TURUN YLIOPISTO

Psychological well-being in monogamous and consensually non-monogamous individuals: a multinational study

Master's thesis
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Suostumuksellinen non-monogamia (CNM) viittaa parisuhdejärjestelmään, jossa yksilöt yhteisesti sopivat, että he tai heidän kumppaninsa voi harrastaa seksuaalista tai romanttista toimintaa useamman, kuin yhden henkilön kanssa. CNM-suhteet voivat olla monenlaisessa eri muodossa. Kolme yleisintä muotoa ovat polyamoria, jossa yksilöt ylläpitävät useampaa kuin yhtä romanttista suhdetta; avoin suhde, jossa yksilöt sallivat seksuaalista toimintaa pääsuhteensa ulkopuolella; ja swingaaminen, jossa pariskunnat harrastavat seksuaalista toimintaa muiden kanssa, usein sosiaalisissa tilanteissa, tai kokoontumisissa. Viime vuosina CNM on noussut yleisemmäksi parisuhdemuodoksi, haastaen perinteisiä kulttuurisia normeja, jossa monogamiaa pidetään oletusarvoisena tai parempana parisuhdemuotona. Vaikka yleisesti ottaen CNM on stigmatisoitu suhdemuoto, jota pidetään vähemmän tyydyttävänä ja vakaana, tutkimus on osoittanut, että nämä suhteet voivat olla yhtä tyydyttäviä, toimivia ja emotionaalisesti tukevia kuin monogamiset suhteet. Tässä tutkimuksessa tutkitaan, kokeeko CNM-suhteissa olevat ihmiset poikkeavia määriä masennus- tai ahdistusoireita monogamisissa suhteissa oleviin ihmisiin verrattuna, ja kuinka paljon parisuhdemuoto selittää mahdollista vaihtelua. Tässä tutkimuksessa käytetään MRMS-projektissa kerättyä aineistoa, jossa on 1178 aikuista osallistujaa joko monogamisessa, tai CNM-suhteessa. Aineisto on kerätty useammasta valtiosta, jossa osallistujat täyttivät internetissä kyselyn, joka koostui mielenterveyttä koskevista kyselyistä, demografisista kysymyksistä, ja parisuhteisiin liittyvistä muuttujista. Yleistetyillä lineaarisilla malleilla arvioitiin, kuinka paljon ahdistuksen ja masennuksen määrässä olevia eroja voitiin selittää parisuhdemuodolla. Sukupuoli, seksuaalinen suuntautuminen, työllisyystilanne ja ikä toimivat sekoittavina muuttujina. Tulokset näyttivät pieniä efektikokoja, sekä suurimmaksi osaksi ei-merkitseviä eroja ahdistu- ja masennusoireissa monogamisten ja CNM-henkilöiden välillä. Kun sekoittavat tekijät lisättiin malliin, vähenivät pienet eroavaisuudet entisestään, joka osoittaa, että parisuhdemuoto ei vaikuta masennus- ja ahdistusoireiluun merkitsevällä tasolla. Nämä löydökset korostavat tärkeyttä puuttua väärinkäsityksiin koskien CNM-suhteita, ja auttaa mieleneterveyden alan ammattilaisia ymmärtämään paremmin yksilöitä CNM-suhteissa näiden tulossa vastaanotolle, ilman että virheellisesti patologisoi heidän suhdemuotoaan. Tulevissa tutkimuksissa olisi hyödyllistä käyttää kattavampia mielenterveyden kliinisiä mittareita, laajentaa edustavuutta eri CNM-yhteisöissä ja tutkia muita psykologisia ja ihmissuhteisiin liittyviä tekijöitä, jotka voivat vaikuttaa hyvinvointiin CNM- ja monogamisissa suhteissa.

Consensual non-monogamy (CNM) refers to relationship arrangements in which individuals mutually agree that they or their partners may engage in sexual and/or romantic relationships with more than one person. CNM can take several forms, including polyamory, where individuals maintain multiple simultaneous romantic relationships; open relationships, in which partners allow sexual involvement outside the primary relationship; and swinging, where couples engage in sexual activity with others, often in social or organized settings. In recent years, CNM has become an increasingly visible relationship practice, challenging dominant cultural norms that assume monogamy as the default or superior relationship structure. Despite common stigmatization and assumptions that CNM relationships are less stable or less satisfying, research has shown that CNM relationships can be equally functional, fulfilling, and emotionally supportive as monogamous relationships. The present study examines whether individuals identifying as CNM report different levels of anxiety or depression symptoms compared to individuals in monogamous relationships, and the extent to which relationship identity contributes to these differences. The study uses data from the MRMS project, consisting of 1178 adults in either monogamous or CNM relationships across several countries, who completed an online survey assessing mental health, demographic characteristics, and relationship-related variables. General Linear Models were used to evaluate how much variance in anxiety and depression scores could be explained by relationship identity. Gender, sexual orientation, employment status, and age were included as confounding variables. The results indicated very small effect sizes and largely non-significant differences in anxiety and depression between monogamous and CNM participants. When confounding variables were included, the effect of relationship identity on mental health outcomes decreased further, suggesting that relationship identity does not meaningfully influence an individual's anxiety or depression levels. These findings highlight the importance of addressing misconceptions surrounding CNM relationships and may help mental health professionals better understand and support CNM clients without pathologizing their relationship structure. Future research would benefit from using more comprehensive clinical measures of mental health, broadening representation across diverse CNM communities, and examining additional psychological and relational factors that may influence well-being within CNM and monogamous relationships.

Key words: Consensual non-monogamy, monogamy, polyamory, open relationship, swinging, anxiety, depression

Contents

1.1 Introduction

Romantic relationships—characterized by intimate, affectionate, and voluntary interactions between two or more partners—are a central context for human connection and emotional fulfillment (Collins et al., 2009). They often play a pivotal role in shaping individuals' identity, well-being, and social status, and offer positive emotional experiences like love, passion, social support, and company (Apostolou et al., 2023).

Throughout human history, a diverse variety of romantic relationship forms have existed (Harris, 2023); yet, Cross & Joo (2023) discuss that traditional definitions of romantic relationships tend to be quite narrow and culturally defined. These influence the societal norms and the way individuals think about relationships and family formation. The western idea of a romantic relationship has for a long time been that of a heteronormative and monogamous relationship with sexual exclusivity. This archetype of a relationship has been represented in public norms, media, and religious traditions (Cross & Joo, 2023). Recently, this standard loosened, and individual partner choices and relationship duration have seen greater emphasis, allowing for more independence on who individuals want to date and for how long (Horowitz et al., 2019). Despite these shifts, governments shape how romantic relationships are societally legitimized through legal recognition via, for example, determining the minimum age for marriage, who can get married, and with whom (Encyclopaedia Britannica, 2025). In many countries, women and sexual minorities also have less marital rights compared to heterosexual, cisgender (Kawas, 2023). These laws shape cultural and societal norms and can restrict people from engaging in relationship practices which may be more ideally suited for them.

