

## AN INTEGRATIVE INTERVENTION FOR PROMOTING RECOVERY FROM EXTRAMARITAL AFFAIRS

Kristina Coop Gordon  
*University of Tennessee-Knoxville*

Donald H. Baucom  
*University of North Carolina-Chapel Hill*

Douglas K. Snyder  
*Texas A&M University*

*The discovery or disclosure of an extramarital affair can have a devastating impact on partners, both individually and on the relationships. Research suggests that affairs occur relatively frequently in relationships and are a common presenting problem in couple therapy. However, despite their prevalence, there is little empirical treatment research in this area, and most therapists describe this problem as one of the more difficult to treat. In this study, we used a replicated case-study design to explore the efficacy of an integrative treatment designed to help couples recover from an affair. Six couples entered and completed treatment. The majority of these couples were less emotionally or maritally distressed at the end of treatment, and the injured partners reported greater forgiveness regarding the affair. Details of the intervention, suggested adaptations of the treatment, and areas for future research are discussed.*

Data from the National Opinion Research Center at the University of Chicago suggest that the lifetime prevalence of affairs may be approximately 40% for men and 20% for women (Lauman, Gagnon, Michael, & Michaels, 1994). Furthermore, 40% of divorced women and 44% of divorced men report more than one extramarital sexual contact during the course of their marriages (Janus & Janus, 1993). Consequently, extramarital affairs constitute a significant problem for many couples. Moreover, clinicians have noted that extramarital affairs often contribute to individual as well as relationship distress. Injured partners' intense reactions often include rage toward the participating partner, feelings of shame, depression, overwhelming powerlessness, victimization, and abandonment, as well as difficulties with concentration, persistent rumination about the event, and disrupted daily functioning (e.g., Abrahm Spring, 1996; Glass & Wright, 1997; Moultrup, 1990; Pittman, 1989; Reibstein & Richards, 1993). The existing empirical evidence supports clinicians' observations. Researchers have noted a high incidence of clinical depression among partners experiencing a recent discovery or disclosure of an extramarital affair (e.g., Beach, Jouriles, & O'Leary, 1989; Cano & O'Leary, 2000).

Despite the prevalence of this problem and its clear implications for both individual and relationship functioning, this area has received little empirical examination. Despite a variety of theoretical articles, case studies, and popular trade books addressing extramarital affairs (e.g., Abrahm Spring, 1996; Brown, 2001; Dattilio, 2000; Glass, 2003; Glass & Wright, 1997; Lusterman, 1998; Pittman, 1989), none of the treatments

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Kristina Coop Gordon, PhD, Department of Psychology, University of Tennessee-Knoxville; Donald H. Baucom, PhD, Department of Psychology, University of North Carolina-Chapel Hill; Douglas K. Snyder, Department of Psychology, Texas A&M University.

Correspondence concerning this article should be addressed to Kristina Coop Gordon, 310B Austin Peay Building, Department of Psychology, University of Tennessee, Knoxville, Tennessee, 37996. E-mail: kgordon1@utk.edu

described in these publications has undergone empirical scrutiny. Furthermore, although there are several empirically supported couple treatments in the psychotherapy literature (e.g., Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998), it has been the current investigators' experience that couples who have not resolved past betrayals, such as extramarital affairs, often show limited benefit from these treatments. Instead, they remain mired in the past, refusing or unable to take risks on new behaviors and perspectives because of their distrust of their partners. Clinical observations also suggest that if they end their marriage following an affair, partners sometimes enter into subsequent relationships with similar problems. Similarly, a majority of couple therapists report that they, too, need guidance in addressing this problem. Surveys of practicing couple therapists reveal that therapists consider affairs to be one of the most damaging problems couples face and one of the most difficult problems to treat (Geiss & O'Leary, 1981; Whisman, Dixon, & Johnson, 1997). Consequently, it is critical to develop a treatment approach aimed specifically at helping couples to address these past injuries and to move forward in a healthy manner. The current replicated case study provides initial data regarding a treatment for infidelity based on the authors' research on forgiveness of betrayals, as well as existing theoretical and case-study literature on extramarital affairs.

This treatment conceptualizes recovery from an affair as analogous to recovery from an interpersonal trauma; thus, the treatment incorporates selected elements from the existing trauma literature, particularly the literature involving violated assumptions (Janoff-Bulman, 1989; McCann, Sakheim, & Abrahamson, 1988; Resick & Calhoun, 2000). In addition, because the discovery or disclosure of an affair often constitutes a major relational betrayal, this treatment also incorporates aspects from the authors' three-stage forgiveness model (Gordon & Baucom, 1998, 1999, 2003; Gordon, Baucom, & Snyder, 2000). The treatment model described in this paper integrates cognitive-behavioral strategies for couple therapy (Baucom & Epstein, 1990; Epstein & Baucom, 2002) with insight-oriented strategies (Snyder & Wills, 1989; Snyder, 1999). In describing this model, we present both quantitative and qualitative findings from an initial intervention study with six couples. Treatment sessions emphasize collaborative work involving both the individual participating in the affair and their injured partner. Specific goals and interventions comprising the three stages of this treatment are summarized in the Appendix and are explicated below.

The terminology used to designate the roles of partners in this process varies in the literature. In this article, the terms "participating partner" and "injured partner" designate the individual having engaged in the extramarital affair and his or her primary partner, respectively.

### *Stage 1: Dealing with Impact*

The first stage of treatment addresses the affair's impact. The first goal involves assessment of individual and relationship functioning, both currently and developmentally, using individual and conjoint sessions. The purposes of this assessment are to (a) identify immediate crises requiring intervention (e.g., suicidality or physical aggression), (b) construct an initial formulation summarizing partners' individual and relationship strengths, as well as vulnerabilities potentially contributing to and resulting from the affair, and (c) develop a shared treatment plan outlining each participant's responsibilities. In this study, couples were selected if one, but not both, partners had engaged in an affair during the previous 12 months, and the affair was reported to have ended. In extending this model to couples for whom the affair is on going, interventions during this first stage would be expanded to work toward a decision to end or suspend interactions with the outside person as a basis for continuing with further interventions.

Following this assessment and treatment formulation, initial interventions during this first stage derive primarily from a cognitive-behavioral perspective. The first step involves assisting partners in articulating desired boundaries or guidelines for interaction between themselves and with others. For example, partners often need to negotiate how much time to spend together or apart; whether to sleep together or to maintain sexual relations; what further contact, if any, the participating partner will have with the outside affair person; and what information to share with potential interested parties (e.g., children, in-laws, or friends). Even couples with a previous history of effective problem-solving skills often find it difficult to resolve basic boundary issues due to the emotional turmoil following an affair without therapeutic intervention.

Because the emotional sequelae of affairs often involve feelings of anxiety, depression, and shame, a further step in this first stage of treatment involves helping both partners take better care of themselves.

Individual sessions and written guidelines are used to facilitate physical self-care (e.g., sleep, diet, exercise), engaging social support while maintaining appropriate boundaries, and spiritual support if consistent with the partner's belief system. Because of frequent negative interactions between partners during this initial stage of recovery, most couples need a strategy that allows them to disengage when their level of emotion becomes too high. Consequently, both "time-out" and appropriate "venting" strategies are presented in individual sessions and discussed in subsequent conjoint sessions, with partners instructed on when and how to implement these strategies effectively. The supportive nature of these individual sessions also aids in strengthening rapport with each partner.

