefs about Psychological Services measure (Ægisdóttir & Gerstein, 2009). The researcher adapted the measure in the following ways: items worded to reflect a variety of mental health services/professionals through utilizing the phrase "mental health professional" (as opposed to only "psychologist") and the directions for completing the measure were updated to include the following "For the purposes of this study, a "mental health professional" is defined as a psychologist or masters level clinician (such as a therapist, social worker, or counselor)" to clarify the definition of mental health professionals for participants. Participants then completed an adapted (for CNM negativity) measure of internalized homonegativity, The Reactions to Homosexuality Scale (Ross & Rosser, 1996; Smolenski et al., 2010). Lastly, participants completed the General Well-Being Schedule (Dupuy, 1977).

Instruments

Demographics Questionnaire

Participants were asked demographic questions regarding their age in years, gender identity, sex at birth, race/ethnicity, highest level of education completed, current employment status, approximate yearly income, fluency in English language, sexual orientation, relationship orientation, and previous experiences with mental health services ("Have you previously sought mental health services, if yes, was it a positive, neutral, or negative experience on a scale of 1-10?"). Data related to participants' age, gender identity, sex, race ethnicity, sexual orientation, current employment status, yearly income, and education levels was collected to examine the diversity (and subsequent generalizability) of the sample. Data regarding participants' relationship orientation and fluency in English language were collected to confirm participants' eligibility for participation in the study (those who identified as monogamous and/or were not fluent in the English language did not meet criteria for participation in the study). Lastly, data regarding participants' prior experiences with counseling was collected to determine if previous experiences with psychological services are related to participants' current help seeking attitudes, beliefs, and intentions. A MANOVA analysis was run using data from participants' yes or no responses to investigate if there was a difference in attitudes, beliefs, and intentions among participants who have prior experience and those who do not.

Beliefs About Psychological Services (BAPS)

The Beliefs About Psychological Services scale is an 18-item scale using a Likert-type scale ranging from 1 (Strongly Disagree) to 6 (Strongly Agree) designed in 2009 by

Stefanía Ægisdóttir and Lawrence Gerstein. This scale was designed to measure beliefs and attitudes an individual holds surrounding seeking psychological help and contains three subscales: intent (designed to measure willingness to seek services, e.g. "At some future time, I might want to see a psychologist"), stigma tolerance (designed to measure labeling, stigma, and negative beliefs surrounding seeking services, e.g., "if I thought I needed psychological help, I would get this help no matter who knew I was receiving assistance"), and expertness (designed to measure the beliefs surrounding the professional, e.g., "Psychologists provide valuable advice because of their knowledge about human behavior") (Ægisdóttir & Gerstein, 2009, p.205-6). The scale is summed, with items 5, 8, 10, 11, 13, 15, and 17 reversed scored, higher scores on this measure indicate a more positive attitude toward seeking psychological services (Ægisdóttir & Gerstein, 2009). For the purposes of this study, this measure was modified to include the term "mental health professional" rather than psychologist, to reflect individuals' beliefs about mental health services rather than solely psychological services.

This measure was shown to have high internal consistency, with a 0.88 Cronbach's alpha for the total score (each item contributed significantly to the overall measure), and Cronbach alphas of 0.78, 0.72, and 0.82 for stigma tolerance, expertness, and intent, respectively (Ægisdóttir & Gerstein, 2009). The alpha coefficients were consistent across multiple studies, demonstrating a stable internal reliability and the two-week test-retest reliability coefficient for the total score was found to be 0.87, demonstrating stability over time (Ægisdóttir & Gerstein, 2009).

Adapted for CNM Reactions to Homosexuality Scale

The Reactions to Homosexuality Scale was developed by Ross and Rosser in 1996 and revised by Smolenski et al. in 2010. The scale was adapted to measure three factors of internalized CNM negativity: social discomfort, personal discomfort, and public identification (A. Moors et al., 2021). The authors first modified and reached agreement on the scale, before the scale was reviewed by three individuals in the CNM community and six experts in the field of sexuality and romantic relationship science. An exploratory factor analysis found that two of the factors had Eigenvalues over 1 (the third factor had an Eigenvalue of .94) and together accounted for 67.89% of the variance (A. Moors et al., 2021). The survey contains 7 items total (the personal discomfort subscale contains 3 items, the social discomfort and public identification subscales each contain 2 items) and utilizes a Likert-type scale ranging from 1 (Strongly Disagree) to 7 (Strongly Agree) (A. Moors et al., 2021). All items (except for item 7) are reverse scored and summed, with higher scores reflecting a higher degree of greater levels of internalized CNM negativity (A. Moors et al., 2021).

The General Well-Being Schedule

The General Well-Being Schedule was developed in 1977 by Dupuy and examines an individual's subjective feelings of psychological well-being over the last month (Dupuy, 1977). The scale consists of 18 items and six subscales: general health (e.g. "Have you been bothered by any illness, bodily disorder, pains, or fears about your health?"), vitality (e.g. "How much energy, pep, and vitality have you felt?"), depression (e.g. "How depressed or cheerful have you been?"), anxiety (e.g. "How relaxed or tense have you been?"), positive well-being (e.g. "has your daily life been full of things that

were interesting to you?"), and self-control (e.g. "Have you been feeling emotionally stable and sure of yourself?") (Dupuy, 1977; Fazio, 1977, p. 34-6). The first 14 questions are rated on a six-point scale to indicate intensity or frequency of the experience, the last four questions are rated on a scale of 0-10 with adjectives related to the prompt at each end (e.g. 0- Not concerned at all, 10- Very concerned) (Fazio, 1977). Scores for this measure range from 0-110 with higher scores indicating a better general sense of well-being (Fazio, 1977). This measure has been shown to have a high level of internal consistency, with a Cronbach's alpha of 0.9 or greater, across three studies (McDowell & McDowell, 2006). The three month test-retest reliability coefficient was found to be .85, demonstrating stability over time and correlations between the individual subscales and respective criterion ratings ranged between 0.65 and 0.9, indicating a high degree of concurrent validity (McDowell & McDowell, 2006).

Attention Checks

Consistent with Lappin (2019), four attention checks were presented at various points throughout the study. These questions directed participants to select a specific response ("Select Agree" "Select No" etc.), participants who answered more than one attention check incorrectly (score less than 75%) were excluded from data analysis.