Consensual non-monogamy (CNM) is a term for relationships in which individuals consent to engage sexually, romantically, or otherwise intimately with multiple people (Moors et al., n.d.). CNM relationships come in a variety of forms, the most common of which are polyamorous, open, and swinging relationships (Moors et al., 2021). The structure and nature of the relationship may also evolve with time according to changing relationship agreements made by the parties involved (Astle et al., 2024). In North America, it is estimated that about 5-7 % of people are currently in a non-monogamous relationship, and about 20 % of people have ever engaged in some form of ethical non-monogamy (Balzarini & Muise, 2020). Several studies have shown that CNM people are generally as satisfied and have equally as good relationship functioning as monogamous individuals (Scoats & Campbell, 2022). People participating in CNM relationships may find

relational success from for example jealousy regulation, higher independence and need fulfillment. (Wood et al., 2021)

Romantic relationships can also influence an individual's mental health. Studies show that better mental health predicts entry into a romantic relationship (Mastekaasa, 1992), and greater relationship satisfaction correlates with better mental health (Røsand et al., 2012). Conversely, relationship dissatisfaction is associated with poor mental health (Braithwaite & Holt-Lunstad, 2017). Goodness of fit between one's romantic relationship ideals and reality may shape both relationship satisfaction and the person's wellbeing (Buyukcan-Tetik et al., 2017). Therefore, it is important for individuals to form the types of relationships most suitable for them.

1.2 Defining Monogamy and Consensual Non-Monogamy

Monogamy is the practice of a two-partner relationship where they remain sexually and emotionally exclusive to each other (Moors et al., n.d.). This has become the norm in western society (Cross & Joo, 2023). Monogamy varies culturally, however, depending on ecological factors (Cross & Joo, 2023). Lifelong monogamy is also rare, with most people having multiple partners during their lifetime (Conley et al., 2013). Infidelity is also relatively common, and it is the biggest reason for divorce, suggesting that monogamy may not be the ideal relationship identity for many people (Fincham & May, 2017). Still, monogamy is often considered the default relationship identity that should be pursued, causing alternate forms of relationships to be comparatively invisible or stigmatized (Scoats & Campbell, 2022).

In contrast, CNM is defined as a practice where individuals consent to having multiple partners to engage with sexually or romantically (Moors et al., n.d.). The key difference between infidelity and non-monogamy is that partners are aware of each other's extradyadic engagements and provide one another the right to engage sexually and/or romantically with other people (Moors et al., n.d.). As defined by Scoats & Campbell (2022), CNM is an umbrella term that encompasses several distinct relationship structures:

- Open relationships, where partners allow sexual encounters with others outside the primary relationship, typically without additional emotional or romantic bonds.
- Swinging, often characterized by couples engaging in sexual activity with others, usually in organized or social settings.

- Polyamory, which involves having multiple romantic relationships simultaneously with the knowledge and consent of everyone involved. Polyamorous relationships often emphasize emotional intimacy and ongoing connections with multiple partners (Scoats & Campbell, 2022).

CNM relationships are fairly common, with around 5-7 % of the North American population currently involved in one, and around 20% of individuals report having engaged in CNM at some point in their lives (Haupert, Gesselman, et al., 2017; Rubin et al., 2014). Sexual and gender minorities are more likely to engage in CNM; homosexual men are particularly likely to practice CNM, with some studies showing prevalence of over 60% of gay, intimate relationships being open (Barker & Langdridge, 2010). This rate has been critiqued, however, with recent studies showing a prevalence of sexual minorities overall who have experience in CNM ranging from 7-8% up to 45 %, (Haupert, Gesselman, et al., 2017). However, studies consistently show that sexual and gender minorities are more likely to engage in CNM (Haupert et al., 2017).

1.3 Social Stigma of CNM

CNM as a practice is subjected to stigmatization (Conley et al., 2013). Public perception of CNM suggests that individuals participating in it are more likely to have STDs, have higher jealousy and lower relationship and sexual satisfaction (Mahar et al., 2024). Sexual forms of CNM (swinging, open) are evaluated more negatively than emotional forms (polyamory) (Grunt-Mejer & Campbell, 2016; Matsick et al., 2014). Studies have also found that CNM individuals are seen as having fewer secondary emotions than monogamous, suggesting dehumanization (D. Rodrigues et al., 2018). Individuals in monogamous relationships seem to be also regarded with a halo effect, where traits unrelated to relationship orientation are seen as superior, such as intelligence or morality (Conley, et al., 2013).

Some reported forms of experienced stigma include disapproval of CNM relationships, devaluing of relationship and character quality, and being subjected to threatening behavior (Mahar et al., 2024). Many people may not experience stigma this way but may rather suffer from minority stress (Mahar et al., 2024). Frost & Meyer (2023) state that the minority stress theory comes from a hypothesis that minority health suffers from stress faced by minority populations because of their stigmatized

social status. This stress is distinguished from general stress all individuals may experience from its origin in prejudice and stigma (Frost & Meyer, 2023). The minority stress theory is usually regarded as being experienced by sexual and gender minorities, but with these groups being more likely to be CNM and CNM people reporting clear experiences of stigma, the theory can be applicable to CNM individuals as well, even if they are not sexual or gender minorities (Frost & Meyer, 2023)..

So, stigma can be experienced proximately and also through internalization and anticipation of stigma, which can lead to elevated psychological distress (Mahar et al., 2024). This could mean that CNM individuals are more at risk of mental health problems.

1.4 Relationships and Mental Health

The link between romantic relationships and mental health has been widely studied, with evidence suggesting that the quality of intimate relationships is associated with individuals psychological well-being (Braithwaite & Holt-Lundstad, 2017). Mental health issues can mean higher levels of depression and anxiety, leading to problems such as excessive worrying, negative self-image and higher levels of jealousy, fear, sadness and anger (NHS, 2023a; NHS, 2023b;). Good mental health on the other hand can mean lower levels of depression and anxiety, a positive self-image, effective emotional regulation and interpersonal functioning (Fusar-Poli et al., 2020).

With previous research showing that better mental health scores predict a higher likelihood of entering a romantic relationship (Mastekaasa, 1992), and that greater relationship satisfaction is associated with lower levels of mental health problems (Røsand et al., 2012), it seems that romantic relationships have functions that require better mental health and that also improve it. Romantic relationships can support mental health through mechanisms such as emotional support, companionship, and need fulfillment (Feeney & Collins, 2015). Conversely, lower relationship satisfaction has been linked to higher levels of psychological distress, particularly symptoms of depression (Whisman, 2001). This relationship appears to be bidirectional, as both relationship dissatisfaction and depressive symptoms can predict one another over time, and the effect does not seem to differ by gender (Fincham et al., 1997)

Cramer (2000) argues that one of the most important factors in how relationships impact mental health is conflict style. Conflict style means different strategies of responding to interpersonal

disagreements in relationships (Cann et al., 2008). Research shows conflict style itself has a bigger association with relationship distress and mental wellbeing than the amount of conflict. Couples who avoid conflict report higher levels of dissatisfaction, regardless of how often disagreements occur. Unresolved conflict is more associated with distress than conflict per self (Cramer, 2000).