After some degree of stabilization has been achieved in individual and relationship functioning, the couple can address the critical task of examining the affair's impact on themselves and their relationship. For example, the therapist works with the couple to identify major assumptions about their partners, their relationships, and even themselves that have been violated as a result of the affair. Furthermore, a near-universal need of the injured partner involves expressing to the participating partner how he or she has been deeply hurt by the affair. However, the intensity of these feelings as well as participating partners' own feelings of hurt, anger, or shame often contribute to intensely negative and escalating exchanges. Thus, couples are taught to use appropriate emotional expressiveness skills for both speaker and listener to promote more effective communication regarding the affair's impact (e.g., Epstein & Baucom, 2002). In addition to facilitating discussion of the affair's impact within conjoint sessions, supervised letter writing is used as a means for helping partners to explore and exchange their feelings and changed perceptions in a more reflective manner. In these letters, with their therapist's guidance, injured partners explore why the affair may have a particular impact for them, given their developmental history. Once the therapist is satisfied that the letter is written in a skillful and effective manner, it is read aloud in session to the participating partner, who has received special instructions from the therapist about how to manage his or her reactions to the letter and how to listen nondefensively. This procedure is described in more detail elsewhere (Gordon & Baucom, 1999; Snyder, Gordon, & Baucom, in press).

Despite initial stabilization and affective containment, many couples recovering from an affair continue to wrestle with episodic "flashbacks" involving the injured partner's reexperiencing of intense emotional reactions to the affair. These are particularly frequent during the initial stage of treatment, but may persist at a reduced intensity and frequency for months or even years following the initial discovery or disclosure. Thus, a critical final component of this first stage of treatment involves helping couples to achieve a greater understanding of what flashbacks are and why they occur, and assisting partners to articulate steps they can take both individually and as a couple to cope with these more effectively.

### *Stage 2: Exploring Context and Finding Meaning*

The second stage of treatment involves exploring factors that contributed to the affair's occurrence and evaluating both their on-going effects and potential response to intervention. Toward this end, a comprehensive conceptual model is proposed to the couple that integrates both recent (proximal) and early developmental (distal) factors across multiple domains influencing vulnerability to, engagement in, and recovery from an affair. Domains of potential contributing factors include (a) aspects of the couple's own relationship (e.g., high conflict, low emotional warmth), (b) situational factors outside the relationship (e.g., work-related stressors, pursuit by a potential partner outside the relationship), (c) characteristics of the participating partner (e.g., anger at the injured partner, insecurities about self, unrealistic relationship expectations, developmental history, or enduring personality disorders), and (d) characteristics of the injured partner (e.g., discomfort with emotional closeness, avoidance of conflict, developmental history, and long-standing emotional or behavioral difficulties).

Factors from each of these domains are explored as potential contributors to the course of an extramarital affair including (a) preexisting and enduring vulnerabilities, (b) initial approach behaviors (e.g., flirtatious behavior outside the couple's own standards), (c) implicit or explicit decisions to engage in or maintain the affair, (d) disclosure or discovery of the affair (e.g., participating partner's feelings of guilt, injured partner's increased vigilance), and (e) the couple's immediate and potential long-term response (e.g., capacity for emotional self-regulation and containment of intense couple conflict). In discussing these

various factors, individual responsibility is placed on the partner involved in the affair, but a careful assessment of the context within which the individual decided to have an affair is important. It is essential to differentiate between understanding the context for the affair versus “blaming the victim” for the affair.

This second stage of treatment has several goals. An overriding objective involves deriving a comprehensive explanatory formulation of the affair’s occurrence that facilitates a realistic appraisal regarding potential reoccurrence of this traumatic experience and aids in creating a new understanding of the couple’s relationship—both as it functioned prior to the affair as well as its current dynamics. The injured partner’s recovery of perceived relational security is critical to his or her ability to move beyond the hurt, anger, and anxiety that typify their initial response to an affair. A second goal is to promote the participating partner’s tolerance for the injured partner’s continued emotional reactivity and persistent “need to know” why the affair occurred. Partners often have conflicting timelines for recovery, with participating partners preferring to “move on” and put the affair behind them well before their injured partners feel emotionally prepared to do so. Unless this difference is understood and normalized, and the participating partner’s engagement in exploring the context is facilitated, a couple’s long-term recovery following some initial stabilization of affect is frequently compromised. Third, examination of contributing factors promotes initial problem-solving processes and provides the couple with an opportunity to evaluate their ability to initiate changes critical to the long-term viability of their relationship.

Finally, through the process of examining enduring developmental processes potentially contributing to vulnerability and response to the affair, both partners have an opportunity to understand their own and each other’s emotions and behaviors in a more comprehensive manner. This new understanding often reduces the intensity of negative affect surrounding the affair, diminishes confusion and anxiety about partners’ own reactivity, and often facilitates an optimism regarding potential for change and greater emotional fulfillment in the relationship. That is, understanding persistent dysfunctional relationship patterns from a developmental perspective often promotes more effective modification of these patterns using cognitive and behavioral strategies (Snyder & Schneider, 2002).

### *Stage 3: Moving On*

The third stage of treatment begins by integrating information obtained in previous sessions in preparing to reach an informed decision about how to “move on.” Verbal and written summaries by the therapist, along with letters written by each partner to the other, are used to converge on a shared formulation regarding factors contributing to the affair’s occurrence. During the construction of this formulation, particular attention is paid to how the couple now understands previously violated assumptions. Similar to the cognitive processing therapy for post-traumatic stress disorder (PTSD) described by Resick and Calhoun (2002), any remaining questions or fears about the relationship are then addressed and reconstructed beliefs about the relationship are evaluated. Once this goal is achieved, handouts and written exercises are used to promote partners’ evaluation and discussion of their relationship’s viability, its potential for change, and partners’ commitment to work toward change based on what they have learned about themselves and each other. Partners explore the process of moving on by examining the meaning of this construct as it relates to both their personal and relationship values and belief systems.

For many couples, this process involves examining personal beliefs about forgiveness. The treatment model promotes a view of forgiveness as a process whereby partners pursue increased understanding of themselves, each other, and their relationship to free themselves from being dominated by negative thoughts, feelings, and behaviors. This process is distinguished from a view of forgiveness as excusing or forgetting that the affair occurred, or requiring a decision to reconcile the couple’s relationship. An important aspect of the investigators’ conceptualization of forgiveness is that it *does not* stipulate that partners must reconcile for forgiveness to occur. Partners can decide to terminate the relationship and still fulfill the conditions of forgiveness.

Instead, this model suggests that forgiveness consists of three components: (a) A realistic, undistorted, balanced view of the relationship, (b) a release from being controlled by negative affect toward the participating partner, and (c) a lessened desire to punish the participating partner. (For a more thorough explication of this approach to understanding forgiveness and its place in the forgiveness literature, see Gordon &

Baucom, 1998.) The forgiveness process also allows for the possible development of warmer and more positive feelings toward the participating partner. However, healthy forgiveness requires a realistic appraisal of the partner, not an assessment that ignores real and dangerous aspects of the partner or the relationship. Forgiveness means that negative affect no longer dominates their lives or controls their actions toward their partner and that this event has been resolved to such an extent that the injured partner no longer carries its negative effects into other relationships.