Analyses

The data was initially cleaned by establishing a filter that removed participants who were under age 18, not fluent in the English language, who identified as monogamous and/or failed two or more attention checks incorrectly. Descriptive and frequency analyses were then run on the demographic data to examine the diversity and homogeneity of the sample. The researcher examined validity of the measures by

performing correlation and reliability analyses among the items for each subscale and measure used in the study. The main regression analyses examining the relationship between the three factors of CNM negativity and attitudes (model one), intentions (model two), and beliefs (model three) were then completed. Following these analyses, a MANOVA was conducted to examine if there were significant differences among participants with previous experiences with mental health services and those without. Previous experience was then added as an additional independent variable and all three models were again examined. Lastly, well-being was examined as a mediating variable using a Monte Carlo method of assessment (Selig & Preacher, 2008).

IV. RESULTS

This study served to investigate the attitudes, beliefs, and intentions surrounding seeking mental health services in the consensually non-monogamous community as they relate to internalized consensual non-monogamy (CNM) negativity. It was hypothesized that people who reported higher levels of internalized CNM negativity will also have reported less positive attitudes and beliefs surrounding mental health services and their intentions to seek help would be lower. Previous experiences with mental health services were examined as an additional independent variable to see if the relationships between CNM negativity and help seeking attitudes, intentions, and beliefs remained. Internalized CNM negativity was also hypothesized to have a negative relationship with overall well-being, such that people who reported a higher degree of internalized CNM negativity were hypothesized to also report poorer overall well-being.

Data Collection

Participants were recruited using an online, snowball sampling approach (Johnson, 2014; Baltar & Brunet, 2012). More specifically, a community sample of participants were recruited online via social networking groups (i.e., on Facebook, Instagram, Reddit, and Twitter) and websites related to CNM (e.g., posting in Facebook discussion groups for people in CNM relationships). Eligible participants responded to an online survey that took approximately 10-15 minutes to complete. Participation was voluntary and participants were able to opt out at any time by discontinuing the survey. The researcher used Qualtrics to host the online survey and collect data.

Sample Size

A power analysis was conducted using G*Power software to determine the minimum sample size required for statistical confidence in estimating the predicted effects (Faul et al., 2009). It was determined that a minimum sample size of 138 individuals would be required to detect a medium effect size (f^2=0.15) with 95% confidence. After removal of participants who did not meet study criteria (under 18 years of age, not fluent in the English language, and did not identify as consensually non-monogamous) and participants who failed more than one attention check (n=61) the final sample size included 167 participants.

Analysis Overview

Demographics

Participants were eligible to participate if they were 18 years of age or older, self-identified as consensually non-monogamous, and were fluent in the English language. Participants in this study largely identified as female regarding both gender (n = 98) and sex (n=121). Similar to other samples within the body of consensual non-monogamy research, participants mainly identified as White or Caucasian (n=140), and polyamorous (n=129). The average participant was their mid-thirties (*M*=37.43 years, *SD*=10.75 years; see Table 1 for more demographic details).

Measures

Internalized CNM Negativity

The researcher used a recent adaptation of the Reactions to Homosexuality Scale which has been revised to capture reactions to individuals in CNM relationships to measure Internalized CNM negativity or stigma (Moors et al., 2021; Ross & Rosser,

1996). Within the scale, the following three dimensions of internalized CNM negativity were assessed: public identification (2 items examining comfort identifying as CNM in a public setting; e.g., "I feel comfortable being seen in public with consensually non-monogamous individuals"; r= .54, p<.001, M= 2.18, SD=1.19), social discomfort (2 items; examining comfort in CNM social settings, e.g., "I feel comfortable in consensual non-monogamy friendly communities/locations"; r=.44, p<.001, M= 1.56, SD= .76), and personal discomfort (3 items examining personal comfort with CNM; e.g., "I feel comfortable having a consensual non-monogamy lifestyle"; α=.70, M= 1.93, SD= 0.99). Although each subscale consists of only 2-3 items, previous researchers have found this measure to be both valid and reliable. This measure used a Likert-type scale ranging from 1 (Strongly Disagree) to 7 (Strongly Agree), and the items that correspond with each subscale were mean aggregated, with higher scores reflecting greater levels of internalized CNM negativity (Moors et al., 2021; Ross & Rosser, 1996).

Beliefs About Psychological Services

The three dimensions measured by this scale include: help seeking intentions (6 items; e.g., "I would see a mental health professional if I were worried or upset for a long period of time"; α=.84, M= 4.93, SD= 0.77), beliefs surrounding expertness (4 items; e.g., "because of their training, mental health professionals can help you find solutions to your problems"; α=.78, M=4.64, SD=0.8), and attitudes toward seeking counseling (stigma tolerance; 8 items; e.g., "going to a mental health professional means that I am a weak person"; α=.73, M=5.24, SD= 0.62; Ægisdóttir & Gerstein, 2009). This scale consisted of a Likert-type scale ranging from 1 (Strongly Disagree) to 6 (Strongly Agree), and the items that correspond with each subscale were mean aggregated, with higher

scores on this measure indicating a more positive attitudes, beliefs, and intentions toward seeking psychological services (Ægisdóttir & Gerstein, 2009).

The researcher adapted this instrument to better fit the study in the following ways: items worded to reflect a variety of mental health services/professionals through utilizing the phrase "mental health professional" (as opposed to only "psychologist") and the directions for completing the measure have been updated to include the following "For the purposes of this study, a "mental health professional" is defined as a psychologist or masters level clinician (such as a therapist, social worker, or counselor)" to clarify the definition of mental health professionals for participants.

Well-Being

The researcher used The General Well-Being Schedule (Dupuy, 1977) to explore participants' perceived levels of general well-being (18 items; α=.90, M=75.87, SD= 19.88). The first 14 questions were rated on a six-point scale to indicate intensity or frequency of the experience, and the last four questions were rated on a scale of 0-10 with adjectives related to the prompt at each end (e.g. 0- Not concerned at all, 10- Very concerned; Fazio, 1977), with higher scores indicating a better general sense of well-being.