Relationship identity seems to not influence well-being in ways people assume they do. While monogamous relationships are presumed to be more emotionally fulfilling and healthier, research shows that people in CNM relationships report similar levels of relationship satisfaction and sexual fulfillment as those in monogamous relationships (Rubel & Bogaert, 2015). Possible differences in mental health could be due to stigma surrounding CNM rather than the relationship orientation itself. Stigma and social disapproval can lead to stress, concealment of one's relationship style, and reduced social support, all of which are known risk factors for poorer mental health (D. L. Rodrigues et al., 2024). With sexual and gender minorities being more likely to engage in CNM and these groups showing more psychological distress, it could also play a factor in CNM relationships showing more mental health issues (Källström et al., 2022)

The research in this area is lacking, with only a few studies investigating the effect of CNM engagement on mental health, so the known effects are hazy at best. The research surrounding CNM individuals and mental health seems to point towards little to no differences in scores of depression or anxiety tests compared to monogamous individuals (Rubel & Bogaert, 2015). Some studies have shown that CNM individuals have higher levels of psychological distress however (Borgogna et al., 2024).

1.5 Motivations behind CNM practice

Individuals may choose to engage in CNM for a variety of reasons. Ryan and Deci (2013) explain that the self-determination theory posits that people have innate psychological needs that must be satisfied in order to foster healthy functioning and growth. The three basic psychological needs are autonomy, competence and relatedness. These psychological needs are considered universal. The three types of motivation are amotivation, intrinsic and extrinsic motivation. These three motivation types are in a continuum (Ryan & Deci, 2023). Sexual motivation has become the subject of increased attention in relationship and sexuality literature. Moskovitz (2024) argues that sexual motives can be placed in a continuum. Intrinsic motivations for sex are enjoyment and intimacy and

increase sexual and relational happiness. Extrinsic motivations, for example because of guilt or for a reward may decrease sexual and relational happiness. Amotivational sex is when a person does not want to have sex but does so because they feel pressured (Moskowitz, 2024). CNM individuals have reported similar reasons for sex with monogamous individuals, though CNM individuals are more likely to report reasons for their own pleasure, suggesting higher intrinsic motivation (Wood et al., 2018).

CNM may offer individuals more freedom in expressing their sexuality, ideologies and personality. Wood et al. (2021) studied motivations for engaging in CNM relationships. Most commonly reported reasons are emotional, sexual and social need fulfillment through multiple partners. Autonomy and personal growth are also important. These offer the opportunity to refrain from norms and allow for freedom and security for CNM individuals. Connection and relationship enhancement can also motivate individuals to engage. Some individuals felt sex outside the primary relationship made the sex and intimacy inside them more exciting. Many find sexual and emotional variety important. Swinging and polyamorous individuals may want to seek experiences that their primary partner cannot offer. Personality and attachment style seems to play a role also, with CNM individuals more likely to be less avoidant or anxiously attached, higher in openness and lower in conscientiousness (Wood et al., 2021).

Individuals may also be drawn to CNM because they are often based on valuing transparency, communication and alternative strategies to combat negative feelings such as jealousy. CNM relationships often include frequent open negotiation and agreement about needs, boundaries and desires (Cardoso et al., 2021). Some individuals are drawn to CNM for ideological or political reasons. They can find interest in challenging heteronormative relationship standards as the natural default (Wood et al., 2021). CNM can also provide friendship and community (Codrington & du Plooy, 2024).

On the other hand, there are also barriers and concerns that can discourage individuals from engaging in CNM. Jealousy can be a big challenge. Studies have shown that even though CNM individuals have more strategies to combat feelings of jealousy, for example compersion, the feeling of happiness for a partners relationship with other people (Flicker et al., 2022), that jealousy can still be a struggle, it just changes its shape depending on the context (Mogilski et al., 2019). Codrington & Du Plooy (2024) note that another challenge can be partner differences. The desire to engage in CNM can be different in partners and it can cause rifts. Maintaining multiple relationships is also time consuming and emotionally taxing, which can cause issues (Codrington & du Plooy, 2024). The social stigma attributed to CNM can also discourage individuals from

engaging in it (Conley et al., 2013). This stigma can result in discrimination or strained family and workplace relationships, adding stress to individuals who are otherwise in healthy partnerships (Mahar et al., 2024).

Finally, legal and institutional frameworks generally favor monogamous partnerships (The Editors of Encyclopaedia Britannica, 2025). CNM relationships may lack access to legal recognition, healthcare decision-making rights, or parental protections, which can make them more vulnerable in certain life situations (Mahar et al., 2024).

1.6 Potential Confounders

When discussing mental health issues like anxiety and depression, multiple factors have been identified to play a part in peoples wellbeing (Blanco et al., 2014; Choi et al., 2020). When conducting statistical analysis, multiple confounding factors must be considered to measure mental health scores as accurately as possible. Several demographic and relational factors have been identified in prior literature as relevant confounders in studies of CNM and monogamous relationships (Rubel & Bogaert, 2015).

Age can play a significant role. Older individuals are more likely to report longer lasting relationships, better relationship satisfaction and lower mental health issues than younger individuals (Bühler et al., 2021). Younger individuals are also more likely to engage in CNM relationships (Borgogna et al., 2024). If unaccounted for, these age-related differences could skew results unfavorably.

Gender is another factor that can confound results. Gender minorities are more likely to engage in CNM (Scoats & Campbell, 2022). Gender minorities also suffer from more mental health problems, meaning controlling this factor is vitally important for more accurate results. This is also true for sexual minorities (Rothblum, 2020). This means that CNM individuals could be more likely to suffer from minority stress, which has been shown to influence mental health negatively (Frost & Meyer, 2023). Intersectionally this could lead to compounding negative factors, where different stressors add up to cause more anxiety and depression (Veldhuis et al., 2025).

Another relevant factor to consider is employment status. Unemployment is known to be associated with mental health problems (Paul & Moser, 2009). It is not known whether CNM individuals are

more or less likely to be employed, but minority status does predict lower job satisfaction, higher prevalence of workplace bullying and poorer health outcomes, so controlling this could be important (Lee et al., 2019).

1.7. Current Study

Some research has shown CNM individuals to be more likely to suffer from depression (Borgogna et al., 2024) whereas some research seems to point to there not being a clear association (Rubel & Bogaert, 2015). CNM relationships are a newer area of interest in research so clear associations cannot be made accurately. Individual anxiety and depression are affected by multiple factors, so relationship satisfaction alone is not accurate enough to make associations (Blanco et al., 2014; Choi et al., 2020). This is why seeking confounding factors and including them in statistical analyses is vital to get results as accurately as possible. I am also testing different methods of measuring depression and anxiety to see whether there are differences based on how depression and anxiety questionnaires are conceptualized. There is evidence that different screening tools for anxiety and depression measure different concepts of anxiety and depression (Faravelli et al., 1986; Wall & Lee, 2021), which could lead to differences in scores of anxiety and depression in the same population. This thesis aims to determine whether individuals in CNM relationships have higher levels of anxiety and depression compared to monogamous individuals.

The data for this study were drawn from the Multiple Relationships Project (Mogilski et al., under review), an international collaborative effort conducted between 2019 and 2023 to examine how individuals maintain multiple concurrent intimate relationships. Because CNM individuals are more likely to belong to sexual minority groups, who may suffer from minority stress, and be subjected to mononormative stigma, and some research showing CNM individuals to be more likely to suffer from depression and anxiety issues (Borgogna et al., 2024), I formed the following research questions:

1. Are there differences in anxiety and depression symptoms between individuals identifying as monogamous and CNM?

Hypothesis 1: Individuals identifying as CNM will report higher levels of anxiety and depression compared to individuals identifying as monogamous.

