Polyamory: What Therapists Need To Know

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Abstract

Polyamorous clients are presenting for therapy, yet few college programs offer training in working with this population. When therapists encounter polyamorous clients, the therapists may lack education, cultural competence and may harbor myths and biases about polyamorous people. Since the 1970s, research on polyamory has focused on defining polyamorous relationships and polyamorous identity. We conducted a survey to gather information about the therapeutic experiences of polyamorous people, including: the presence or absence of personal and familial mental health diagnoses, presenting concerns for therapy, reasons for seeking and/or discontinuing therapy and beneficial traits in a therapist. An increased understanding of polyamorous people can assist therapists and educators as we work to create and enhance culturally competent models for therapy. ((STATEMENT: General findings and conclusions))

Introduction

Polyamory is defined as "the practice of ethically and consensually embracing more than one intimate relationship at one time" (Weitzman, Davidson and Phillips, 2010). The word intimate is not limited to sexuality, but rather can encompass friendship, being a personal confidant, or acting as a spiritual companion (American Heritage Dictionary, 2011). Sheff (2007) describes polyamorous people who are emotionally intimate with partners, but are not sexually intimate, as polyaffective. A polyamorous person may define polyamory as a personal identity, a sexual orientation, or both. Relationship status does not define whether or not a person identifies as polyamorous anymore than being in a relationship defines whether or not a person identifies as monogamous. Polyamorous relationships are distinct from hetero-normative dyadic relationships in that relationship partners - with the consent and blessing of all partners -

are free to enjoy emotionally intimate friendships and/or romantic relationships with one or more partners (Weitzman, 2006). Polyamorous relationships are characterized by self-definition, individual relationship choices, and new visions for how to form relationships (Baker, 2005). Polyamory encompasses, but is not limited to, polyfidelity, a relationship structure in which three or more people commit to an exclusive relationship, for example, a group marriage. Another common polyamorous relationship structure is a cohabiting couple with non-cohabiting partners (Sheff, 2007; Fierman & Poulsen, 2011; Labriola, 2012). Polyamory is distinct from infidelity in that people are openly non-monogamous. This does not mean polyamorous people are immune from feeling jealousy.

Polyamory and Therapy

Polyamorous clients are engaging in individual, relationship, and familial therapy, yet few college programs offer training in working with this population (Rubin, 2001; Weitzman, 2006; Weitzman, Davidson & Philips, 2009-2010; Fierman & Poulsen, 2011; Berkey, Gaines & Moran, 2012). Anatlaffy (2011) describes the majority of media representations of polyamory both as titillating and as unacceptable, a "frightening scenario to which the solution is monogamy" (p.3). In the media, polyamory is often equated with cheating and infidelity. Polyamorous people are portrayed as having low self-esteem or as being addicted to sex. In the news media, proponents of the "slippery slope" argument posit that legalizing same-sex marriage will lead to multi-partner marriage and legalizing multi-partner marriage will invalidate traditional dyadic heterosexual marriage (Anatlaffy, 2011).

Researchers have conducted studies to assess therapists' attitudes about working with clients who engage in non-monogamous relationships (Knapp, 1975; Roman, Charles & Karasu,

1978; Ford & Hendrick, 2003). In a survey of 190 therapists, one third reported a belief that people who engage in open marriages have a personality disorder (Knapp, 1975). If therapists hold biases based on fictional and media representations of polyamorous people, then therapists may operate from a perspective that monogamy is the relationship gold standard, view polyamorous people in terms of infidelity, and treat polyamory as if it is pathology. The clients may feel pressured to explain what a polyamorous relationship is to the therapist rather than feel at ease to seek therapeutic services (LaSala, 2004, Weitzman, 2006).

Through quantitative and qualitative research, mental health practitioners have gained a more accurate view of polyamorous clients. Using batteries of psychological assessments, including the California Personality Inventory and the Dyadic Assessment Scale (DAS), researchers have established no significant difference between the scores of polyamorous people and the scores of control groups in areas of relationship satisfaction, marital stability, and personality traits (Ramey, 1975; Knapp, 1976; Rubin & Adams, 1986; Watson; 1981; LaSala, 2004). Mental health practitioners have conducted qualitative studies in an effort to create a thorough picture of polyamory including: relationship structures, relationship models, rules, boundaries, self-identity, cultural context, race, ethnicity, gender, sexuality, (dis)ability and a framework for considering issues of discrimination specific to this population (Labriola, 1999; Barker, 2003; McLean, 2004; Cook, 2005; Haritaworn, Lin, Klesse, 2006; Klesse, 2006; Noel, 2006; Frank & DeLamater, 2010; Barker, 2010).