Missing Data

There were very few cases involving missing data (3% of data, n=6). The researcher excluded the cases in which missing data were present from the relevant analyses only and found no significant patterns or commonalities among those cases using a missing values analysis in SPSS (IBM Corp, 2020; p= 0.73).

Outliers and Distribution of Data

Skewness within this study ranged from -1.477 to 1.651 (indicating the data ranged from more responses falling to the left of the median point to more responses falling to the right of the median point), while Kurtosis ranged from -.582 to 4.673 (indicating most responses largely fell near the median point and surrounding deviations, with fewer responses in the tails). A box plot for each variable was created to determine if there were extreme outliers in the tails of the data. A histogram was then created to confirm that the distribution of data appeared to be normally distributed. Cases identified in SPSS as extreme outliers were examined and found to be present only within the Intent and Expertness subscales of the Beliefs About Psychological Services scale (Ægisdóttir & Gerstein, 2009). Cases two standard deviations outside of the normal distribution (Intent n=2, Expertness n=2) were examined using an independent samples t-test to compare means within the sample and determine if a significant pattern exists. No significant pattern was found among these cases (p=0.174). These cases were then filtered out and excluded from analysis to examine if there was any impact on results. The correlations between the three dimensions of CNM stigma and intent as well as the correlations between the three dimensions of CNM stigma and expertness were re-examined and there were no changes in the significance of any relationships found. As there was no change in the significance of relationships, these participants were included in the final analyses to maintain the largest sample size possible without compromising data integrity.

Relationship Between Internalized CNM Stigma and Help Seeking

Using SPSS (IBM, 2020), a multiple regression analytic approach was run to examine the main hypotheses by examining the degree to which Internalized CNM negativity (i.e. public disclosure, personal discomfort, and social discomfort) relates to and predicts help seeking attitudes, beliefs, and intentions (all outcomes tested separately). The initial model demonstrated the predictive nature of internalized CNM negativity (as measured by the adapted Reactions to Homosexuality Scale (i.e., public identification, social discomfort, and personal discomfort, all tested independently; Moors et al., 2021) on stigma tolerance toward help seeking (as measured by the Beliefs About Psychological Services Scale; Ægisdóttir & Gerstein, 2009). A significant regression equation was found ($F(3, 162)= 4.815$, $p =.003$), with an R^2 of .082 indicating a predictive relationship that accounts for 8.2% of the variance between internalized CNM negativity and stigma tolerance. Although the model with all three variables significantly predict stigma tolerance, the public identification subscale was a significant predictor of stigma tolerance ($p=.044$), while the other two subscales were not significantly related to stigma tolerance (personal discomfort: $p=.082$, social discomfort: $p= .88$). This finding suggests that the more negatively concerned with publicly associating as a consensual non-monogamous individual one is, the more negative judgements related to seeking help they will hold as well.

A secondary analysis with only the public identification and stigma tolerance subscales was completed, results from this analysis revealed that while public identification and stigma tolerance were significantly related, public identification accounted for only 6.2% of the variance in stigma tolerance ($R^2 = .062$). This finding

indicates that while stigma tolerance was the only significantly related dimension of CNM negativity, the other two factors (social discomfort and personal discomfort) do account for an additional 2% of variance within the model. In summation, stigma tolerance (one's attitude toward help seeking) is predicted in part by concerns surrounding public identification as part of internalized CNM negativity, and in a less significant part by personal discomfort with CNM identity and discomfort in CNM conversations and social situations (social discomfort) as well. This finding may be a result of participants who hold negative attitudes about their CNM identity (in the form of CNM negativity) also being likely to hold negative attitudes toward seeking help.

The second model sought to illustrate the predictive nature of CNM negativity on help seeking intention. It was hypothesized that a negative relationship between CNM negativity and help seeking intentions would exist. More specifically, it was hypothesized that people who reported more internalized CNM negativity will also report lower help-seeking intentions. No significant predictive relationship between CNM negativity and help seeking was found ($F(3, 162)= 2.127$, $p= .099$), with an R^2 of .038, nor was any significant relationship found among the three individual factors of CNM negativity and help seeking intentions (personal discomfort: p=.128, public identification: p=.802, social discomfort: p=.218), indicating that CNM negativity is not likely to influence ones' intentions to seek help, perhaps in part because CNM negativity may not cause a high degree of distress or perhaps because CNM individuals seek help from sources other than mental health professionals.

The third model sought to illustrate the predictive nature of internalized CNM negativity on beliefs related to expertness. It was hypothesized that CNM individuals

would not perceive mental health professionals as being knowledgeable experts of their concerns and would hold lower beliefs related to mental health professional expertness when they experience more internalized CNM stigma. No significant predictive relationship between CNM negativity and beliefs related to expertness was found (F(3, 162)= .509, p= .677), with an R^2 of .009 (personal discomfort: p=.48, public identification: p=.984, social discomfort: p=.576), indicating that CNM negativity may not impact one's beliefs related to the ability of mental health professionals to competently help them, perhaps because CNM is not the primary reason for seeking help, and thus, the helping professional would not need to have specialized knowledge to adequately address their presenting concerns.

Previous Experience as an Additional Variable

A one way MANOVA was conducted after the linear regression models to examine if there is a significant difference among participants with previous experiences with mental health services and those without in regard to beliefs about expertness, help seeking stigma tolerance, and help seeking intentions F (3,161) = 5.99, *p*= .001; Wilk's Λ= 0.9. There was a significant difference in beliefs about expertness (*F* (1, 163)= 4.41; p= .037) and intentions to seek help (*F* (1, 163)= 15.15; p< .001) among participants who had previously had experience with mental health services and those without, no significant difference was found within the stigma tolerance subscale *(F* (1, 163)= 1.57; p=.212). Previous experience was then included as an additional independent variable within the linear regression models to examine how previous experience contributes to the variance within the model, or how much of the predictive relationship could be explained by previous experience.

The first model examined how stigma tolerance may be predicted by internalized CNM negativity with previous experience with mental health services included as an additional independent variable. A significant regression equation was found ($F(4,160,)=3.95$, p=.003), with an R^2 of .09, indicating a predictive relationship that accounts for 9% of the variance between the three factors of internalized CNM negativity and previous experience with mental health services on help seeking stigma tolerance. This finding indicates that individuals who have a higher degree of internalized CNM negativity and no previous experiences with mental health services hold more negative judgments toward seeking help, perhaps due to a lack of firsthand experience or not previously having experience due to these negative judgements and attitudes toward help seeking.