Because depression and anxiety symptoms are associated with a multitude of factors (Fusar-Poli et al., 2020), the following research question was formed:

2. Does relationship identity remain associated with anxiety and depression symptoms when controlling for age, gender, sexual orientation, and employment status?

Hypothesis 2: The association between relationship identity and mental health will decrease or become non-significant when demographic confounders are controlled for.

Because the effects of minority stress can stack and affect individuals intersectionally (Veldhuis et al., 2025), the study asks:

3. Is the association between relationship identity and mental health moderated by age, gender, sexual orientation or employment status?

Hypothesis 3: The relationship between relationship identity and depression and anxiety symptoms will vary across demographic groups, particularly among gender and sexual minorities.

Finally, because different forms of CNM may be subjected to more stigma than others (Grunt-Mejer & Campbell, 2016), the following research question was formed:

4. Do specific relationship identity subtypes differ from monogamous individuals in anxiety and depression symptoms?

Hypothesis 4: Different CNM subtypes will show different levels of anxiety and depression symptoms, with more stigma-associated forms (e.g., open relationships) reporting higher levels of anxiety and depression.

This thesis used AI model ChatGPT 5.0 for assistance with language refinement and structuring written text.

2. Methods

2.1 Data collection

The data was collected in 6 countries as part of the Multiple Relationships Maintenance Scale project (Mogilski et al., in review.)) using Qualtrics survey software, except for the Finnish survey, which was administered via REDCap. The original survey was developed in English and then translated with researcher, professional translator, and lay person input. The surveys included items related to participants' background information, the Multiple Relationships Maintenance Scale (MRMS), and measures related multiple dimensions of health and wellbeing. The survey was promoted via 1) social media advertisement on Facebook, Instagram, and Twitter/X; 2) snowball sampling via project members' personal networks (e.g., undergraduate research participant pools, email listservs, personal social media accounts); and 3) posts to social media websites frequented by people in CNM relationships (e.g., CNM-focused Facebook groups, the r/polyamory and r/swingers sub-Reddits). 1178 individuals participated in the online surveys.

2.2 Anxiety and Depression measures

This study utilized three dependent variables, each measuring participants' mental health. Their mental health was assessed using two psychological instruments: the DSM-5-TR self-rated level 1 cross-cutting symptom measure for adults (Mahoney et al., 2020*;* 23 items) and the General Health Questionnaire ((Goldberg & Hillier, 1979; 12 items). Subscales of these instruments were used to create variables measuring the anxiety and depression symptoms of participants. The DSM-5-TR is a self-reported questionnaire that measures 13 domains of psychopathology, including depression (2 items) and anxiety symptoms (3 items) separately (Mahoney et al., 2020).

The DSM-5 depression and anxiety are made up of the following items, assessed on a Likert scale (0-4 points; 0 = no symptoms, 4 = highest level of symptoms): "During the past TWO (2) WEEKS, how much (or how often) have you been bothered by the following problems?"

For DSM-5 depression:

- “Little interest or pleasure in doing things?”
- “Feeling down, depressed, or hopeless?”

For DSM-5 anxiety:

- “Feeling nervous, anxious, frightened, worried, or on edge?”
- “Feeling panic or being frightened?”
- “Avoiding situations that make you anxious?”

A variable representing each of these subscales (DSM5-D and DSM5-A) was created from the average score of their respective items.

The GHQ is widely used for screening psychopathological morbidity, and factorial analysis of the GHQ supports the use of a 4-item subscale measuring anxiety and depression (Gao et al., 2004). The following Likert scale (1-4 points; 1 = no symptoms, 4 = highest level of symptoms) items were combined into a single variable measuring symptoms of depression or anxiety:

Following the example from Gao et al. (2004),I used the following GHQ items to create a combined measure of depression and anxiety:

- Have you recently lost sleep over worry?
- Have you recently felt constantly under strain?
- Have you recently felt you couldn't overcome your difficulties?
- Have you recently been able to enjoy your normal day-to-day activities?

I created a “GHQ-DA” variable from the average score of the above items.

The internal consistency of the items was tested to ensure the reliability and suitability of the variables for analysis. The internal consistency of the scales was assessed using Cronbach’s alpha. The DSM-5 Depression scale demonstrated good reliability (N = 810, Cronbach’s $\alpha = .83$). The DSM-5 Anxiety scale showed good internal consistency (N = 810, Cronbach’s $\alpha = .80$). The General Health Questionnaire (GHQ) subscale measuring depression and anxiety showed acceptable reliability (N = 810, Cronbach’s $\alpha = .71$). The DSM-5 variables are used to test specific symptoms of depression and anxiety, whereas the GHQ-DA variable is used to measure more general psychological well-being.

2.3 Relationship identity measure

The independent variable in this analysis was relationship identity, consisting of four categories (i.e. subtypes), asked by: “Which relationship orientation do you identify with the most?”, The categories were: monogamous, polyamorous, open relationship and swinging.

To study the difference between monogamy and the three types of consensual non-monogamy, these three categories were combined into one, creating a dichotomous relationship identity variable (N_{CNM}= 501). In this study, participants were not required to be in a current relationship, but only state which relationship type they either were in or most identified with.

2.4 Participant characteristics

After creating the mental health variables, the data was cleaned for missing values. Only participants who had provided complete responses to all items used in the analysis were included in the analytical sample. This resulted in participants being from 4 different countries, despite people from 6 countries answering the survey. The items used were “DSM-5-D”, “DSM5-A”, “GHQ-DA”, “age”, “gender”, “sexual orientation”, “employment status” and “dataset country”. The resulting sample size for this study was N=810.

The following variables were selected from the dataset to control for variation in depression and anxiety symptoms: age (years 18-100), gender (“what most accurately describes your current gender?”), sexual orientation (“how do identify your sexual orientation”), and employment status (“do you currently have paid employment?”). The nationality of participants was also asked but was not used to control results. The descriptive characteristics of the participants are shown in tables 1 and 2.

AI model chatGPT 5.0 was used to form APA-style tables from SPSS results.

Table 1. Participant characteristics for categorical variables.