Thus, partners' beliefs about forgiveness are explored, along with their apprehensions or fears regarding moving on. Potential risks and benefits of moving on emotionally are examined, including research on adverse consequences of sustained anger on individuals' physical and emotional health as well as relationships with others. Furthermore, if the couple decides during this stage of treatment to continue their relationship, additional sessions aid the couple in identifying areas of their relationship that require additional assistance and provide them with strategies to address these difficulties. Alternatively, if as a result of their exploration in Stage 2, the couple decides to separate or pursue divorce, additional sessions help partners plan how to pursue this goal in a manner that is least hurtful to them and others they care about (e.g., children and extended family) and that promotes a process of moving on emotionally and rebuilding healthy, but separate, lives. These sessions are primarily focused on problem solving, helping the couple to identify issues facing them as they begin to separate and aiding them in compromising around these issues.

Overall, the treatment is designed to be implemented in approximately 26 sessions over a 6-month period. Couples may require fewer or more sessions depending on the degree and persistence of their initial affective dysregulation, the complexity and chronicity of factors contributing to the affair and moderating partners' recovery, and the extent of additional factors requiring attention pursuant to the couple's decision in the final stage of treatment to maintain or terminate their relationship.

It is important to contrast the goals of this intervention with the goals of more traditional couple treatments. Whereas most couple therapies strive to improve overall relationship functioning, the goals of this treatment are more focused. That is, this treatment was designed primarily to help couples recover from an extramarital affair by structuring their interactions to provide "damage control" and by facilitating an in-depth exploration of the multiple influences on their relationship contributing to participating partners' involvement in an affair. Furthermore, in this study, we did not require partners' commitment to their marriage as a condition for therapy, because couples often could not realistically make such a pledge until they understood what factors had brought them to this predicament. Hence, this treatment was not designed to address all of a couple's problems. Instead, it was designed to help partners to explore themselves and their relationship to develop a better understanding of their relationship's vulnerability to an affair and to facilitate efforts to address those difficulties.

## METHOD

### *Participants*

Participants were six married, heterosexual couples, recruited using newspaper ads and radio and television announcements. Each member of the couple was individually screened for the following exclusionary criteria: (a) On-going affair, (b) affair ending > 1 year prior to entry into treatment, (c) multiple affairs by both partners, (d) psychoticism, (e) alcohol abuse, or (f) borderline or antisocial personality disorder. Sexual orientation was not an exclusionary criterion (although all of our couples were heterosexual), nor was cohabitation, provided both partners defined the cohabitation as a mutually committed relationship. In our sample, only one couple was cohabiting; the rest were married. Both partners had to agree to treatment and to have their sessions videotaped. The first six couples who met the criteria for inclusion were accepted into treatment. In four couples, the wife was the injured partner, and the husband was the partner participating in the affair; for the remaining two couples, these roles were reversed. All couples completed treatment and the 6-month follow-up. None of the couples received any incentive other than free therapy for participating in this study. By restricting this initial intervention study to couples meeting these criteria, we attempted to ensure sufficient homogeneity in couple characteristics to describe a relatively consistent set of interventions across couples.

## Measures

Because this study comprised the first empirical investigation of a treatment developed for couples recovering from an affair, a broad range of measures was used to capture specific components of both individual and relationship functioning targeted by this intervention.

*Initial screening and assessment.* All participants were administered the Structured Clinical Interview for Diagnosis of Axis II Personality Questionnaire (SCID-II-Q; Spitzer, Williams, Gibbon, & First, 1989) to screen for psychoticism and personality disorders; the SCID-II-Q presents 119 items describing feelings and behaviors to be endorsed as descriptive of oneself or not. The SCID-II-Q possesses acceptable reliability and validity and is recommended for use as a diagnostic measure in treatment-outcome studies (Horowitz, Strupp, Lambert, & Elkin, 1997).

Couples participated in individual and conjoint assessment interviews with their assigned therapist, and completed additional self-report measures of individual and relationship functioning. Self-report measures examining individual symptomatology included the Beck Depression Inventory (BDI; Beck, Rush, Shaw, & Emery, 1979) and the Post-Traumatic Stress Disorder Symptom Scale–Self Report (PSS-SR; Foa, Riggs, Dancu, & Rothbaum, 1993). The BDI includes 21 depressive symptoms rated on a scale of 0–3; scores of 10–20 have been linked to mild but clinically significant depression, with scores of 21–30 and scores > 31 indicating moderate and severe depression, respectively (Kendall, Hollon, Beck, Hammen, & Ingram, 1987). The mean for a community sample is 7.65 ( $SD = 5.90$ ; Kendall et al., 1987). The PSS-SR includes 17 items of PTSD symptomatology, each rated on a 4-point scale, yielding both a PTSD diagnosis according to DSM-IV criteria and a measure of PTSD symptom severity. The PSS-SR has high internal consistency and test-retest reliability, high diagnostic agreement with the SCID PTSD module, and good sensitivity and specificity (Foa et al., 1993). Scores > 15 have been suggested for diagnosing PTSD in a community sample (Falsetti, Resnick, Resick, & Kilpatrick, 1993). The community mean is 12.5 ( $SD = 10.5$ ; Foa, Cashman, Jaycox, & Perry, 1997).

The Marital Satisfaction Inventory–Revised (MSI-R; Snyder, 1997) was also given at intake. The MSI-R is a 150-item measure assessing overall relationship satisfaction and specific domains of a couple's relationship (e.g., problem-solving and affective communication, sexual dissatisfaction, interactions regarding children). Previous studies have affirmed the MSI-R's reliability, criterion-related validity, and sensitivity to treatment response (Snyder & Aikman, 1999). A *T*-score of 50 is the average for community couples, and a *T*-score of 55 is the average from most clinic samples posttreatment.

A new measure used in this study was the Forgiveness Inventory (FI), a 25-item questionnaire developed to evaluate injured partners' progress through the 3-stage forgiveness model outlined by Gordon and Baucom (2003). The FI has 3 subscales assessing: (a) Stage-1 experiences, such as the desire to lash out at one's partner and feeling overwhelmed by affect (community mean = 12.05,  $SD = 5.02$ ); (b) Stage-2 experiences, such as efforts to understand the traumatic event and gain increased clarity of emotion (community mean = 21.12,  $SD = 6.40$ ); and (c) Stage-3 experiences, such as success in relinquishing intense negative thoughts and feelings, and deciding how to move on (community mean = 29.97,  $SD = 4.53$ ). Progress toward forgiveness is reflected by decreases in Stage 1 and Stage 2 scores and an increase in Stage 3 scores. Previous research has supported the proposed factor structure, reliability, and convergent validity of this measure (Gordon & Baucom, 2003). Only the injured partners received this measure.

*Midtreatment assessment.* On two occasions, following Stages 1 and 2 of treatment, couples completed the Global Distress (GDS) scale of the MSI-R and the FI, because of the interest in examining specifically how the authors' stage-theory of forgiveness applied to the couples' responses to treatment at different stages of intervention.

*Termination assessment.* At completion of treatment, couples completed all measures included in the initial assessment as well as an Impact of Treatment scale. This scale asked individuals to rate on a 7-point scale how positive or negative the impact of treatment had been on themselves, their partners, and their relationships. They were also asked to describe the impact of treatment in their own words.

*Follow-up assessment.* Finally, at 6 months following treatment, couples again completed the GDS scale of the MSI-R, along with the FI and the Impact of Treatment scale. This was a reduced version of the intake and termination assessment packets; because treatment had ended, this packet was shortened to

reduce the burden on the participants and increase the likelihood of them completing and returning the measures.