As therapists work with polyamorous clients, feedback from both clinical and non-clinical polyamorous populations is invaluable to avoid the perpetuation of stereotypes and to support quality care. We gathered data from polyamorous people over the age of eighteen on: personal and familial mental health diagnoses, therapeutic experience, reasons for seeking and

discontinuing therapy, and beneficial traits in a therapist. We hypothesized that polyamorous adults were no more likely than monogamous adults to have personal and/or familial mental health diagnoses. We further hoped to explore the therapeutic experience of polyamorous people and their reasons for seeking and/or discontinuing therapy.

Methods

Materials & Procedures

We developed an 8-section online survey. As a guiding framework, we drew from culturally competent practices for working with polyamorous clients, as well as culturally competent practices for working with gay and lesbian clients (Crisp, 2006; Weitzman, Davidson & Phillips, 2010). We based our standards of client care on the principles in the American Association of Marriage and Family Therapy Code of Ethics and used the mental health diagnostic categories in the Diagnostic and Statistical Manual TR-IV for mental health diagnoses (American Psychiatric Association, 2000; American Association of Marriage and Family Therapy, 2012). Our survey was expert reviewed by the Consortium Academy for Research on Alternative Sexualities (CARAS) and received approval from the Human Research Participants Board at Edgewood College.

Our survey consisted the following eight sections.

Implied consent. The implied consent explained the purpose of the survey, what to expect, the potential risks and benefits, confidentiality, and freedom to withdraw from the survey at any time.

General instructions. The survey consisted of 24 forced answer questions with the option to fill-in "other, please specify_____," when appropriate, and "decline to answer," on each

question. Instructions: "Please answer every question as best you can. If a word or phrase could have more than one meaning, please interpret it according to your own word usage. If you do not know an answer, click 'don't know' if applicable. Click the circle that answers the question."

Part I demographics. "Click the circle that most accurately describes you. For some questions, there will be an option to click more than one answer. If you click 'other' please type your answer in the blank."

Part II therapeutic experiences. If participants had clinical experience with a mental health practitioner, then they were directed to Part II-A and became our clinical population. If participants did not have clinical experience with a mental health practitioner, then they were directed to Part II-B and became our non-clinical population.

In Part II-A, we gathered information from the clinical population about beneficial traits in a therapist, reasons for seeking therapy and, if the participants had discontinued therapy, reasons for discontinuing therapy. In Part II-B, we gathered information from the non-clinical population about beneficial traits in a therapist. If the participants were interested in seeing a therapist, we gathered data on participants' reasons for seeking therapy and, if participants reported a desire to see therapist, but decided not to seek therapy we gathered data on the participants' reasons for not seeking therapy.

Beneficial traits. We used a table of 15 beneficial traits in a therapist. Participants scaled each trait using a 5-point Likert-type scale from "strongly agree" to "strongly disagree" along with the options "don't know," and "decline to answer." Nine of the questions related directly to polyamory, for example "the mental health practitioner indentifies his/her/hir

practice as poly friendly." Six of the question related to general traits, for example: "the mental health practitioner expresses empathy."

Presenting concerns. We used a table of 51 presenting concerns, divided into 5 sections: Relationship Concerns, Legal Concerns, Identity Concerns, Social/Environmental Concerns, and Mental Health Concerns, to gather data on the reasons for seeking therapy. Thirteen questions were specific to polyamory for example "Address lack of external support for a polyamorous relationship…" The lists of presenting concerns were the same for both populations. Participants were able to select as many presenting concerns as they were would to select and in each category the option of "other, please specify" was included, at then end of the entire list there was the option "decline to answer."