The second model examined how help seeking intentions may be predicted by the three factors of internalized CNM negativity as well as previous experience. A significant regression equation was found ($F(4,160)=5.63$, p<.001, with an R^2 of .123). However, only previous experience was a significant predictor of help seeking intentions (p<.001), the three CNM negativity subscales were not significantly related to help seeking intentions. This finding indicates that that help seeking intentions may be predicted by previous experience, which accounted for an additional 3.9% of the variance between CNM negativity and help seeking intentions. In essence, although CNM negativity does not appear to impact help seeking intentions, previous experiences with mental health services do appear to impact help seeking intentions such that those with previous experience were more likely to report higher intentions to seek out help if needed in the future. It is possible that individuals who have previously sought mental health services

are simply more likely to seek mental health services again in the future and/or it may be that those who have not previously sought mental health services do not intend to seek services in the future as they have other sources of support.

The third model examined how beliefs about helping professionals' expertness may be predicted by the three factors of internalized CNM negativity as well as previous experience. A significant regression equation was not found ($F(4,160)=1.51$, $p=.203$, with an R^2 of .036). However, previous experience was found to be significantly correlated to beliefs about expertness ($p=.036$), while the three dimensions of internalized CNM negativity were not significantly related. These findings indicate that although the three factors of consensual non-monogamy and previous experience do not predict beliefs about a mental health professional's ability to effectively address their concerns, previous experience is related to beliefs about a mental health professional's ability to help. This finding could be explained by CNM identity not being a primary concern when seeking help, and thus not impacting beliefs about mental health professionals' effectiveness. Additionally, previous experiences with mental health services are likely sought by those who believe the mental health professional will help them, whereas those who hold more negative views about mental health professionals' effectiveness are less likely to have previously sought mental health services.

Well-Being as a Mediator

Next, a mediation model was run as an exploratory test to determine whether well-being mediates the association between the public identification dimension of internalized CNM negativity and help-seeking attitudes, specifically, stigma tolerance. This was accomplished by estimating the *a* pathway (the relationship between the

independent variable, in this case internalized CNM negativity, specifically, public identification, and the mediator, which was well-being), the *b* pathway (the relationship between the mediator (or well-being) and the dependent variable (in this case, stigma tolerance in relation to help seeking)), and then by calculating the indirect effects (or the mediation effects well-being influenced in the relationship between the public identification and stigma tolerance) using the Monte Carlo method for assessing mediations (Selig & Preacher, 2008). Within-person centered variables were used for the estimates by calculating the mean for each variable and centering the variables by subtracting the mean from the original variable to center the mean at 0 for each variable. Well-being was not found to be a significant mediator for the relationship between public identification and stigma tolerance. Step one of the model showed that the regression of public identification and overall well-being was not significant R^2=.006, $F(1,165)$=.996, p=.32. However, well-being was found to be negatively correlated with the Personal Discomfort dimension of Internalized CNM negativity, $r(165)$=-.191, p=.013. Although well-being does not appear to mediate the relationship between the public identification aspect of CNM negativity and stigma tolerance, there is a significant relationship between the personal discomfort factor of CNM negativity and well-being such that the more personal discomfort related to their CNM identity an individual experiences, the lesser degree of overall well-being they experience. This may be due in part to experiences of minority stress (Meyer & Frost, 2013) and negative self-judgement impacting mental health and subsequent well-being.

Summary and Conclusion

Public identification significantly predicted stigma tolerance ($F(3, 162)= 4.815$, $p <.05$), with an R^2 of .082, indicating the model accounts for 8.2% of the variance between CNM negativity and help seeking attitudes, such that those with higher concerns related to public identification of their CNM identity were more likely to hold more negative attitudes toward seeking help.

When previous experience was included as an additional independent variable, a significant regression equation was found for a predictive nature between help seeking intentions and the three factors of internalized CNM negativity as well as previous experience ($F(4,160)=5.63$, $p<.001$, with an R^2 of .123). However, only previous experience was a significant predictor of help seeking intentions ($p<.001$), indicating that previous experience may predict future help seeking intentions such that those with previous experience are more likely to intend to seek help in the future. Additionally, previous experience was found to be significantly related to beliefs about expertness ($p<.05$), such that those with previous experience were more likely to believe mental health professionals could adequately help them address their concerns.

Lastly, well-being was found to be negatively correlated with the Personal Discomfort dimension of Internalized CNM negativity, $r(165)=-.191$, $p=.013$, such that the more discomfort related to their CNM identity an individual holds, the lesser degree of overall well-being they reported.

V. DISCUSSION

This study served to investigate the predictive nature of three dimensions of internalized CNM negativity (i.e., social discomfort, personal discomfort, and public identification) on help seeking attitudes, beliefs, and intentions. Specifically, the researcher examined whether the three dimensions of CNM negativity predict willingness to seek help (intent), beliefs about expertness (expertness), and attitudes toward help seeking (stigma tolerance) using three separate models (all outcomes tested independently). Well-being was additionally examined as a potential mediator for the relationship between internalized CNM negativity and help seeking beliefs, attitudes, and intentions.

Major findings of this study include the predictive relationship between the public identification dimension of internalized CNM negativity and stigma tolerance attitudes toward help seeking. Additionally, a negative relationship was found between the public identification aspect of CNM negativity and overall well-being. Support for the relationship between the social discomfort and personal discomfort dimensions of internalized CNM negativity and help seeking intentions and beliefs about expertness was not found.

Discussion of Results

Internalized CNM Negativity and Help Seeking Attitudes

As hypothesized, there was a positive relationship found between internalized CNM negativity (i.e., public identification, personal discomfort, and social discomfort) and help seeking stigma tolerance ($F(3, 162)= 4.815$, $p <.005$), with an R^2 of .082. That is, the higher degree of CNM stigma an individual experiences, the more stigma related

to seeking help an individual would experience. However, only public identification was a significant predictor of an individual's stigma tolerance toward help seeking ($p < 0.05$). In essence, the more worry about public disclosure of their CNM identity an individual experiences, the more stigmatized they would feel about seeking help when seeking help. This finding suggests that internalized CNM negativity impacts individual's attitudes (stigma tolerance) toward seeking help.