### *Procedures*

*Therapists.* Therapists were three doctoral-level candidates in an American Psychological Association–accredited clinical psychology program and were trained by the investigators. Two therapists had completed 3 years of clinical training; the third had completed 5 years of clinical training. All had received at least 1 year of training in cognitive–behavioral couple therapy, and had at least 1 additional year of experience in couple therapy, as well as 3 months of additional training in the current intervention prior to the study. During treatment, therapists met with the first two authors for clinical supervision. Couples were not matched to any characteristic or aspect of a particular therapist; an order of therapist assignment was established, and couples were assigned to a therapist on the basis of their order of entry into treatment.

*Treatment.* Treatment followed the 3-stage intervention model described earlier. Each therapist followed a treatment manual (Baucom et al., in press) detailing objectives for each session and scripts demonstrating how to pursue these goals. Videotapes were reviewed weekly by the second author to monitor therapists' continued adherence and competence in delivering this treatment.

In addition to the planned conjoint sessions, therapists could offer supplemental individual sessions to partners if these were necessary. The purposes of these individual sessions were to collect information difficult to obtain with the other partner present, to strengthen the therapeutic alliance with that partner, or to address specific individual needs or concerns not yet ready to be addressed in conjoint sessions. Furthermore, because many of these couples experienced crises throughout treatment (e.g., continued intrusions by the outside person, threats to job security, crises in the extended family), additional conjoint sessions could be scheduled to deal with those problems requiring immediate attention. However, because crises frequently involved manifestations of on-going problems, rather than issues requiring immediate solution, initial guidelines were developed to aid therapists in knowing when to deviate from the treatment protocol versus when to reframe the crisis in terms of on-going challenges. In addition, some couples did not require sessions tailored to specific phenomena that often occur following an affair but were not occurring for them; in such situations, therapists were advised to omit those sessions. Consequently, not all couples received the same number of sessions; three couples each received 26 sessions, two couples received 24 sessions, and one couple received 30 sessions.

The decision to constrain the number of sessions permitted within this pilot outcome study reflected efforts to (a) standardize recruitment and intervention procedures; (b) distinguish between this intervention targeting individual and couple processes specific to an extramarital affair versus more general couple therapy addressing broader individual and couple difficulties potentially triggered or exacerbated by, but not uniquely resulting from, an affair; and (c) impart more rigor to our evaluation of treatment effectiveness. Had the number of sessions not been constrained, then particularly difficult couples could have conceivably continued in therapy for a year or longer, artifactually inflating estimates of treatment effectiveness from deferred outcome measures.

## RESULTS

### *Summary Data for All Couples*

Table 1 provides group summary data for the six couples. For each measure, information is presented both in terms of raw scores (*M*s and *SD*s) and in standardized *z*-scores to provide a common metric by which to compare participants' deviation from community couple norms across measures. Standardized *z*-scores also facilitate comparisons across measures related to progress in treatment. Results are summarized in terms of group *z*-scores for pretreatment, posttreatment, and follow-up. Table 1 also presents effect sizes that reflect changes from pre- to posttreatment and from pretreatment to 6-month follow-up. Effect sizes were calculated by dividing the absolute value of the difference between the pre- and posttreatment means by the pretreatment standard deviation. Like *z*-scores, effect sizes are interpreted with respect to the unit-normal

Table 1  
Group Summary Scores for All Six Couples

	Pretreatment z-score	Posttreatment z-score	6-month follow-up z-score	Effect size at posttreatment	Effect size at 6-month follow-up
<u>Injured partners</u>					
PTSD symptoms (Raw <i>M</i> ; <i>SD</i> )	0.81 (21.0; 12.4)	0.04 (12.0; 8.8)	N/A	0.72	N/A
Depressive symptoms (Raw <i>M</i> ; <i>SD</i> )	1.36 (15.7; 16.8)	0.62 (11.3; 11.4)	N/A	0.38	N/A
Global marital distress ( <i>T</i> -score <i>M</i> ; <i>SD</i> )	1.65 (66.5; 9.0)	1.02 (62.5; 8.5)	1.02 (60.2; 10.4)	0.70	0.70
Forgiveness Stage 1 score (Raw <i>M</i> ; <i>SD</i> )	2.01 (22.2; 5.4)	0.45 (14.3; 4.2)	0.51 (14.7; 4.9)	1.45	1.38
Forgiveness Stage 2 score (Raw <i>M</i> ; <i>SD</i> )	0.91 (27.7; 5.0)	0.16 (22.2; 3.3)	0.26 (22.8; 4.9)	1.10	0.97
Forgiveness Stage 3 score (Raw <i>M</i> ; <i>SD</i> )	-1.36 (23.8; 6.1)	-0.66 (27.7; 4.8)	-0.39 (28.2; 4.9)	0.63	0.72
<u>Participating partners</u>					
PTSD symptoms (Raw <i>M</i> ; <i>SD</i> )	0.06 (11.8; 5.0)	0.65 (5.7; 2.1)	N/A	1.03	N/A
Depressive symptoms (Raw <i>M</i> ; <i>SD</i> )	0.62 (11.3; 7.3)	0.13 (6.8; 9.0)	N/A	0.61	N/A
Global marital distress ( <i>T</i> -score <i>M</i> ; <i>SD</i> )	1.25 (61.2; 8.3)	1.18 (61.8; 10.3)	1.10 (61.0; 12.5)	0.08	0.07
<i>Note.</i> <i>N</i> = 6 each cell. N/A = not applicable. Standardized z-scores were computed to permit comparison of participants' relative deviation from community couple norms across measures. Effect sizes were derived by dividing change scores by the pretreatment standard deviation.					

distribution. For example, an effect size of 1.0 means that the average individual was better off at the end of treatment than 84% of the sample at pretreatment.

As can be seen from Table 1, at intake the injured partners' scores were highly elevated on the PTSD, depression, global marital distress, and forgiveness Stage 1 measures. Furthermore, they were much lower than the community sample on their forgiveness Stage 3 scores. Participating partners reported much less individual distress, but were still more than one standard deviation above the norm for global marital distress. At the end of treatment and at follow-up, all scores were within one standard deviation of the community sample means, with the exception of marital discord. Continued elevations on the GDS scale may be attributable in part to items on that measure assessing previous relationship distress, rendering this measure less sensitive to change (Snyder, 1997; Whisman & Jacobson, 1992). Furthermore, with the exception of depression, the effect sizes in these domains were moderate to large (ranging from 0.86 to 1.74) and generally exceeded average effect sizes for efficacious marital therapies (cf., Baucom et al., 1998).

#### Case Studies

Drawing on strengths specific to a replicated case-study design, the most salient issues related to each

couple's progress, or lack of thereof, were examined. The cases are presented here in order of most responsive to least responsive to treatment. Content and process themes that occurred across couples are discussed following the case studies. Although there were significant common themes and processes across couples, case-study analyses also revealed unique individual, couple, and outside contextual factors that influenced the course of treatment for these couples. Hence, treatment required sufficient flexibility to address these unique factors. A table of data detailing each couple's progress across the three treatment stages is available on request from the first author.

*Couple 1.* Mary, a 30-year-old Caucasian woman, and Tom, a 43-year-old Hispanic man, entered treatment 2 months after the discovery of Mary's affair with a mutual friend of the couple. They reported a 4-year marital history that included such stressors as two major relocations, several job changes, and a period of unemployment for Mary. An examination of Mary's and Tom's scores on the GDS indicated that they were experiencing a moderate-to-high level of marital discord. Furthermore, Mary's score on the BDI indicated a moderate level of depressive symptomatology. At termination, both partners scored in the nondistressed range on measures of individual functioning and in the low-to-moderate distress range of relationship functioning. Furthermore, Tom's forgiveness scores steadily improved over treatment. The couple's individual gains were maintained and their global marital distress continued to diminish at follow-up. Mary stated in her follow-up narrative regarding therapy that treatment had "saved our marriage."