Discontinuing Therapy. We used a table of 19 reasons for discontinuing therapy. The table used a 5-point Likert-type scale from "strongly agree" to "strongly disagree" along with the options "don't know," and "decline to answer." Ten questions for discontinuing therapy explored concerns related polyamory and nine questions explored concerns unrelated to polyamory including other forms of discrimination and lack of financial resources.

Part III personal experience. Using a table of 14 categories based on DSM-TR-IV diagnostic categories, participants reported mental health diagnosis/diagnoses made by a mental health or medical health professional. Participants who reported no mental health diagnoses bypassed to the section.

Part IV family history. Using a table of 14 categories based on DSM-TR-IV diagnostic categories, participants reported parent or guardian mental health diagnoses. Using a table, of up to 17 family members participants selected immediate and extended family members

who identify as polyamorous. If participants did not have this information to either of these questions they could select "don't know" or "decline to answer."

Part V personal write-up. Participants could provide feedback. Instructions: "If you have any questions, concerns, thoughts, or comments, please feel free to write them in the following box."

Part VI debriefing. We thanked the participants for completing in the survey, described the purpose and application of the information gathered, and reassured the participants that their identity would remain confidential. The debriefing form provided our contact information for questions, requests for survey results, and provided reiterated the purpose of the survey.

Participants

One hundred eighty three people participated in our survey. In order to be eligible, participants needed to be 18 or over, and to self-identify as polyamorous. We recruited from 42 states and 5 national polyamorous listservs, websites, blogs and organizations for example: http://archives.binhost.com/pipermail/fem-anth-l/2012-January/000279.html, http://www.polygroups.com/groups/Madison-Area-Polyamory-Society, https://carasresearch.org as well as through word of mouth (Table 1). We, or a group moderator, posted a recruitment message to the listserv, including a link to the survey, which was posted to an on-line survey generator, www.Qualitrics.com. Participant demographic information is included in tables 1-8. We received responses from 10 countries, 88% of participants were from the United States, the state with the highest number of participants reporting residing in California, followed by Michigan and then Texas. Ninety percent of participants reported having seen a mental health

practitioner as defined as a “Licensed Marriage and Family Therapist, Licensed Social Worker, Licensed Professional Counselor, Psychiatric Nurse, Psychologist, Psychiatrist, or other mental health practitioner.” One hundred and two of the participants reported a mental health diagnosis or diagnoses.

Country	Percent of Sample
US	88%
UK	4%
Canada	3%
Ireland	1%
Italy	1%
Finland	1%
Germany	1%
Sweden	1%
Switzerland	1%
South Africa	1%
Decline to Answer	1%

Table 1: Country of Origin

Table 2

Age	Percent of Sample
18-24	7%
25-34	30%
35-44	33%
45-54	16%
55-64	10%
65+	3%
Decline to Answer	1%

Table 2: Age

Table 3

Identified Gender	Percent of Sample
Female	50%
Male	37%
Genderqueer	8%
F to M Transgender	2%
Other	2%
M to F Transgender	1%
Intersex	1%
Decline to Answer	1%

Table 3: Identified Gender

Table 4

Sexual Orientation	Percent of Sample
Bisexual	43%
Heterosexual	40%
Kinky	31%
Pansexual	16%
Queer	9%
Lesbian	3%
Gay	3%
Polyamorous	2%
Other	2%
Asexual	1%
Demisexual	1%
Bi-curious	1%
Heteroflexible	1%
Decline to Answer	1%

Table 4: Sexual Orientation

Table 5

Race	Percent of Sample
White	84%
Multi-racial	5%
Black or African American	3%
Hispanic or Latino	2%
American Indian or Alaskan Native	1%
Middle Eastern	1%
Jewish	1%
Asian	0%
Native Hawaiian/Pacific Islander	0%
Other, Please Specify:	1%
Decline to Answer	2%

Table 5: Race

Table 6

Education	Percent of Sample
No H.S. diploma	0%
H.S. diploma/ equivalent	2%
>1 year college	3%
<1 year college/no degree	17%
Associate Degree	4%
Bachelor's Degree	36%
Master's Degree	25%
Professional Degree	5%
Doctorate Degree	8%
Decline to Answer	1%