It is possible this finding may be related to concerns and worries related to the judgment and subsequent consequences of disclosing their CNM identity (Brown, 2020; Valadez et al., 2020; Conley et al., 2012; Henrich & Trawinski, 2016) that an individual may experience when considering seeking help. This finding may also be due in part to personal discomfort and social discomfort not being as directly relevant to seeking help in the same way that public identification is (e.g., a mental health professional may ask directly about relationship orientation during the initial session or intake process, whereas they are not as likely to ask individuals' directly about their personal comfort levels with CNM until later in the helping process, if at all, nor will they explore CNM with clients in a social setting).

Although this study is novel in examining the relationship between internalized negativity and help seeking attitudes, beliefs, and intentions in the CNM community, this result partially aligns with previous findings within the LGBQ community that indicate the greater degree of stigma an individual experiences, the more likely they are to have negative attitudes, beliefs, and intentions toward help seeking. Previous research completed by Lappin (2019) found that stigma in the LGBQ community is negatively related to help seeking attitudes, such that the higher degree of stigma an individual

experiences, the less positive attitudes they hold toward seeking help. Additionally, findings from this study offer some insight into ways in which the experiences of stigma in the CNM and LGBQ populations may overlap and differ, namely that the stigma experienced by those in the CNM community does not appear to impact help seeking attitudes in the same way as experienced by those in the LGBQ community.

Internalized CNM Negativity and Help Seeking Intentions

The results of the study indicated no significant relationship between any of the three dimensions of internalized CNM negativity (i.e., public identification, personal discomfort, and social discomfort) and intentions to seek mental health help. This finding suggests that internalized CNM negativity does not relate to one's intention to seek mental healthcare. These results indicate that although there may be negative effects of stigma, these effects may not be related to a desire to seek mental healthcare. Another possible explanation for this relationship is that individuals in the CNM community may seek help from sources other than mental health professionals (such as family, friends, or others in the community) and thus do not intend to seek help from mental health professionals. These results offer some additional insights into ways in which CNM and LGBQ populations differ in their experiences of stigma and subsequent help seeking intentions.

Internalized CNM Negativity and Help Seeking Beliefs

Data analysis indicated no relationship between any of the three dimensions of internalized CNM negativity (i.e., public identification, personal discomfort, and social discomfort) and beliefs about expertness (the perceived ability of the counselor/mental health professional to help the client with their concerns). This finding suggests that

internalized CNM negativity does not relate to an individual's views of a mental health professional's expertness. This result may offer some insight into ways in which CNM and LGBQ populations differ, as well as the possibility of protective factors being present within this community.

This finding differs from previous research that found significant relationships between stigma and help seeking beliefs found in the LGBQ community (Lappin, 2019; Spengler & Ægisdóttir 2015), as no significant relationship was found within this sample. It is possible that although stigma within the LGBQ population impacts the perceived expertness of mental health professionals, a similar stigma experienced within the CNM community does not impact perceived expertness of mental health professionals the same way as CNM identity may not be a primary reason for seeking help (as compared to sexual identity or sexual development) and thus, counselors would not be perceived to need specialized knowledge to help with their concerns. Nevertheless, counselors working with this population should educate themselves on common concerns and best practices for working with CNM individuals.

Previous Experiences with Mental Health Services

When added as an additional independent variable, previous experiences with mental health services were not found to significantly change the relationship between the three CNM negativity factors and help seeking attitudes (stigma tolerance). This finding may be a result of participants with strong attitudes related to help seeking not having previous experience with mental health services as a direct result of their attitude/judgement. This finding could also be explained by participants without previous experience holding more negative perceptions regarding how seeking help is viewed by

themselves or others, whereas those who have previously sought help have directly experienced the process and understand the impacts and perceptions of help seeking firsthand.

When added as an additional independent variable, previous experiences with mental health services were found to be significantly related to help seeking intentions, such that those with previous experiences with mental health services were more likely to report intentions to seek help if needed in the future. This relationship may be due to the fact that individuals with previous experience were more likely to seek help initially and thus, more likely to seek help again subsequently in the future. This relationship may also be a result of previous firsthand experiences with mental health services influencing individuals to seek mental health services again in the future.

When previous experiences with mental health services was added to the model as an additional independent variable, the relationship between beliefs about expertness of the mental health professional and the three dimensions of CNM negativity was again not found to be significant. However, previous experiences were found to be significantly related to help seeking intentions. This finding may be due to those with previous experience having firsthand knowledge of a mental health professional's ability to help, whereas those without that direct experience may be less certain mental health professionals will be able to effectively help. Additionally, those who do not believe that mental health professionals will be able to effectively help them may not have sought mental health services previously, whereas those who do believe mental health professionals can effectively help will have previously sought their services.

Well-Being and CNM Negativity

Well-being was negatively associated with the personal discomfort dimension of internalized CNM negativity. This suggests that individuals who experience higher levels of personal discomfort with their CNM status may also experience a lesser degree of overall well-being, perhaps in part due to experiences of minority stress (Meyer & Frost, 2013). This finding does partially support the hypothesis that CNM negativity would be negatively correlated with well-being, although it is important to note there was no significant relationship found between the other two dimensions of CNM negativity and well-being.

Limitations

As with many self-report studies, limitations of this study may include a social desirability bias from participants when reporting their experiences and beliefs and as this survey was administered online, participants were limited to individuals with internet access. Although previous research has found that individuals of color are no less likely than White individuals to participate in consensual non-monogamy (Rubin et al., 2014), this sample was compromised largely of White/Caucasian individuals (n=140). This largely White sample is consistent with findings from an earlier meta-analysis completed by Sheff and Hammers (2011) that found that most samples of consensually non-monogamous populations consisted mainly of white, middle to upper middle class, educated professionals, yet the sample is not representative of the diversity of the CNM community overall. Results of this study may not generalize to Black and Indigenous People of Color (BIPOC) and future studies should work to more accurately reflect the diversity present within the CNM community. Additionally, the majority of participants

in this survey had previously sought mental health services (n= 153) and thus, may not be a representative sample of the CNM community at large. Another possible limitation of the study includes the measurement of help seeking intentions, attitudes, and beliefs but not actual help seeking behaviors. Although an individual may report positive beliefs and attitudes toward seeking help, they may not actually engage in mental health help seeking. Lastly, the sample collected largely identified as polyamorous and individuals of other CNM identities (i.e., those who are in open relationships or practice swinging) may have different experiences.