	Monogamous		CNM								Full Sample	
			Total CNM		Polyamorous		Open relationship		Swinging			
Characteristics	*n*	%	*n*	%	n	*%*	*n*	*%*	*n*	*%*	*n*	%
Gender												
Male	101	32.7	139	27.7	78	22.2	37	32.4	24	68.6	240	29.6
Female	194	62.8	260	51.9	185	52.6	68	59.6	7	20.0	454	56.0
Other*	14	4.5	102	20.4	89	25.3	9	7.8	4	11.4	116	14.3
Sexual orientation												
Heterosexual	201	65.0	146	29.1	88	25.0	40	35.1	18	51.4	347	42.8
Other**	108	35.0	355	70.9	264	75.0	74	64.9	17	48.6	463	57.2
Employment Status												
Employed	190	61.5	380	75.8	265	75.3	86	75.4	29	82.9	570	70.4
Unemployed	119	38.5	121	24.2	87	24.7	28	24.6	6	17.1	240	29.6
Dataset Country												
U.S.	69	22.3	87	17.4	52	14.8	18	15.8	17	48.6	156	19.3
Portugal	2	0.6	0	0	0	0.0	0	0	0	0	2	0.2
Italy	73	23.6	113	22.6	77	21.9	28	24.6	8	22.9	186	23.0
Finland	165	53.4	301	60.1	223	63.4	68	59.6	10	10	466	57.5
Total	309	100	501	100	352	100	114	100	35	100	810	100

*= The “Other” gender includes transgender, non-binary, genderqueer, agender, genderfluid and other

**= The “Other” sexual orientation Includes homosexual, bisexual, pansexual, asexual, queer, fluid, don’t know and other

Table 2. Participant characteristics for continuous variables. (M, (SD))

Variable	Monogamous (N= 309)	CNM (N=501)				Total (N = 810)	Min–Max
		Total CNM	Polyamorous (N=352)	OR* (N=114)	Swinging M (N= 35)		
Depression (DSM-5)	1.44 (1.09)	1.27 (1.05)	1.32 (1.06)	1.24 (0.97)	0.87 (1.17)	1.33 (1.07)	0–5
Anxiety (DSM-5)	1.27 (0.95)	1.20 (0.98)	1.24 (0.98)	1.23 (0.96)	0.80 (0.90)	1.23 (0.97)	0–4
GHQ-DA	2.33 (0.57)	2.35 (0.56)	2.32 (0.54)	2.35 (0.56)	2.63 (0.61)	2.34 (0.56)	1–4
Age (years)	31.83 (12.16)	36.86 (11.54)	35.30 (10.76)	34.68 (9.18)	40.60 (13.80)	34.70 (11.72)	18–79

*=Open Relationship

2.4 Statistical analysis

The data was analyzed using the IBM SPSS Statistics (v. 29) software package. I ran descriptive statistics for all dependent and control variables across different relationship identities. A set of General Linear Models (GLM) were used to examine whether relationship identity (monogamous vs. CNM) was associated with depression and anxiety symptoms as measured by the DSM-5 and the GHQ, as stated in the research questions.

Before conducting the GLM, I checked that the data met the assumptions of GLM. Four separate GLMs were created: the first model included only dependent variables and relationship identity to test the main effects between monogamous and CNM individuals; the second model added covariates employment, age, gender, and sexual orientation, to test the model with controls; the third model included interaction terms between relationship identity and age, gender, and sexual orientation respectively; and finally, the fourth model tested specific relationship identity subtype differences, with covariates included in the model.

3.Results

3.1 Testing assumptions for the use of GLM

To assess multicollinearity between the independent variables, Pearson correlations were examined for the continuous and dichotomous variables. No correlations exceed r = .80 (table 3). For the gender variable which contains three categories, one-way ANOVAs with η^2 effect sizes were calculated. A significant difference between gender groups was observed in anxiety symptoms ($p < .001$, $\eta^2 = .042$), while no significant difference was found in general mental health scores (GHQ; $p = .202$). Gender groups also differed significantly in age ($p < .001$, $\eta^2 = .064$), sexual orientation ($p < .001$, $\eta^2 = .153$), and relationship orientation ($p < .001$, $\eta^2 = .017$). VIF values were calculated and all values ranged from 1.05 to 1.28. These results suggest that there are no major concerns for multicollinearity. Levene's tests were conducted to assess the assumption of homogeneity of variances for the dependent variables. The results indicated that the assumption was met for DSM-5-depression symptoms, $F(3, 806) = 1.23$, $p = .297$; anxiety symptoms, $F(3, 806) = 0.70$, $p = .551$; and GHQ symptoms, $F(3, 806) = 0.66$, $p = .579$. Therefore, the assumption of homoscedasticity was not violated. Standardized residuals were tested for normal distributions using Kolmogorov-smirnovs test (Table 4). Histograms were also made to assess normality (Figure 1). Despite the statistical significance (likely due to large sample size), histograms suggest that the residuals approximate normal distributions reasonably well. There are no major skewness or kurtosis issues visually. Although the Shapiro–Wilk and Kolmogorov–Smirnov tests indicate deviations from normality, visual inspection of the histograms suggests that the residuals are approximately normally distributed, supporting the assumption of normality for GLM procedures, especially considering the robustness of GLM to moderate deviations from normality in large sample

Table 3. Pearson correlations between continuous and dichotomous variables

Variable	DSM-5-D	DSM-5-A	GHQ-DA	Age	RI	ES	SO
1. DSM-5-D	—						
2. DSM-5-A	.68*	—					
3. GHQ-DA	-.38*	-.28*	—				
4. Age	-.24*	-.30*	.02	—			
5. Relationship identity (RI)	.11	.07	-.07	-.16	—		
6. Employment status (ES)	.07	.13	-.04	-.18*	.14	—	
7. Sexual orientation (SO)	.04	.01	-.05	-.08	-.20*	.03	—

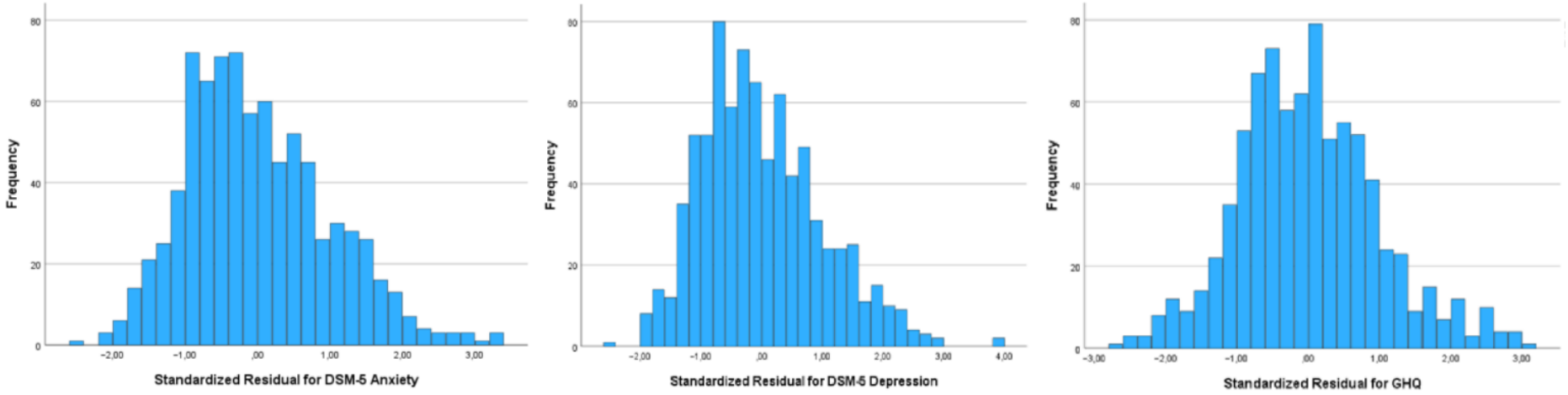
*= $r < .05$

Table 4. Kolmogorov-Smirnovs tests for standardized residuals.