Table 6: Education

Table 7

Household Income	Percent of Sample
> $10,000	5%
$10,000 to $19,999	6%
$20,000 to $29,999	6%
$30,000 to $39,999	9%
$40,000 to $49,999	7%
$50,000 to $59,999	9%
$60,000 to $69,999	6%
$70,000 to $79,999	8%
$80,000 to $89,999	4%
$90,000 to $99.999	5%
$100,000 to $149,999	12%
$150,000 or more	15%
Decline to Answer	8%

Table 7: Household Income

Table 8

Reported Mental Health Diagnosis	Percent of Sample
Depression/Mood Disorder	64%
Anxiety Disorder	58%
Attention Deficit Disorder	15%
Adjustment Disorder	6%
Eating Disorder	6%
Personality Disorder	6%
AODA	3%
Sexual Desire/Arousal Disorder	3%
Autism Spectrum Disorder	1%
Paraphilias	0%
Schizophrenia or Psychotic Disorder	0%
Somatoform Disorder	0%
Delirium/Dementia/Cognitive Disorder	0%
Other Addiction Issues	0%
Other, Please Specify:	9%
Decline to Answer	2%

Table 8: Reported Mental Health Diagnoses

Results

Therapeutic Experience

Beneficial traits. Using a table of 15 therapist traits, participants scaled traits using a 5-point Likert-type scale from "strongly agree" to "strongly disagree." Participants were also given the options of "Don't Know" and "Decline to Answer."