There were several key factors involved in this couple's treatment progress. Initially, both Tom and Mary were fearful of confronting each other or discussing their problems in therapy. Thus, the first task of treatment was creating a safe environment in which the couple could fully disclose the difficulties they were having. This task was accomplished by a brief module of communication training and by a discussion of the benefits of confronting these issues versus the consequences of avoiding them. The skills gave them increased confidence in tackling their relationship issues and reduced their conflict avoidance, which had been a major factor in the affair's occurrence. Because Mary had not felt able to confront Tom with her growing dissatisfaction in the marriage, both because of her own developmental issues regarding conflict and Tom's own confrontational style, she instead withdrew from him and found a supportive outlet for her frustrations in her male colleague, who eventually became her affair partner. Consequently, the couple's continuing difficulty in addressing conflict had created vulnerability in their relationship and was a risk factor for the development of affairs.

Another key issue was addressing Mary's guilt and subsequent lack of self-care; giving her permission to take care of herself and engage in pleasurable activities helped to reduce her depression and made her less affected by Tom's moods and behaviors. Her failure to do so in the past had also made their relationship vulnerable, because Mary would become more emotionally reactive to Tom, and she relied heavily on his attention and presence for her emotional well-being. At the same time, Tom's own strategies of withdrawal during times of stress made him less available and responsive to Mary. The self-care strategies introduced in treatment encouraged Mary to develop her own sources of self-nurturing, which in turn reduced her angry dependence upon Tom. Finally, the developmental and affective exploration conducted in Stage 2 of the treatment brought to light many similarities in both partners' lives; for example, both came from chaotic, conflicted families, and both experienced a great deal of social rejection during adolescence. Drawing on these similarities helped them to empathize with each other's struggles and develop a more compassionate understanding of each other's methods of coping with negative affect. Tom and Mary made particularly good use of these insights, developing new strategies to manage their differences and committing themselves to using these strategies. Moreover, Tom was able to recognize how he, too, had made mistakes in his relationships, both with Mary and in his past; this acknowledgement helped him to forgive Mary, and increased his motivation to be more responsive to and inclusive of Mary, particularly during difficult times.

*Couple 2.* Deborah, a 31-year-old Caucasian woman, and Jeff, a 31-year-old Caucasian man, presented for treatment nearly 1 year following Deborah's discovery of Jeff's affair with a coworker. During that year, Deborah gave birth to their first child, a daughter, and the couple relocated across country to distance themselves from Jeff's affair partner. The couple had been married for 3 years and reported having an emotionally distant relationship. Their initial data indicated that they were both experiencing a moderate level of marital distress but not a significant level of individual distress. Over the course of treatment,

Deborah reported a gradual decrease in marital distress, whereas Jeff's progress was more variable. Furthermore, Deborah's forgiveness scores gradually improved across treatment. At follow-up, their gains in forgiveness and marital functioning were maintained.

The most critical issue of treatment for this emotionally restricted couple centered on helping them to address emotional issues. They had a long-standing pattern of conflict avoidance that kept both from expressing their emotional needs. Their therapist addressed this by examining the consequences of continued avoidance and by providing communication skills training to increase their sense of efficacy. As they began to express their levels of hurt and frustration with each other, both stated that the process was very painful, and they experienced some disruption in their normal functioning. At the same time, Jeff's honesty was reassuring to Deborah because she felt she was "getting the real Jeff." At the same time, addressing conflicts in the marriage increased Deborah's anxiety because it deviated from her expectations of "perfection" in her marriage, expectations that were stressful for both her and Jeff. However, as she experienced an increase in intimacy, her anxiety decreased and she was willing to reexamine and challenge these expectations.

Another key issue addressed in treatment was that, throughout his life, Jeff did not typically examine his feelings or his motives, so the exploration of what influenced his affair decision was difficult for him. However, using a variety of homework assignments in which Jeff was instructed to think about his relationship, and which provided a focus on his internal experiences in the session, the couple was able to satisfactorily reconstruct the factors contributing to the affair. Their communication steadily improved, and the couple accepted more risks in expressing negative feelings to each other, which again was reassuring to Deborah and reinforcing for Jeff. In the last stage of treatment, Deborah expressed a willingness to forgive Jeff; however, she also acknowledged a sense of sadness at realizing her relationship was not "perfect." Both partners were committed to their relationship. They completed treatment by working on deepening their communication and intimacy with each other, although both expressed their wish to continue this work in couple therapy following this specific treatment.

*Couple 3.* Brian, a 31-year-old Caucasian man, and Liz, a 32-year-old Caucasian woman, entered treatment 8 months after the discovery of Liz's affair with a mutual friend. Liz had moved out of the home but had returned and decided to try to repair their relationship a week prior to presenting for treatment. During their initial assessment, the couple reported a 2-year marital history that included such stressors as a major relocation and a period of unemployment for Liz. At intake, both partners reported a clinically elevated level of marital distress, particularly Liz. Furthermore, Brian reported a clinically elevated level of PTSD symptoms and very little forgiveness toward Liz. However, by the end of treatment, his PTSD symptoms had decreased and his forgiveness measures had all greatly improved. In addition, their global marital distress levels had decreased, although they were still reporting a high level of distress; at follow-up Brian reported a desire to continue couple treatment with their therapist. All treatment gains were maintained or improved at follow-up. Liz also reported at follow-up that she was pursuing individual therapy to explore issues that were revealed during this treatment.

An initial focus of treatment involved helping Brian express emotions other than anger toward Liz, which had only served to increase her defensiveness and guilt. However, with their therapist's encouragement and assistance, Brian wrote and read a letter in which he was able to identify and express some of his more vulnerable experiences such as his fear of losing her and how her behavior had caused him to question himself and to feel worthless. Similarly, with their therapist's support, Liz was able to reflect her deep understanding of these feelings to Brian nondefensively; he found this very gratifying, and the couple experienced an increase in intimacy.

During Stage 2, Brian displayed considerable defensiveness and frustration, and was often unable to listen to Liz's descriptions of her thought processes at the time of her affair, because they made him feel inadequate and guilty for not "solving her problems." However, his defensiveness decreased when the therapist helped them both to draw links between their behaviors and their developmental histories. In one session, Liz read a letter describing her role in her family of origin and how that influenced her behavior in her own marriage. She explored how her role as "peacekeeper" kept her constantly smoothing over problems; therefore, when she encountered emotionally charged issues that needed to be addressed directly,

she instead avoided the issues and her dissatisfaction grew. Brian developed considerable empathy regarding Liz's vulnerability, and became sad and regretful about her experience. This shift in affect appeared to be a turning point for him in the treatment and allowed him to move beyond the affair, helping him to understand why Liz had not turned to him when she was upset about their marriage.

Finally, the third key issue for this couple was their continued ambivalence about their relationship, which was highly anxiety provoking and fatiguing. The therapist relieved this pressure by giving them permission to work on the relationship one day at a time, promising that they would revisit the issue of their future relationship in Stage 3. The permission to focus only on the present was comforting to this couple, and they experienced immediate emotional relief. When they finally addressed their future together during Stage 3, they had made enough improvements in their marriage that they committed to stay together and to forgive one another. At the end of treatment, they still reported relationship distress but felt committed to and capable of resolving these problems in the future.