Implications for the Counseling Profession

Counselors should be aware that clients who experience stigma pertaining to public identification of their CNM identity may feel more uneasy about seeking counseling services due to the negative effects of stigma, such as fewer legal protections relating to discrimination, children, shared property, and inheritance (Conley et al., 2012; Henrich & Trawinski, 2016) and condemnation and marginalization from family members and society at large (Henrich & Trawinski, 2016), as previously mentioned in the literature review. Outreach efforts to this population may benefit from emphasizing services being offered without judgment as well as confidentiality to assuage concerns regarding public identification. Additionally, counselors should maintain awareness that although there is considerable overlap among the LGB and CNM communities, these communities remain unique in their experiences. Counselors should also consider best practices when working with this population (Schechinger et al., 2018) and be comfortable exploring clients' views and perceptions of their CNM identity.

Counselor education and supervision programs may utilize these results to inform trainees and supervisors that individuals within the CNM community may experience not only internalized stigma related to their CNM identity, but also additional stigma as a result of seeking help. Counselors should be encouraged to celebrate their CNM clients' strengths and resiliency in seeking help, in addition to any internalized negativity they may experience. Additionally, education regarding the considerations of working with a marginalized population may allow counselors in training to develop a more informed approach to working with this population, that could, over time, increase trust within the CNM community of counselor's efficacy in aiding this population and decrease the stigma of seeking help.

Future Research

Future areas of research may include the protective factors within this population that insulate them from negative effects of internalized stigma pertaining to help seeking behaviors and beliefs. Future studies may also investigate the relationship between help seeking attitudes, beliefs, and intentions within a CNM population who has not previously sought help, as a larger sample is needed to determine the relationship between internalized CNM stigma and help seeking in a population that has not sought previous mental health care. Future research should also focus on recruitment within a BIPOC population to gain a deeper understanding through a more accurately representative sample of the CNM community, with a focus on the intersection of stigma for BIPOC within the CNM community. Lastly, future research may involve studying actual help seeking actions and behaviors (e.g., contacting mental health professionals to

obtain services, attending therapeutic groups, or attending individual counseling) to examine if attitudes, beliefs, and intentions are reflective of help seeking behaviors.

Conclusion

Although this study found partial support for the relationship between help seeking attitudes and internalized stigma, further research into the help seeking experiences of the CNM community is warranted. The results of this study demonstrate that although there is often overlap among the CNM and LGB communities, these communities may be unique in their perceptions of help seeking attitudes, intentions, and beliefs. Results from this study demonstrate the importance of counselor education regarding working with the CNM community to further develop trust and comfort when overcoming stigma to seek help as well as the importance of being aware of the experiences of stigma within marginalized populations such as the CNM community. Future research may benefit from a more inclusive and representative sample as well as an examination of help seeking behaviors. Both future research and clinical practice should prioritize mitigating the perpetuation of stigma and its negative effects.

APPENDIX SECTION

Table 1

Demographic Characteristics of Participants

Baseline characteristic	Full sample	
	n	*%*
Gender		
Female	45	26.9
Male	98	58.7
Non-Binary/third gender/gender queer	17	10.2
Other	7	4.2
Sex		
Male	43	25.7
Female	121	72.5
Intersex	1	0.6
Other	2	1.2
Race/Ethnicity		
Asian	2	1.2
Black/African American	2	1.2
Caucasian/White	140	83.8
Hispanic or Latino	5	3
Native Hawaiian or Other Pacific Islander	1	0.6
Other	3	1.8
Highest educational level		
Some education but no high school degree or equivalent	1	0.6
High school degree or equivalent	4	2.4
Some college, no degree	34	20.4
Associate degree	9	5.4
Bachelor's degree	57	34.1
Master's degree	40	24
Doctorate	19	11.4
Other professional certification	3	1.8
Employment		
Employed full time	86	51.5
Employed part time	23	13.8
Unemployed and seeking work	4	2.4
Unemployed and not seeking work	5	3

Baseline characteristic	Full sample	
	n	*%*
Employment (cont.)		
Retired	3	1.8
Homemaker	10	6
Self-Employed	23	13.8
Unable to work	4	2.4
Other	9	5.4
Income		
Less than $13,000	16	9.6
$13,000 to $19,999	12	7.2
$20,000 to $34,999	23	13.8
$35,000 to $49,999	16	9.6
$50,000 to $74,999	38	22.8
$75,000 to $99,000	25	15
Over $100,000	31	18.6
Did not disclose	6	3.6
Sexual Orientation		
Exclusively heterosexual	23	13.8
Predominately heterosexual, only incidentally homosexual	65	38.9
Equally heterosexual and homosexual (bisexual)	65	38.9
Predominately homosexual, only incidentally heterosexual	11	6.6
Exclusively homosexual	3	1.8
Asexual or nonsexual	0	0
Relationship Orientation		
Polyamorous	129	77.2
Open relationship	16	9.6
Swinging	8	4.8
Other	14	8.4
Previous Experience with Mental Health Services		
Yes	153	91.6
No	13	7.8

Note. $N = 167$. Participants were on average 37.43 years (SD=10.75 years).

Appendix A

Survey

Start of Block: Default Question Block

Q2

Welcome

Megan Tracy, a graduate student at Texas State University, is conducting a research study to investigate consensually non-monogamous individuals' willingness to seek help. You are being asked to complete this survey because you are over 18 years of age, and identify as a consensually non-monogamous individual.

Participation is voluntary. The survey will take approximately 30 minutes or less to complete. You must be at least 18 years old to take this survey.

This study involves no foreseeable serious risks. We ask that you try to answer all questions; however, if there are any items that make you uncomfortable or that you would prefer to skip, please leave the answer blank. Your responses are anonymous.

By participating in this study, you will have the opportunity to participate in research that could be used to help future mental health professionals better understand consensually non-monogamous relationships and how to best help those in consensually non-monogamous relationships.