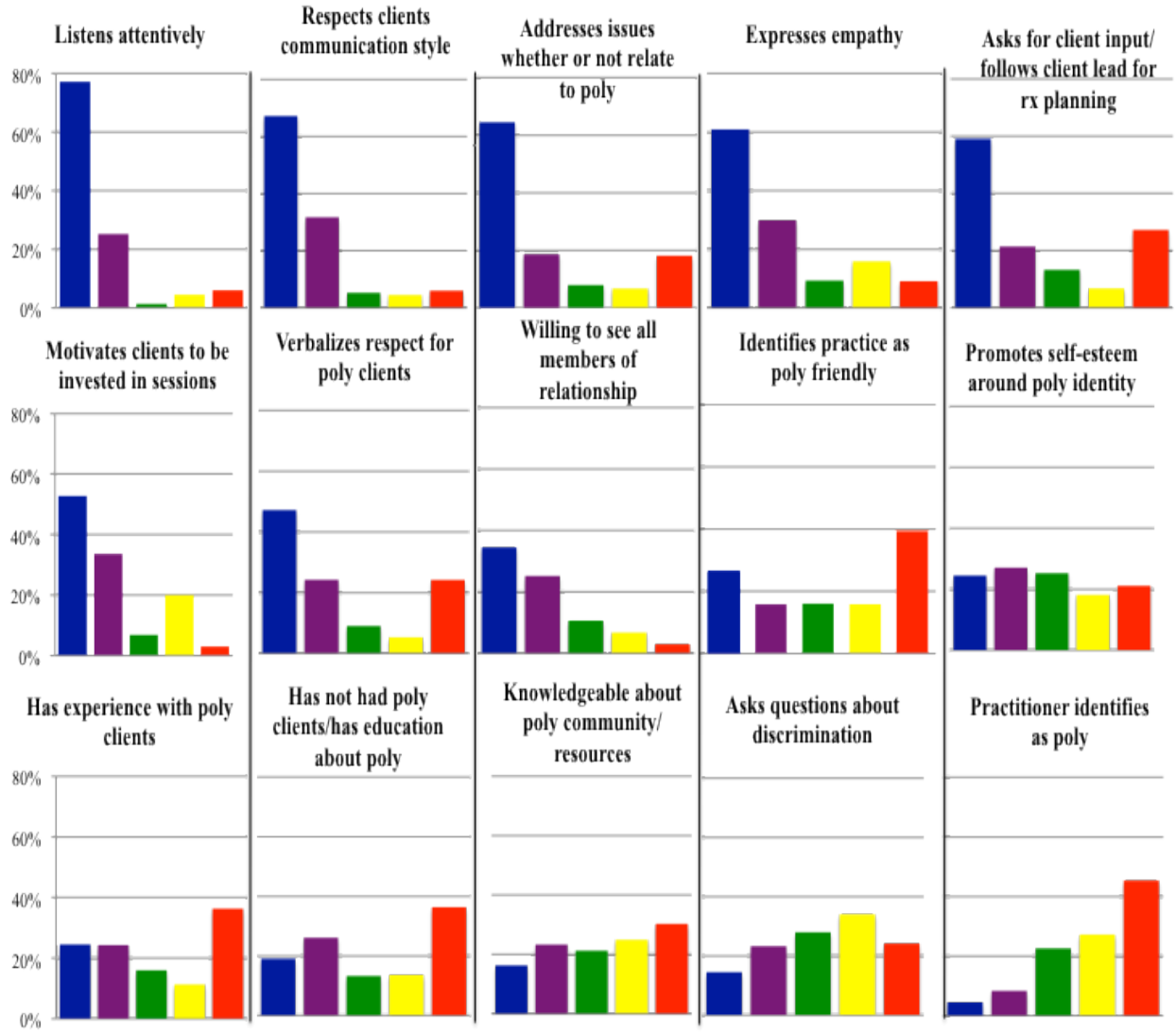

Figure 1: Beneficial Traits Clinical Population

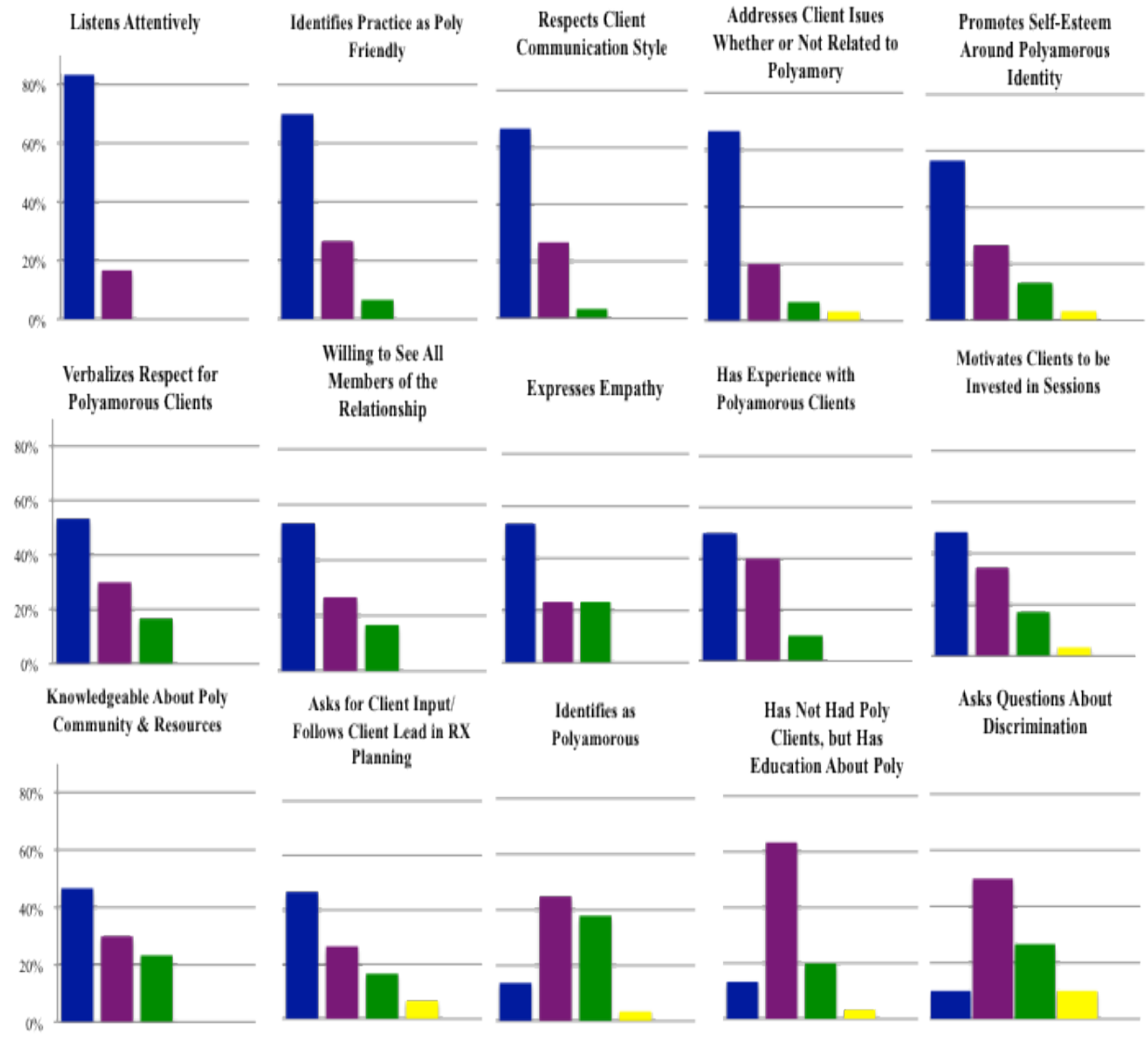

Figure 2: Beneficial Traits Non-Clinical Population

Using a table of 51 choices, we asked participants to select presenting concerns for therapy, participants were able to select as many concerns as they would like to select.

Table 11
Presenting Concerns

Presenting Concerns	Clinical Population	Non-Clinical Population Interested in Seeing a Therapist
Depression/Hopelessness	58%	57%
Anxiety/Worry	56%	57%
Improve Communication with Partner(s)	44%	43%
Cope with Relationship Change & Ambiguity	40%	29%
Improve Problem Solving Skills	30%	29%
Discuss Sexual Concerns Related to Polyamory	22%	0%
Loss/Grief	21%	14%
Divorce/End of Relationship	20%	14%
Set Comfortable Relationship Guidelines	19%	14%
School/Job Changes	19%	14%
Sleep Problems	18%	0%
Anger Issues	16%	43%
Sexual Concerns Related to Polyamory	16%	14%
Life Stage Concerns	16%	43%
Feelings of Possessiveness/Jealousy	15%	14%
Other Mental Health Concerns	15%	29%
Address Identity in Relations to Polyamory	14%	0%
Process Feelings of Isolation/Self-Doubt Related to Being in a Polyamorous Relationship	14%	14%