Dependent Variable	Statistic	df	*p*
DSM-5 Depression	.076	810	< .01*
DSM-5 Anxiety	.062	810	< .01*
GHQ Anxiety/Depression	.041	810	< .01*

*$p < .05$

Figure 1. Histograms of standardized residuals



3.2 Model 1

Model 1 was formed to answer the first research question; Are there differences in anxiety and depression symptoms between individuals identifying as monogamous and CNM? The results are shown in Table 5. Relationship identity was significantly associated with variation in the DSM-5-D scores. However, the effect size was very small. Associations were nonsignificant for the GHQ and DSM-5 Anxiety measures. The model explained only a negligible portion of variance in each scale.

Table 5. Model 1: Between-Subjects Effects of Relationship Identity (Monogamous vs. CNM) on Depression and Anxiety Symptoms

Dependent Variable	F	*p*	Partial η^2
DSM-5-D	4.50	.03*	.01
DSM-5-A	0.75	.39	< .01
GHQ-DA	0.26	.61	.000

* $p < .05$

DSM-5-D adjusted $R^2 = .004$

DSM-5-A adjusted $R^2 = .000$

GHQ-DA adjusted $R^2 = -.001$

3.3 Model 2

Model 2 was formed to test the second research question; Does relationship identity remain associated with anxiety or depression symptoms when controlling for age, gender, sexual orientation and employment status? The results of the main effects are shown in Table 6. Relationship identity was not significantly associated with depression and anxiety symptoms across any of the three measures. Employment status, age, and gender were significantly associated with variation in scores on the DSM-5-A scale. Age was significantly associated with variation in scores on the DSM-5-D scale. The variance explained by Model 2 was small, indicating other unmeasured variables may play a larger role.

Table 6. Model 2: Between-Subjects Effects on depression and anxiety symptoms predicted by relationship identity and confounding variables

Independent Variable	Dependent Variable	F	*p*	Partial η^2
	DSM-5-D	3.03	.08	< .04
Monogamous vs CNM	GHQ-DA	1.19	.28	< .01
	DSM-5-A	0.00	.98	.00
	DSM-5-D	0.06	.81	.00
Sexual Orientation	GHQ-DA	0.11	.74	.00
	DSM-5-A	0.70	.41	< .01
	DSM-5-D	0.31	.58	.00
Employment Status	GHQ-DA	0.69	.41	<.01
	DSM-5-A	4.92	.03*	<.01
	DSM-5-D	2.08	.13	<.01
Gender	GHQ-DA	0.82	.44	<.01
	DSM-5-A	7.08	<.01*	.02
	DSM-5-D	31.20	<.01*	.04
Age	GHQ-DA	0.04	.84	.00
	DSM-5-A	49.79	<.01*	.06

* $p < .05$

DSM-5-D adjusted $R^2 = .06$

DSM-5-A adjusted $R^2 = .11$

GHQ-DA adjusted $R^2 < -.01$

3.4 Model 3

Model 3 was formed to test the third research question; Is the association between relationship identity moderated by age, gender or sexual orientation? The results of are shown in Table 7. Relationship identity was again not found to be significantly associated with variance in scores on anxiety and depression symptoms across any of the three measures. One small, significant interaction effect emerged between relationship identity and gender, suggesting gender-dependent variance in monogamous and CNM individuals' anxiety/depression scores as measured by the GHQ-DA. Again, the explained variance in this model was very small. To further analyze the significant interaction, the effects were plotted (Figure 2), and a simple effects analysis was run (Table 8). The plot shows a large difference in mean GHQ-DA scores among monogamous versus CNM "other" gender category, suggesting that monogamous individuals identifying with one of the "other" gender categories score higher in anxiety and depression symptoms than their CNM counterparts. The post-hoc general linear model showed that, while the effect varied significantly by gender, the associations between monogamous versus CNM relationship identity and GHQ-DA scores were still not significant for men, women, nor other gender identities.

Table 7. Model 3: Between-subjects effects on depression and anxiety symptoms predicted by relationship identity, confounding variables, and interaction terms

Independent Variable	Dependent Variable	F(df)	*p*	Partial η^2
RI	DSM-5-D	1.83 (1, 802)	.18	.00
	GHQ	3.40 (1, 802)	.07	.00
	DSM-5-A	0.80 (1, 802)	.37	.00
SO	DSM-5-D	1.10 (2, 802)	.30	.00
	GHQ	2.80 (2, 802)	.10	.00
	DSM-5-A	0.13 (2, 802)	.72	.00
Employment Status	DSM-5-D	0.33 (1, 802)	.56	.00
	GHQ	0.69 (1, 802)	.41	.00
	DSM-5-A	4.41 (1, 802)	.04*	.01
Gender	DSM-5-D	0.11 (2, 802)	.90	.00
	GHQ	0.72 (2, 802)	.49	.00
	DSM-5-A	3.47 (2, 802)	.03*	.01
Age	DSM-5-D	29.21 (1, 802)	<.01*	.04
	GHQ	0.17 (1, 802)	.68	.00
	DSM-5-A	48.72 (1, 802)	<.01*	.06
RI x SO	DSM-5-D	0.01 (2, 802)	.91	.00
	GHQ	2.88 (2, 802)	.09	.00
	DSM-5-A	0.39 (2, 802)	.53	.00
RI × Age	DSM-5-D	2.68 (1, 802)	.10	.00
	GHQ	2.49 (1, 802)	.12	.00
	DSM-5-A	0.20 (1, 802)	.65	.00
RI × Gender	DSM-5-D	1.08 (2, 802)	.34	.00
	GHQ	3.36 (2, 802)	.04*	.01
	DSM-5-A	1.39 (2, 802)	.25	.00

*p <.05.

DSM-5-D adjusted R^2 = .06

DSM-5-A adjusted R^2 = .11

GHQ-DA adjusted R^2 = .008

RI = Relationship Identity

SO = sexual orientation

Table 8. Simple effects scores of interaction effect between gender and relationship identity on GHQ-DA results