Reasonable efforts will be made to keep the personal information in your research record private and confidential. Any identifiable information obtained in connection with this study will remain confidential and will be disclosed only with your permission or as required by law. The members of the research team, and the Texas State University Office of Research Compliance (ORC) may access the data. The ORC monitors research studies to protect the rights and welfare of research participants.

Your name will not be used in any written reports or publications which result from this research. Data will be kept for three years (per federal regulations) after the study is completed and then destroyed.

If you have any questions or concerns feel free to contact Megan Tracy or her faculty advisor:

Megan Tracy, Graduate Student
Dept of Counseling, Leadership, Adult Education & School Psychology
mlt158@txstate.edu

Dr. Shaywanna Harris-Pierre, Professor
Dept of Counseling, Leadership, Adult Education & School Psychology
s_h454@txstate.edu

This project [insert IRB Reference Number or Exemption Number] was approved by the Texas State IRB on [insert IRB approval date or date of Exemption]. Pertinent questions or concerns about the research, research participants' rights, and/or research-related injuries to participants should be directed to the IRB chair, Dr. Denise Gobert 512-716-2652 – (dgobert@txstate.edu) or to Monica Gonzales, IRB Regulatory Manager 512-245-2334 -(meg201@txstate.edu).

If you would prefer not to participate, please do not fill out a survey.

If you consent to participate, please complete the survey.

End of Block: Default Question Block

Start of Block: Demographics

Q5 What is your age in years?

_____

Q6 Which of the following best describes your gender identity?

- ○ Male (cisgender or transgender)
- ○ Female (cisgender or transgender)
- ○ Non-binary / third gender / gender queer
- ○ If you feel that none of the above options accurately represent your gender identity, please write how you identify your gender below:

_____

Q7 Which of the following best describes your sex at birth?

- ○ Male
- ○ Female
- ○ Intersex
- ○ Don't know
- ○ If you feel that none of the above options accurately represent your sex at birth, please write how you identify your sex below:

_____

Q8 What is your race/ethnicity?

- ○ American Indian or Alaska Native or Aboriginal or First Nation
- ○ Asian
- ○ Black or African American
- ○ Hispanic or Latino
- ○ Native Hawaiian or Other Pacific Islander
- ○ White or Caucasian
- ○ Mixed race or multi-race
- ○ If you feel that none of the above options accurately represent your race/ethnicity, please write how you identify your race/ethnicity in the space below:

_____

Q35 What is the highest level of education you have completed?

- ○ Some education, but no high school degree or equivalent
- ○ High school degree or equivalent (GED, etc.)
- ○ Some college, no degree
- ○ Associate degree
- ○ Bachelor's degree
- ○ Master's degree
- ○ Doctorate (PhD, MD, DVM, JD, etc.)
- ○ Other professional certification

Q36 What is your current employment status?

- ○ Employed full time (40+ hours per week)
- ○ Employed part time (up to 39 hours per week)
- ○ Unemployed and seeking work
- ○ Unemployed and not currently seeking work
- ○ Retired
- ○ Homemaker
- ○ Self-employed
- ○ Unable to work
- ○ Other (please describe below)

_____

Q37 What is your approximate yearly income (in US dollars)?

- ○ Less than $13,000
- ○ $13,000 to $19,999
- ○ $20,000 to $34,999
- ○ $35,000 to $49,999
- ○ $50,000 to $74,999
- ○ $75,000 to $99,000
- ○ Over $100,000

Q9 Are you fluent in the English language?

- ○ Yes
- ○ No

Q10 Please rate your degree of heterosexuality and homosexuality using the scale below:

- ○ Exclusively heterosexual
- ○ Predominately heterosexual, only incidentally homosexual
- ○ Equally heterosexual and homosexual (bisexual)
- ○ Predominately homosexual, only incidentally heterosexual
- ○ Exclusively homosexual
- ○ Asexual or nonsexual

Q11 Which relationship orientation do you identify with most?

- ○ Monogamous (exclusively dating one person, despite their relationship orientation)
- ○ Polyamorous (dating multiple people with each partner(s) acknowledgement)
- ○ Open relationship (only sexual and casual relationships with others)
- ○ Swinging (having sexual interactions, usually as a couple, that **do not** involve emotional intimacy with those outside of relationship)
- ○ If none of the above options accurately reflect your relationship orientation, please write your relationship orientation in the space below:

_____

Page Break

Q80 Have you previously sought mental health services?

- ○ Yes
- ○ No

Q81 On a scale of 0-10, how positive were your previous experiences with mental health services?

- ○ 0
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10

End of Block: Demographics

Start of Block: Adapted BAPS

Q34 Please read the following statements and rate them using the scale provided. Place your ratings to the left of each statement by recording the number that most accurately reflects your attitude toward seeking psychological help. For the purposes of this study, a "mental health professional" is defined as a psychologist or masters level clinician (such as a therapist, social worker, or counselor).

	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
If a good friend asked my advice about a problem, I would recommend that they see a mental health professional.	○	○	○	○	○	○
I would be willing to confide my intimate	○	○	○	○	○	○

concerns to a mental health professional.						
Seeing a mental health professional is helpful when you are going through a difficult time in your life.	○	○	○	○	○	○
At some future time, I might want to see a mental health professional.	○	○	○	○	○	○

I would feel uneasy going to a mental health professional because of what some people might think.	○	○	○	○	○	○
If I believed I were having a serious problem in my life, my first inclination would be to see a mental health professional.	○	○	○	○	○	○

Because of their training, mental health professionals can help you find solutions to your problems.	○	○	○	○	○	○
Going to a mental health professional means that I am a weak person.	○	○	○	○	○	○
Mental health professionals are good to	○	○	○	○	○	○

talk to because they do not blame you for mistakes you have made.

Page Break

Q39 Please read the following statements and rate them using the scale provided. Place your ratings to the left of each statement by recording the number that most accurately reflects your attitude toward seeking psychological help. For the purposes of this study, a "mental health professional" is defined as a psychologist or masters level clinician (such as a therapist, social worker, or counselor).