Sexual Abuse/Rape	14%	14%
Chronic Pain or Illness	13%	0%
Suicidal Thoughts/Attempts	12%	14%
Affairs/Infidelity	12%	14%
Lack of External Support for a Polyamorous Relationship	12%	0%
Feelings Around Secrecy/Need to Live a Double Life	11%	29%
Job Concerns	11%	14%
Sexual Orientation/Identity	11%	0%
Process Feeling About Discrimination/Social Disapproval of Polyamory	11%	0%
Come out as Polyamorous	10%	0%
Parenting Concerns	10%	29%
Begin a Polyamorous Relationship	9%	0%
Safe Space to Process Others Reactions to Polyamory	8%	14%
Discuss Disclosure of Polyamory to Family Members	8%	14%
Other Social/Environmental Concerns	8%	0%
Cutting/Self-Harm	8%	14%
IPV	7%	14%
Unemployment	7%	0%
Gender Identity	6%	14%
Eating Problems	6%	14%
Relationship w/Mono-Polyamorous Partner	5%	N/A
Legal Concerns Unrelated to Polyamory	5%	0%
AODA	5%	0%
Cultural Identity	5%	0%

Other Relationship Concerns	5%	29%
Other Identity Concerns	5%	0%
Blending Families	4%	0%
Child Custody/Mediation	3%	0%
Housing Concerns	2%	0%
Ethnic Identity	2%	0%
Remarriage/New Relationship	2%	0%
Legal Discrimination Against Polyamorous People	1%	0%
Other Addiction Issues	1%	0%
Other Legal Concerns	1%	0%
Decline to Answer	1%	0%