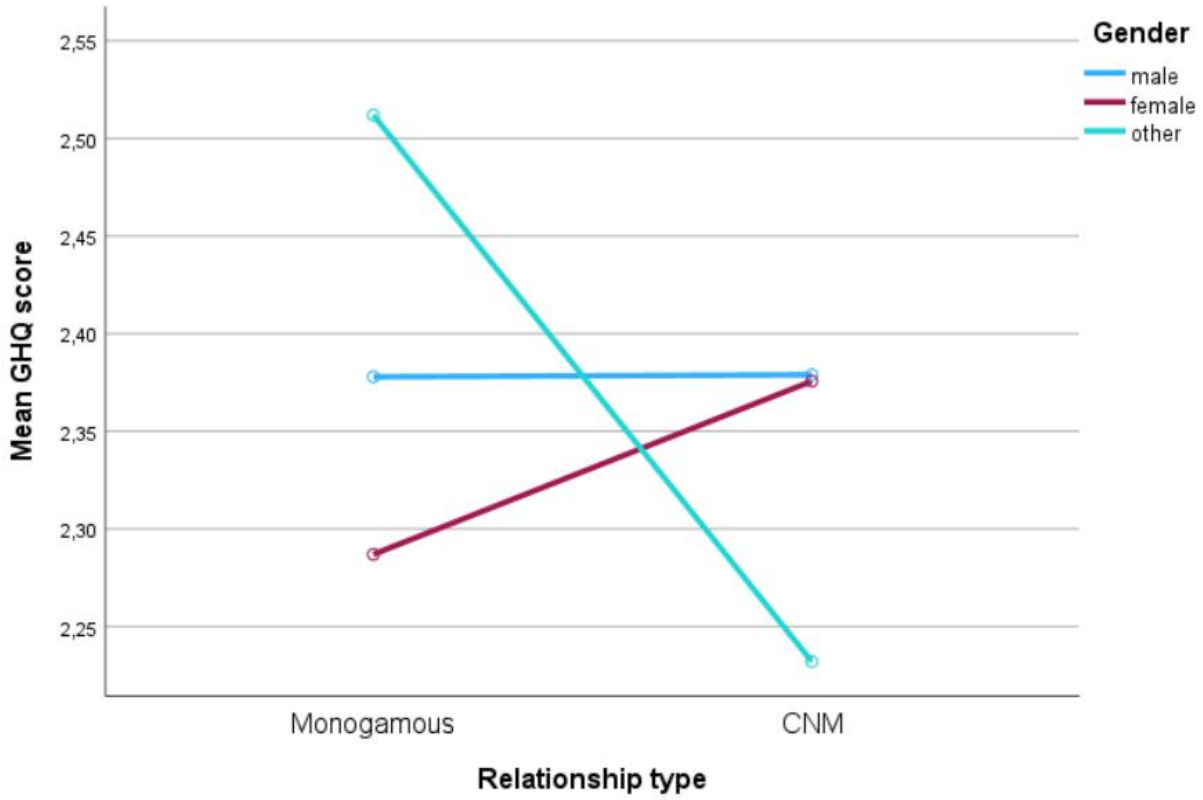
Gender	Relationship Identity	N	M	SD	F	*p*	η^2_p
Male	Monogamous	101	2.38	0.67			
					0.000	.99	.00
	CNM	139	2.38	0.57			
Female	Monogamous	194	2.29	0.51			
					3.27	.07	< .01
	CNM	260	2.38	0.52			
Other	Monogamous	14	2.51	0.52			
					2.85	.09	.02
	Non-monogamous	102	2.23	0.59			

Male adjusted R^2 = .06

Female adjusted R^2 = .11

Other adjusted R^2 < -.01

Figure 2. Plotted interaction effect between relationship identity and gender in predicting GHQ scores.



3.5 Model 4

Finally, model 2 was formed to test the fourth research question; Do specific relationship identity subtypes differ from monogamous individuals in anxiety and depression symptoms? The results are shown in Table 9. DSM-5 scores did not vary significantly by relationship identity subtype. A small effect was found by relationship identity subtype in the GHQ_DA measure, indicating that anxiety/depression scores as measured by the GHQ-DA varied by relationship identity with a small effect size. Bonferroni corrected post-hoc tests were run to further analyze the direction of these results, shown in Table 10. The only significant difference between relationship identity subtypes emerged among swingers and monogamous individuals; swingers had significantly higher GHQ-DA scores suggesting higher levels of anxiety and depression on average compared to monogamous individuals.

Table 9. Model 4: Between-subject effects on depression and anxiety symptoms predicted by relationship identity and confounding variables

Independent Variable	Dependent Variable	F	*p*	Partial η^2
Relationship Identity	DSM-5 Depression	1.81	.15	.01
	DSM-5 Anxiety	0.52	.67	.00
	GHQ Anxiety/Depression	3.12	.03*	.01
Gender	DSM-5 Depression	1.73	.18	.00
	DSM-5 Anxiety	6.39	.00*	.02
	GHQ Anxiety/Depression	0.58	.56	.00
Sexual Orientation	DSM-5 Depression	0.44	.64	.00
	DSM-5 Anxiety	0.30	.74	.00
	GHQ Anxiety/Depression	0.62	.54	.00
Employment	DSM-5 Depression	0.31	.58	.00
	DSM-5 Anxiety	4.84	.03*	.01
	GHQ Anxiety/Depression	0.66	.42	.00
Age	DSM-5 Depression	30.71	<.01*	.04
	DSM-5 Anxiety	48.72	<.01*	.06
	GHQ Anxiety/Depression	0.10	.76	.00

*= $p < .05$

DSM-5-D adjusted $R^2 = .06$

DSM-5-A adjusted $R^2 = .10$

GHQ adjusted $R^2 = .009$

Table 10. Differences between mean scores of GHQ by relationship identity subtype.

Relationship Identity	M (SE)	95% CI	SE	*p* (Bonf.)	95% CI of Difference
Monogamous (reference group)	2.299 (.04)	[2.23, 2.37]	—	—	—
Polyamorous	2.326 (.03)	[2.26, 2.39]	.05	1.000	[-0.10, 0.16]
Open relationship	2.341 (.06)	[2.23, 2.45]	.06	1.000	[-0.12, 0.21]
Swinging	2.61 (1.0)	[2.42, 2.80]	.10	.01*	[0.04, 0.58]

*= $p < .05$

4. Discussion

This study examined the associations between relationship identity and symptoms of depression and anxiety. Based on previous research and theories around it, I hypothesized that CNM individuals would report higher levels of depression and anxiety compared to monogamous individuals. I also hypothesized that this association would be moderated by variables age, gender, employment status and sexual orientation, and controlling for this variance would decrease the association between relationship identity and depression and anxiety symptoms. I also hypothesized that different subtypes of CNM would report different levels of depression and anxiety. According to the results, depression and anxiety scores are not significantly different between individuals across relationship identities, when controlling confounding variables. The effect sizes are also very small, suggesting that relationship identity does not play a big role in an individual's mental health. The scale used to measure anxiety and depression did not matter either, so differences in how depression and anxiety were quantified did not influence the results in a meaningful way. This is why the hypotheses formed for this thesis are disqualified.

4.1. Main results

CNM individuals did not significantly differ from monogamous individuals in depressive or anxiety symptom scores. Some significant p-values were found, but the effect sizes in these measures were very small, and when controlling for confounding variables, these associations disappeared. This finding aligns with previous studies showing that CNM is not inherently associated with poorer mental health outcomes (Rubel & Bogaert, 2015). In line with self-determination theory (Ryan & Deci, 2023), CNM may support psychological needs for individuals through autonomy, competence and relatedness across multiple partners (Wood et al., 2021). These findings contrast with the stigma-based assumption that CNM relationships are psychologically harmful (Conley et al., 2013). In fact, because CNM individuals are more likely to suffer from minority stress (Frost & Meyer, 2023), it could mean that their relationship orientation actually increased their mental health. In this dataset, of the 116 participants identifying as a gender minority, only 14 were in a monogamous relationship. So CNM individuals were much more likely to belong to a minority group. However, because of the way participants were recruited for this experiment, it could be that only CNM individuals who were content in their relationship saw the quiz and wanted to answer. This dataset did not specifically ask participants about their willingness to be in a CNM relationship, so perhaps

this is a direction to take future studies in this field. It is important for healthcare professionals to understand the mechanisms and outcomes of CNM relationships. It has been shown that CNM individuals can face stigma in healthcare services, which can lead to worse outcomes in care, and unwillingness to seek help from healthcare (Vaughan et al., 2019). Knowing that CNM as a practice does not necessarily lead to worse relational or mental health outcomes helps professionals to better service CNM individuals in need.