*Couple 4.* Anne, a 35-year-old Caucasian woman, and Brad, a 35-year-old Caucasian man, entered treatment 3 months after Anne had discovered Brad's affair with a colleague. The couple had been married 12 years; however, in the last 5 years they had become progressively more distant from each other, a problem exacerbated by a year apart during the course of a major relocation. In the clinical interview and in assessment using the SCID-II-Q, Anne came close to meeting criteria for Borderline Personality Disorder and described a history of emotion-regulation difficulties. As was evident from their highly elevated scores on the GDS, this couple was experiencing a great deal of distress when they entered treatment. Anne in particular was extremely distressed, scoring well above clinical cut-off points for PTSD symptomatology and depression. When they ended treatment, this couple was reporting very little marital distress on the GDS, and Anne was reporting a great deal more empathy for Brad. Furthermore, Anne's individual distress, as measured by the BDI, had greatly decreased, as had her PTSD symptomatology, although both remained clinically elevated; however, these gains appeared to have deteriorated at follow-up. Anne also reported that they were pursuing additional couple therapy at follow-up.

Given Anne's level of distress, a key issue in treatment for this couple was dealing with emotional dysregulation. As developmental exploration in Stage 2 revealed, the predominant emotion expressed in Anne's family was abusive anger. Consequently, she continued this pattern with her husband, who reported that all he heard from her was anger and criticism, both prior to the affair and since the affair's discovery. In contrast, Brad's experiences in his family of origin led him to believe that he had to maintain a stoic attitude in his family and eschew expressions of negative affect; thus he felt unable to express his own discontent and painful emotions to Anne. His ensuing dishonesty about his experiences and consequent withdrawal left the couple emotionally distant and unable to resolve any underlying conflict. Consequently, the goal for the therapist was to assess and clarify Anne's more vulnerable feelings and to coach her in expressing these feelings to her husband, which in turn made it easier for Brad to understand and support her. As Anne expressed these more vulnerable feelings, Brad was able to take more risks and gently tell her of his own hurt and anger from her withdrawal in the marriage, which allowed for an increase in empathy and understanding for them both. In his end-of-treatment narrative, Brad stated he had learned a great deal about the need to be honest in his marriage and how to do it well. However, Anne remained emotionally reactive to any perceived withdrawal by Brad, even as they both made slow improvements in their communication and intimacy; Anne's reactivity in this regard severely compromised the progress that they were able to make.

Moreover, the couple's progress was continually undermined by the affair partner's persistent pursuit of Brad. This issue underscored the importance of addressing early, consistently, and forcefully the affair partner's continuing effects on their relationship. Although the therapist and couple problem-solved regarding how they could create and maintain a united front, these encounters continued to undermine Anne's sense of safety, acted as a trigger for overwhelming affect and PTSD-like reactions, and caused continuing problems in their marriage. The other woman's persistence and the couple's initial difficulty in setting adequate boundaries contributed to deterioration in Anne's forgiveness scores at follow-up; in her treatment-impact narrative, she reported that she was bitter toward her husband for bringing this woman into her life.

Finally, an additional, related problem in treatment for this couple involved Anne's beliefs about forgiveness. She strongly believed that forgiveness meant that you should feel no anger and that it had to include trust. Although these beliefs were gently challenged, she was resistant to considering other views of forgiveness. She required additional restitution and proof that Brad would not hurt her again, and she was unable to move beyond her self-protective anger. Despite a great deal of work on this issue, long-standing family-of-origin issues regarding trust and betrayals made it difficult for Anne to proceed beyond this point. Thus, this couple reached the end of the allotted treatment still needing additional work on trust issues, but they both reported increased commitment to their marriage. They were referred for additional couple therapy, and, by their 6-month follow-up, they indicated that they had contacted another therapist. In both of their end-of-treatment narratives, the couple reported a positive treatment impact, but also described their interest in additional therapy to address long-standing individual and relationship concerns.

*Couple 5.* Susan, a 30-year-old Caucasian woman, and Jack, a 38-year-old Caucasian man, entered treatment 2 months after the discovery of Jack's affair with Susan's best friend. During their initial assessment, the couple reported a turbulent 2-year marital history filled with multiple stressors including job losses, health problems, an unplanned and difficult pregnancy, and significant conflicts with their families of origin. Their initial intake data revealed that Susan was extremely distressed when she entered treatment. All of her scores, both individual and marital, were well-above clinical cut-off points, and her husband reported a great deal of marital distress as well. However as treatment progressed, their empathy for one another increased. Jack's shift in emotion occurred after Susan became vulnerable to him in Stage 1, and her increase in empathy and forgiveness occurred after the consolidation work achieved in Stage 3. Susan's individual distress, marital distress, and forgiveness scores also gradually improved over the course of treatment. Although she was able to maintain this level of forgiveness at follow-up, both members of the couple still reported considerable overall relationship distress at the end of treatment and at follow-up. Consequently, they were referred for additional treatment. However, in their follow-up, they reported that they did not find the treatment from their second therapist helpful and expressed a desire to return to our treatment.

A key issue in treatment with this couple was emotional regulation. Susan had difficulty expressing any emotion other than anger; she stated that expressing hurt, anxiety, or caring made her feel too "unprotected." Developmental explorations later revealed that this pattern was deeply rooted in Susan's relationship with her critical father, whom she felt also had "betrayed" her with his alcoholism. Furthermore, her angry reactions were frequent and intense, whereas Jack withdrew until he lost his temper or angrily left the house. The therapist's efforts to help her express these emotions more appropriately were successful, leading to an increase in understanding of and empathy for Susan by her husband, who could then listen to her more easily. Another important therapeutic task was challenging Susan's "black-and-white" cognitive distortions that initially impeded her ability to empathize with Jack. She described her belief system as similar to the following: "If I understand him, then that means I'm the bad guy." The therapist addressed these distortions and worked with her to develop a more holistic view of the relationship and each partner. Once this was addressed, Susan was able to develop good insight about why the affair occurred and expressed a readiness to forgive and move on.

Finally, the third major issue with this couple involved "crisis management." It was often difficult to make progress on affair-related issues because of recurring marital crises that the couple presented, such as major arguments en route to the session, chronic financial difficulties, and visits from warring in-laws. Because many of the crises involved clear external stressors, the therapist responded by scheduling additional sessions to address these crises and to maintain a balance between addressing the affair and contending with other relationship problems, which is a critical issue for many couples working to recover from an affair (see Gordon & Baucom, 1999, for an extended discussion of this issue). At one point, the couple decided to separate. However, as they applied newly acquired problem-solving skills to negotiate their separation and therein treated each other with more respect, both partners reported a significant improvement in their relationship. Each experienced a greater sense of relationship efficacy, which enabled them to stay together. Consequently at the end of this treatment, despite continued relationship distress, Jack and Susan reported greater forgiveness for each other and hope for their relationship.