Table 9: Presenting Concerns

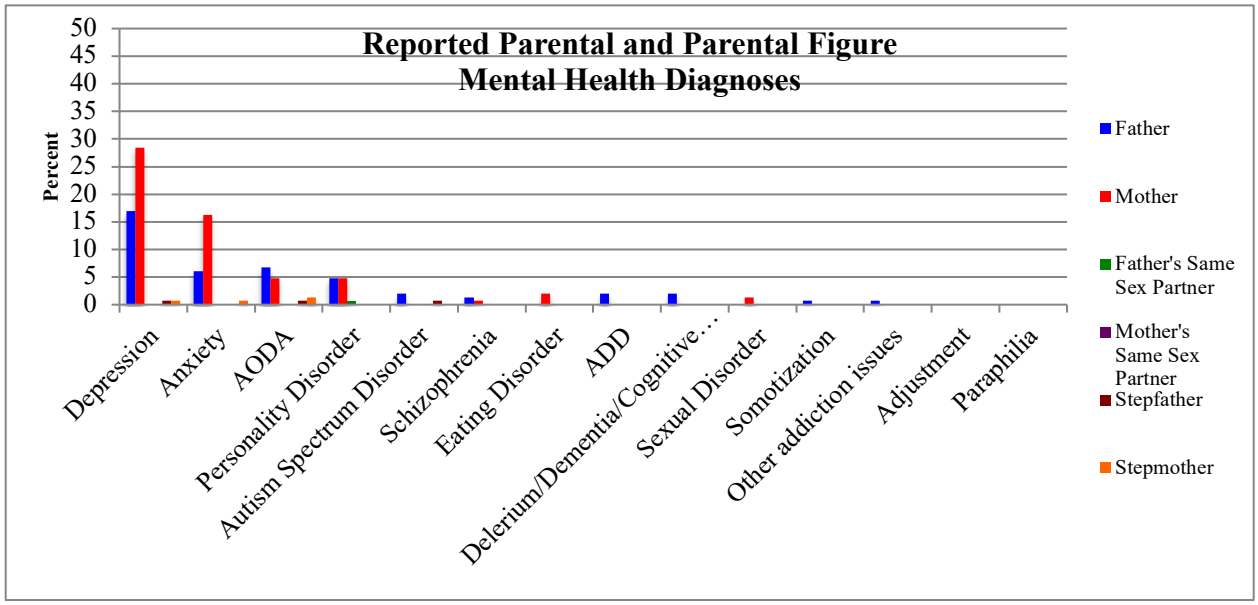

Figure 3: Reported Parental and Parental Figure Mental Health Diagnoses

Discussion

In order to provide ethical treatment, it is important that therapists question biases and stereotypes within our culture and within the therapeutic community. The data we gathered provides challenges to myths about polyamorous clients. Contrary to the long held myth that polyamorous people would present with a personality disorder (Knapp, 1975), our survey participants reported anxiety and depression/mood disorder as their top two diagnoses,

respectively 64% and 58%. Participants reported Attention Deficit Disorder as the third highest diagnosis, 15%. Personality disorder ranked fourth, tied with Adjustment Disorder and Eating Disorders, 6% (*Table* 8). If participants reported a parent or guardian with a mental health diagnosis, then the most common diagnoses reported were: depression/mood disorders, followed by anxiety disorders.

In the 2004 United Census, Anxiety Disorders and Mood Disorders were the top two mental health disorders reported by the general population in the United States (US Department of Health and Human Services, 2013). The top two reported diagnoses for our polyamorous participants and their parents and parental figures (parents, step-parents and parent's same sex partners) were consistent with the top two diagnoses for the general population of the United States.

Negative representations of polyamorous people in the media include images of people who are sexually addicted and who have low self-esteem (Anatlaffy, 2011). Survey participants reported no paraphillia diagnoses and only 1% reported a diagnosis under the category of "other addiction, issues," which would include sexual addition. This is of particular interest, because 31% of the survey participants reported "kinky" as a sexual orientation. A survey participant offered the following feedback: *"In addition to poly issues, I must communicate my kink identity. I was lucky that my last therapist was willing to learn from me about both polyamory and kink and accept both as valid self expressions that were not 'the problem.'"* Therapists and researchers have written extensively on the subject of challenging myths about BDSM/kink clients, working toward cultural competence with this population, and in favor of changing and/or eliminating paraphilla diagnoses in the Diagnostic and Statistical Manual in favor of non-

pathology based views of clients (Kleinplatz, 2001; Kleinplatz & Moser, 2006; Barker, Iantaffi, & Gupta, 2007).