4.2. Role of confounding factors

Because the results were non-significant, the role of confounding factors were left somewhat irrelevant for this study. Still, some minor effects were found that were further tested for. Some small findings were found, particularly in the interaction effects tested to see differences in specific genders and relationship identities. These, however, were too small to detect meaningful differences, particularly with the small group size of monogamous gender minorities. However, for future studies it can be important to note how they influenced results. When adding confounding factors into the models, the small results found disappeared. Also in the models, age, gender and employment status were found to be significantly associated with at least some mental health measures. The adjusted r squares remained fairly small throughout the models, so they did not explain accurately enough the variance that influences an individual's mental health. In future studies, it could be worth adding even more factors known to affect mental health into the models to get a more accurate picture of different factors, such as attachment style, relationship satisfaction, and trauma. CNM individuals have been reported to less likely have avoidant attachment styles, and more likely to have suffered sexual abuse (Borgogna et al., 2024; Ka et al. 2022). Adding these factors could make the findings more accurate, which can influence findings where these factors haven't been controlled. Another interesting factor worth considering is willingness to participate in CNM. If an individual is not motivated to be in the type of relationship they are, whether that be monogamous or CNM, it could negatively impact their mental well-being. Evidence from interviews has suggested that if an individual participates in CNM because of their partner, it could mean worse relational outcomes (Codrington & du Plooy, 2024), but no studies have been made to test this specifically.

4.3 Strengths, limitations and future directions

A notable strength in this study is the number of variables collected to control anxiety and depression scores. Past studies haven't always controlled confounding variables, so adding them in brings up the accuracy of the results. This study also utilized a large sample size, and it also included a large amount of gender minorities, which is usually difficult to obtain. No doubt this was due to the convenience sampling utilized in data collection. This improves the generalizability of the results, with the study having about an equal number of men, women and gender minorities, reducing bias toward any single group and allowing for more reliable comparisons across gender categories. The study also utilized scientifically validated measures that showed at least acceptable internal consistency in this sample. This study provides valuable information to an area of research that is still only emerging. The statistical methods used were strong, and did not rely on p-values only, and showed the variance that plays in an individuals mental wellbeing. These statistical methods also met the assumptions set to use them, making them more robust and reliable.

Despite its contributions, this study has several limitations. First, the cross-sectional design limits the ability to draw causal inferences, and the self-selected nature of CNM participants may have introduced selection bias. This study may be subject to selection bias, as individuals with more positive experiences of CNM may be more inclined to participate and thereby contribute disproportionately favorable accounts. This potential bias may be further amplified by the recruitment of participants from CNM-positive communities, such as r/polyamory, where individuals with similar perspectives are more likely to congregate. At the same time, it is also possible that individuals with more negative experiences may be motivated to participate in order to express dissatisfaction or "vent" about the challenges they have encountered. Therefore, the direction of this potential bias is not necessarily unidirectional, and both positive and negative experiences may be overrepresented in the sample. Second, reliance on self-report measures could be influenced by social desirability or varying levels of comfort in disclosing sensitive information, particularly among participants in stigmatized CNM relationships. Third, although several confounding variables were statistically controlled, unmeasured factors, such as relationship satisfaction or attachment style may still have affected the results. Additionally, the mental well-being variables used in this study were derived from a limited number of items. While these variables demonstrated acceptable internal consistency and have been supported by factorial validation, they may not have captured the full range of depressive and anxiety symptoms. This

limitation is especially relevant for the GHQ, which measures both depression and anxiety with only four items in total. Such constraints could partly explain the relatively low explanatory power of the models. Future research could improve measurement precision by employing established, comprehensive instruments such as the Beck Depression Inventory (BDI) and the Generalized Anxiety Disorder scale (GAD-7), which assess depression and anxiety separately (Upton, 2020; Williams, 2014)

This area of research is young, and more studies are needed to fully grasp all the dimensions that influence the mental health of CNM individuals and also to see if today's monogamous relationship standards are really the ideal way to practice romantic relationships. Longitudinal study designs would help clarify causal relationships between relationship identity and mental well-being, allowing us to see how these associations evolve over time. Recruitment strategies that reach a larger range of CNM individuals would also be valuable. Online recruitment and convenience sampling work well to gather more data, but they might lack in the samples representativeness. Using larger and more in-depth measures of mental health such as BDI and GAD-7, would bring more accuracy in measuring all the dimensions of depression and anxiety. Adding more factors to control mental well-being such as attachment style, sexual and relational satisfaction and jealousy management style may help explain underlying mechanisms and account for confounding effects. Cross-cultural studies are also needed to examine whether the observed patterns are similar across different social, cultural and legal contexts. Cultural context could moderate the associations between relationship identity and mental well-being because of the ways people perceive CNM across different cultures, affecting stigma, jealousy management and emotional intimacy.

Considering the ethics of this thesis, a few points must be addressed. First, the sensitive topics that were addressed in this thesis, anonymity, clear information about data collection and the ability to stop any time the participants wished to were ensured. This is necessary so participants can be as comfortable as possible to answer sensitive questions about their relationships and mental health. Second, when doing research that covers stigmatized minority groups, it is important to make sure not to pathologize their behaviors or contribute to negative stereotypes these groups are affected by (Grunt-Mejer & Campbell, 2016). Finally, because minority groups are subjected to multiple stressors, it is important to not draw conclusions about relationship identities and anxiety and depression and recognize the multitude of factors contributing to these issues in minority groups, especially with the large number of minorities in this sample.

4.4 Conclusions

Consensual non-monogamy has been around for much longer than people might think (Harris, 2023). Today's heteronormative idea of monogamous relationship identity has been established fairly recently, and is supported by cultural, societal and legal constructions (Encyclopaedia Britannica, 2025). CNM is a relationship identity that carries lots of stigma with it (Conley et al., 2013), so researching its mechanisms, benefits, challenges and outcomes is very important to understand whether the outcomes match the stigmatized ideas of CNM relationships and people engaging in them. This study shows that CNM relationship style may not be detrimental to depressive or anxiety symptoms. The effects found were very small, and non-significant, which suggests that relationship style plays only a small role if any in depression or anxiety in people, with other factors affecting individuals much more. This goes against the idea that CNM individuals have lower relationship quality and happiness in life. CNM brings with it lots of opportunities to have more freedom in expressing intimacy and need fulfillment, which can improve well-being, depending on if individuals can manage challenging feelings such as jealousy and emotional demands that come from having multiple partners and having a partner who engages intimately with multiple individuals (Codrington & du Plooy, 2024). Studies in CNM seem to suggest that individuals engaging in it have similar levels of relational outcomes and mental well-being (Rubel & Bogaert, 2015), so studies in this field bring valuable information to combat the stigmatized attitudes that CNM individuals get subjected to. Future studies would benefit from longitudinal studies across multiple cultural contexts and recruitment strategies that bring a more representative sample of CNM and monogamous individuals to better draw causal inferences of the associations between CNM and individual well-being.

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