*Couple 6.* Jill, a 29-year-old Caucasian woman, and Lewis, a 30-year-old African-American man, entered treatment 4 months after Jill discovered Lewis's involvement with a colleague. Although Jill and Lewis were not married, they had been living together in a serious, committed relationship for 2 years. They reported a volatile 3-year relationship history that was plagued by numerous problems, including racial, cultural, and spiritual differences, communication difficulties, problems in their families of origin, and mutual mistrust. In addition, Lewis was a musician whose job required long periods of travel. Furthermore, whereas Lewis did not fully meet criteria for any Axis II disorder during the SCID-II interview, he reported a long history of narcissistic, borderline, and antisocial traits in the clinical interview. As indicated in their intake data, both partners reported a high level of relationship discord and moderate levels of depression. Their situation deteriorated over the course of treatment, particularly for Lewis. Lewis became increasingly distressed both individually and in the relationship and was unable to develop significant empathy for Jill. In contrast, Jill's course was more variable. She was able to experience movement toward forgiveness, but only briefly, and her overall level of relationship distress remained high. She, too, finished treatment more individually distressed at posttreatment and follow-up.

The primary factor in this couple's deterioration appeared to be Lewis's level of characterological problems. It was difficult for him to tolerate his guilt when exploring Jill's reactions to his affair; in response, he attempted to focus on her friendships with male colleagues, rather than his role in the couple's problems. Furthermore, the level and severity of the emotional outbursts that Lewis displayed were quite intense. Given his role as the participating partner, this was a particularly problematic situation that did little to help Jill regain a sense of safety in their relationship. Similarly, Jill's anger at feeling controlled by Lewis was fueled by unresolved issues involving her own father's controlling behavior. Consequently, Jill deliberately engaged in behaviors that she knew would make Lewis feel angry and jealous to demonstrate that Lewis could not dictate her behavior. The couple needed highly structured behavioral interventions to prevent conflict in the sessions from escalating.

During the developmental exploration in Stage 2, the couple had some success in gaining insight into each other's experience, but had grave difficulties translating this knowledge into action outside of the session, despite substantial skills training. Again, this appeared to be due to Lewis's intolerance of any expression of dissatisfaction or hurt from Jill without switching the focus to her behavior, which in turn would reactivate Jill's own anger at his betrayal. Furthermore, whereas developmental exploration aided Jill in developing more empathy for Lewis, Lewis found the many challenges they were facing to be overwhelming and frightening. As an interracial couple in the South with many personality and religious differences, they were facing an extremely high level of stress in their relationship, with very few resources. Thus, the most challenging aspect of therapy with this couple occurred when they were asked to examine their relationship and decide whether they wanted to stay together and work on it. However, because the treatment protocol limited the overall length of this specific intervention, this process did not reach completion, and treatment ended before this issue could be satisfactorily resolved. At one point the couple decided to separate; however, separation and anticipated loss frightened them, so they avoided loss by reuniting and restricting their attention to positive memories of their past. They were referred for additional treatment but failed to attend. They were still together at follow-up, but they reported considerable distress.

### *Recurring Treatment Themes in Stage 1*

*Content.* One striking observation from this study involved the high level of PTSD symptomatology that one-half of the injured partners displayed at intake, a finding that was consistent with our trauma model of affairs. Aside from criterion A requiring serious physical threat, using the procedure outlined for the PSS-R (Foa et al., 1993) four of the six injured partners would have met criteria for PTSD. Three of these individuals were reporting severe symptomatology. In addition, the participating partners also showed symptoms of heightened anxiety and emotional arousal. Not surprisingly, these individuals were all grateful to have this issue addressed and to develop strategies to cope with their overwhelming emotions. However, not unexpectedly, these same individuals had the most difficulty progressing in treatment, probably because of their high levels of emotional reactivity. Another finding from this study, consistent with the trauma model, was that the majority of couples experienced disruptions in their assumptions about their partners

and themselves, stating such things as, “I don’t know what to expect anymore,” or “I thought I knew him, how can I trust my judgments now?” However, as their understanding of the affair increased, these disrupted assumptions often resolved over time.

Similarly, a critical component during this phase was the letter written by the injured partner describing the impact that the affair had had on him or her. The letter gave the therapist a chance to help the injured partner to express emotions effectively, and the participating partners to hear it less defensively. Many couples experienced this session as critical in defusing the angry and hostile feelings surrounding the affair and in developing a sense of empathy and compassion, which readied them to attempt Stage 2 work. Also made apparent was the importance of self-care reminders, particularly for the depressed and emotionally dysregulated clients. Lack of self-care included decreased sleep, poor diet, less exercise, and few positive experiences, which made partners more emotionally reactive and less able to manage their affect during their interactions. Not surprisingly, when individuals improved in this area, they evidenced less emotional reactivity. Finally, in two of the couples (couples 2 and 4), establishing boundaries regarding the affair partner was a crucial issue, needing immediate intervention and clear guidelines. In the case where this attempt was ineffective, the couple showed less improvement.

Although issues regarding sexuality are commonly thought to be a primary concern for couples struggling with an affair, only two of our couples identified sexual difficulties during assessment and during Stage 1 interventions. This outcome is consistent with the empirical literature that demonstrates only a limited association between sexual dissatisfaction and extramarital involvement (e.g., Waite & Joyner, 2001). Our own observations also suggest that there is wide variability in couple functioning on this issue. Whereas many couples’ sexual relationship is seriously compromised following discovery or disclosure of an affair, other couples report increased frequency and quality of their sexual relations. Hence, it is critical that therapists assess individual and couple dynamics related to sexual functioning both prior to and following an extramarital affair, and intervene in these processes accordingly.

*Process.* A major process theme in Stage 1 involved whether the couple required containment of their emotional dysregulation versus an increase in emotional expression and comfort with emotions. In both instances, when communications skills were successfully taught, this enabled couples to approach conflictual issues more effectively. However, those individuals with long-standing difficulties in regulating emotions required considerable intervention by the therapist, and they often failed to generalize these skills to interactions in their homes. Similarly, the emotionally dysregulated couples also required frequent crisis management, often coming into sessions with threats of ending their relationship, jealous fights, or generally chaotic lives. In each of these cases, guidelines had to be developed as to whether the crises were legitimate and how to handle them. If it was a legitimate “crisis” (e.g., interference by in-laws or the affair partner), extra sessions were added to address the crisis.

### *Recurring Treatment Themes in Stage 2*

*Content.* As couples engaged in exploring the context of the affair, several common themes emerged. Most consistently, couples reported a history of significant stressors external to the relationship and conflict avoidance on the part of the participating partner. Instead of addressing his or her problems in the relationship, the participating partner withdrew and sought “safer” emotional outlets, which often involved discussions with colleagues of the opposite sex. Also, not surprisingly, these couples also described feelings of emotional distance, communication difficulties, and problems with physical and emotional intimacy.

Furthermore, as evident from these case studies, the couples typically were experiencing major stressors and transitions in their lives at the time of the affair: major moves, job stresses, pregnancies, and problems with in-laws. Several specific themes emerged that put the participating partners at risk for the affair: Long-standing fears of conflict, often stemming from a family history of severe conflict; fears of abandonment; approval seeking; compartmentalization or the tendency to see different aspects of their lives as completely separate; self-absorption and failure to consider others’ needs when making decisions; long-standing low sexual or physical self-esteem; and conflicts over autonomy and control. Similarly, there were notable themes for the injured partners: perfectionism that often led to conflict avoidance; low self-esteem; fears of abandonment; and the role of mediator in the family of origin, leading them to smooth over potential

problematic areas instead of addressing them. The more of these issues that were present, the more difficult it was for the couple to recover from the affair.