The top 3 presenting concerns for both the clinical and the non-clinical populations were consistent: “depression/hopelessness” (clinical 58%, non-clinical 57%,) “anxiety/worry” (clinical 56%, non-clinical 57%), and “improve communication with partner(s)” (clinical 44%, non-clinical %). In the non-clinical population, the mental health concern of “anger issues” was tied with “improve communication with partner(s)” at 43% and “cope relationship change and ambiguity,” closely followed by “improve communication with partner(s)” at 40% for the clinical population. Depression and anxiety are the number one mental health concerns facing people in the United States and Nichols refers to communication as “the vehicle of the relationship” (p.70).

A topic of interest for our survey was to find out if there was statistically significant trend for discontinuing therapy. What we found was that the only answer that approached a statistically significant trend was “unable to afford services from a mental health practitioner.” A survey participant offered this feedback: *“I am reliant upon the therapist assigned to me so don't have a choice of finding a poly friendly therapist.”*

We asked for participant feedback on beneficial traits in a therapist, using a 5-point likert type scale. When we view both the clinical and non-populations answers the trait “listens attentively” garnered highest agreement for both for both populations. “Respects client’s communication style” was second for the clinical population and third for the non-clinical. “Addresses the client’s issues whether or not they relate to polyamory” was third for the clinical and fourth for non-clinical. These responses point toward the significance of the therapeutic alliance as a basis for successful therapy as well as the importance of the therapist having a clear

understanding the clients' presenting concerns and the therapist questioning whether myths and biases about polyamory may be influencing the diagnostic process. The non-clinical population reported, "identifies… practice as polyamorous friendly" as the second highest trait. For polyamorous clients, who are new to therapy, a therapist who actively includes polyamorous friendly messages in newsletters, websites, and in the clinical setting, can be a benefit to his or her clients. The clinical population reported the strongest disagreement with the trait of a therapist who "identifies as polyamorous." This challenges the myth that polyamorous clients will only want to work with polyamorous therapists.

Participants reported a total of 38 polyamorous immediate or extended family members, 14 of who were the participants' parents or parents' partners. If a client or client's family member is polyamorous, therapists can consider ways to work relationally and intergenerationally with the clients who are polyamorous. New genogram symbols are in use for polyamorous clients and there is a new mapping tool similar to a genogram and ecomap, which provides a visual representation for charting polyamorous relationships (Karathanasis, 2012; Keith, 2013). If therapists become familiar with polyamory and word questions in ways that invite client comfort, then clients may feel at ease discussing polyamory as part of therapy, either as part of their own identity or sexual orientation or if they have a family member or friend who is polyamorous then the therapist can use this time to challenge myths and invite questions. A survey participant offered the following feedback: *"My husband and I didn't tell our couples therapist that we had an open marriage for months because I was afraid of her judgment. We are in the process of switching to another therapist (who we've already told), and I'm much happier."*

Our demographic data was consistent with previous data describing western polyamorous people as white, middle to upper class, professional, educated, bisexual women and heterosexual men (Sheff, 2007). The median household income ???? and was consistent with 2012 the median United States general population of $50,054 (DeNavas-Walt, Proctor & Smith, 2013). A limitation of our survey was that it was an online survey, which narrowed participation to people who have access to computers, which could influence socioeconomic data. We also sent surveys to polyamorous listserves and used snowball survey techniques in order to gather additional participants, which means there could be a greater tendency for participants to be similar other survey participants. By using write-in sections in our demographics sections, we included categories of: queer, heteroflexible, and polyamorous in our sexual identity section and noted genderqueer does not exclude a female or male identity. This demographic data supports an accurate picture of polyamorous people and challenges the media myths or polyamorous people as damaged, dangerous, unknowable (Anatlaffy, 2011). A hope with this survey was to gather information in order to better inform clinical practice. Our survey was a small n survey; future directions for research would be to do a similar survey on a larger scale and to conduct similar surveys to learn more about the perspectives and needs of the many diverse and underrepresented populations.

Conclusion

As therapists, researchers, and educators, we have the opportunity to support a diverse client base. The feedback we have received from this study reminds us to create a safe space that invites new polyamorous clients and creates a strong therapeutic alliance. The more we can display empathy, listen actively, and pay attention clients' presenting concerns, the more we can foster open discussions and avoid stereotypes. The polyamorous people who participated in this

study gave valuable feedback and support: the more we trust our clients, ask for feedback and are ready to hear it, the more we will grow and learn with our clients.

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