	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
Having received relationship help from a mental health professional stigmatizes a person's life.	○	○	○	○	○	○
There are certain problems that should not be discussed with a stranger such	○	○	○	○	○	○

as a mental health professional.						
I would see a mental health professional if I were worried or upset for a long period of time.	○	○	○	○	○	○
Mental health professionals make people feel that they cannot deal with their problems.	○	○	○	○	○	○
It is good to talk to someone like a mental	○	○	○	○	○	○

health professional because everything you say is confidential.						
Talking about problems with a mental health professional strikes me as a poor way to get rid of emotional conflicts.	○	○	○	○	○	○
Mental health professionals provide valuable advice	○	○	○	○	○	○

because of their knowledge about human behavior.						
It is difficult to talk about personal issues with highly educated people such as mental health professionals.	○	○	○	○	○	○
If I thought I needed psychological help, I would get this help no matter who knew I	○	○	○	○	○	○

was receiving this assistance.

Page Break

Q76 Please select "strongly disagree"

- ○ Strongly disagree
- ○ Somewhat disagree
- ○ Neither agree nor disagree
- ○ Somewhat agree
- ○ Strongly agree

End of Block: Adapted BAPS

Start of Block: Adapted Internalized CNM Scale

Q40

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
I feel comfortable being seen in public with consensually non-monogamous individuals	○	○	○	○	○	○	○
I feel comfortable discussing consensual non-monogamy in a public situation	○	○	○	○	○	○	○

I feel comfortable having a consensual non-monogamy lifestyle	○	○	○	○	○	○	○
Even if I could change my relationship orientation, I wouldn't	○	○	○	○	○	○	○
Consensual non-monogamy is as natural as monogamy	○	○	○	○	○	○	○
I feel comfortable in consensual non-	○	○	○	○	○	○	○

monogamy friendly conversations							
Social situations with consensual non-monogamous individuals make me feel uncomfortable							

Page Break

Q77 Please select "true"

- ○ False
- ○ Neither true nor false
- ○ True

Page Break

End of Block: Adapted Internalized CNM Scale

Start of Block: General Well Being Schedule

Q51 For each question, choose the answer that best describes how you have felt and how things have been going for you **during the past month.**

Q52 How have you been feeling in general?

- In excellent spirits
- In very good spirits
- In good spirits mostly
- I have been up and down in spirits a lot
- In low spirits mostly
- In very low spirits

Q53 Have you been bothered by your nervousness or your "nerves"?

- ○ Extremely so-to the point where I could not work or take care of things
- ○ Very much so
- ○ Quite a bit
- ○ Some-enough to bother me
- ○ A little
- ○ Not at all

Q54 Have you been in firm control of your behavior, thoughts, emotions, or feelings?

- ○ Yes, definitely so
- ○ Yes, for the most part
- ○ Generally so
- ○ Some-enough to bother me
- ○ A little
- ○ Not at all

Q55 Have you felt so sad, discourages, hopeless, or had so many problems that you wondered if anything was worthwhile?

- ○ Extremely so-to the point that I have just about given up
- ○ Very much so
- ○ Quite a bit
- ○ Some-enough to bother me
- ○ A little bit
- ○ Not at all

Q56 Have you been under or felt you were under any strain, stress, or pressure?

- ○ Yes-almost more than I could bear or stand
- ○ Yes-quite a bit of pressure
- ○ Yes-some, more than usual
- ○ Yes-some, but about usual
- ○ Yes-a little
- ○ Not at all

Q57 How happy, satisfied, or pleased have you been with your personal life?

- ○ Extremely happy- could not have been more satisfied or pleased
- ○ Very happy
- ○ Fairly happy
- ○ Satisfied-pleased
- ○ Somewhat dissatisfied
- ○ Very dissatisfied

Q58 Have you had any reason to wonder if you were losing your mind, or losing control over the way you act, talk, think, feel, or of your memory?

- ○ Not at all
- ○ Only a little
- ○ Some, but not enough to be concerned or worried about
- ○ Some, and I have been a little concerned
- ○ Some, and I am quite concerned
- ○ Yes, very much so, and I am very concerned

Q59 Have you been anxious, worried, or upset?

- ○ Extremely so- to the point of being sick or almost sick
- ○ Very much so
- ○ Quite a bit
- ○ Some- enough to bother me
- ○ A little bit
- ○ Not at all

Page Break

Q60 Have you been waking up fresh and rested?

- ○ Every day
- ○ Most every day
- ○ Fairly often
- ○ Less than half the time
- ○ Rarely
- ○ None of the time

Q61 Have you been bothered by any illness, bodily disorder, pains, or fears about your health?

- ○ All the time
- ○ Most of the time
- ○ A good bit of the time
- ○ Some of the time
- ○ A little of the time
- ○ None of the time

Q66 Has your daily life been full of things that were interesting to you?

- ○ All the time
- ○ Most of the time
- ○ A good bit of the time
- ○ Some of the time
- ○ A little of the time
- ○ None of the time

Q65 Have you felt downhearted and blue?

- ○ All the time
- ○ Most of the time
- ○ A good bit of the time
- ○ Some of the time
- ○ A little of the time
- ○ None of the time

Q67 Have you been feeling emotionally stable and sure of yourself?

- ○ All the time
- ○ Most of the time
- ○ A good bit of the time
- ○ Some of the time
- ○ A little of the time
- ○ None of the time

Q68 Have you felt tired, worn out, used-up, or exhausted??

- ○ All the time
- ○ Most of the time
- ○ A good bit of the time
- ○ Some of the time
- ○ A little of the time
- ○ None of the time

Q78 Please select "yes"

- ○ Yes
- ○ Maybe
- ○ No

Page Break

Q72 For each of the four scales below, note that the words at each end of the 0 to 10 scale describe opposite feelings. Select any number along which seems closest to how you have generally felt **during the past month.**

Q69 How worried or concerned about your health have you been?

- ○ 0
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10

Q71 How relaxed or tense have you been?

- ○ 0
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10

Q75 How much energy, pep, and vitality have you felt?

- ○ 0
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10

Q74 How depressed or cheerful have you been?

- ○ 0
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10

Q79 Please select "false"

- ○ False
- ○ Neither true nor false
- ○ True

End of Block: General Well Being Schedule

Start of Block: Qual Question

Q43 Is there any additional information you would like to share with the researchers of this study?

_____

End of Block: Qual Question

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