*Process.* As in Stage 1, balancing crisis interventions versus a strict focus on the planned course of treatment presented a frequent challenge, particularly when the focus of treatment was on understanding the role of the past as opposed to addressing on-going issues in the present. At times, the therapist dealt with current relationship difficulties by adding an extra session to focus on more day-to-day difficulties and assigning homework relevant to these areas. When appropriate, the therapist attempted to relate couples' current difficulties to themes that were emerging during exploration of the affair. In addition, balancing empathy for the injured partner with empathy for the participating partner often was difficult. Again, individual sessions to restore the therapeutic alliance and provide extra support often proved helpful in these areas. Finally, helping the couple to integrate the many contributing factors into a coherent formulation of the affair appeared to be critical to treatment success. The more the couple developed a thoughtful, realistic perspective on why the affair had occurred, the more likely they were to move beyond the affair and to achieve higher levels of forgiveness.

### *Recurring Treatment Themes in Stage 3*

*Content.* In this final phase of treatment, there were also some recurrent themes. First, there were several beliefs about forgiveness that complicated the treatment process. These included beliefs such as: "You cannot still be angry if you forgive"; "If I forgive I will be hurt again"; and "Forgiveness reflects weakness." Another theme central to this stage of treatment was the issue of trust; many couples expressed sadness and fear stemming from the knowledge that their partners were capable of causing them great hurt. For couples in which this was a major impediment to their functioning, specific plans were developed to gradually regain trust; for other couples, this issue required more exploration of their sense of loss around this issue and an acceptance of this new knowledge.

*Process.* The most common process issue in this last phase of treatment was that therapy often was not long enough to address the couple's longstanding relationship problems. With more difficult couples, the treatment was only able to help them identify the source of current relationship problems and increase their efforts to address these current concerns nondefensively and cooperatively. Often these relationship difficulties had been identified during treatment as significant factors in the affair's occurrence. In fact, five couples reported at the end of therapy that treatment was helpful in addressing the affair and allowing them to move forward; however, they all expressed some wish for more time to address what they had discovered in treatment. In particular, several couples reported wanting more time to work on such issues as communication skills, trust, and addressing major stressors in their lives that preceded and influenced the affair decision. In this study, treatment was constrained in order to address internal validity issues; however, in the investigators' own clinical practices, which are not limited by research constraints, treatment frequently continues to address longstanding issues and terminates only when the couple and therapist both believe that these issues have been satisfactorily addressed.

## DISCUSSION

This study comprises the first empirical investigation of a conjoint treatment designed specifically to assist couples recovering from an affair. Consistent with anecdotal literature, the majority of injured partners entering this treatment initially showed significantly elevated levels of depression and symptoms consistent with a posttraumatic stress disorder. Concern with emotional regulation and struggles to understand their betrayal dominated. Relationship distress was severe; feelings of commitment, trust, and empathy were low. Injured partners' positive assumptions about themselves, as well as their partners, were disrupted. Overall, their capacity to move beyond profound hurt to pursue a life with renewed optimism and purpose was sorely compromised.

By the time of termination, injured partners demonstrated gains in each of these areas. Most importantly, gains were greatest in those domains specifically targeted by this treatment, such as decreases in PTSD symptomatology and mastery over successive challenges of the forgiveness process. Also, given

that couples struggling to recover from an affair are exceedingly difficult to treat (Geiss & O'Leary, 1981; Whisman et al., 1997) and that distressed couples are not likely to improve over time on a wait list (Baucom, Hahlweg, & Kuschel, 2003), it is important to note that this treatment's effect sizes were moderate-to-large and generally approached average effect sizes for efficacious marital therapies not specifically targeting couples struggling from an affair (cf., Baucom et al., 1998). The effect size for the change in marital distress from pretest to posttest was 0.70 for injured partners, which approximates that which is reported on average for cognitive-behavioral couple therapy for couples not selected because of affairs (0.82), and also is higher than that reported on average for wait-list controls (-0.06; Baucom et al., 2003).

The literature demonstrates very little previous study of partners who have participated in an affair. Contrary to findings reported by Beach et al. (1989), participating partners in this study exhibited as a group only modest disruption of individual functioning in terms of depression or anxiety. However, they displayed moderately high levels of overall dissatisfaction with their marriage. Although the average reduction in marital distress was modest for the participating partners, the treatment was not without impact on them. When describing the impact of treatment, participating partners expressed that the treatment was critical to (a) exploring and eventually understanding their own affair behavior in a manner that reduced likely reoccurrence, (b) tolerating their injured partners' initial negativity and subsequent flashback reactions, (c) collaborating with their partners in a vital but often uncomfortable process of examining factors contributing to the affair, and (d) deferring their own needs for immediate forgiveness until a more comprehensive process of articulating the affair's impact, exploring its causes, and evaluating the risks of reoccurrence had been completed. Hence, future studies with participating partners would do well to examine these specific aspects of treatment response more closely, rather than relying on traditional measures of individual emotional and relationship distress.

The treatment for couples struggling to recover from an affair examined in this study was not intended to resolve all of the diverse and enduring relationship problems that such couples often present. Although considerable attention to additional relationship concerns was promoted throughout treatment, the successful completion of Stage 3 sometimes resulted in a couple's decision to recommit to their relationship despite enduring difficulties and to pursue an extended course of more traditional couple therapy. Thus, criteria for defining treatment "success" among couples moving from a severely to moderately distressed level of functioning and pursuing additional treatment warrant further consideration. In addition, positive findings from this initial investigation suggest the merit of a more extensive study comparing this affair-treatment protocol to alternative active couple therapies not specifically targeting affair-related issues. Given an adequate sample, such a study could more systematically evaluate the aptitude-by-treatment interactions suggested by findings in the present investigation. Finally, because the affair treatment described here clearly involves multiple interventions across distinct stages of recovery, future studies should evaluate specific conditions (e.g., individual partner and relationship factors) that moderate the optimal selection, sequencing, and pacing of specific treatment components.

Clearly, one limitation of this study is the small number of couples. Furthermore, this study was limited to a homogeneous sample of individuals who did not have severe disorders or multiple histories of affairs. By striving to increase internal validity by promoting homogeneity of couple characteristics (and specific therapist interventions), one always potentially risks threats to external validity and generalization. Consequently, replication with a larger sample that might allow for greater diversity is needed. In addition, larger treatment studies with greater resources would allow for independent evaluations of treatment adherence and competence. In contrast, the relatively smaller sample in this investigation provided an initial controlled test of the treatment model and also allowed a careful examination of each case, facilitating hypotheses regarding potential treatment matching considerations for further examination in a larger study.

Overall, this study provides preliminary evidence for the efficacy of this treatment in helping most couples to recover and move on from an extramarital affair. Although many of the techniques described here have been promoted elsewhere in the clinical literature (e.g., Abrahm Spring, 1996; Brown, 2001; Glass & Wright, 1997; Gordon & Baucom, 1999; Lusterman, 1998) this study is the first to provide empirical evidence for the success of these procedures. The multiple case-study design suggests that critical individual and relationship factors potentially distinguishing couples for whom this treatment may be more or less

effective. In addition to further investigation of this treatment's efficacy in larger or more diverse samples, future studies should strive to delineate both moderators of therapeutic impact and specific interventions for addressing these factors in treatment.

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## APPENDIX

### Overview of Goals and Interventions by Stage of Treatment

Treatment goals	Interventions
<u>Stage 1. Dealing with Impact</u>	
Assessment	1 conjoint session; 1 individual session with each partner
Boundary setting	Conjoint sessions using directed problem-solving, instruction in use of time-outs and venting techniques
Self-care and affect regulation	Individual sessions and handouts
Exploring impact of the affair	Conjoint session discussion and supervised letter-writing by each partner regarding impact of the affair
Coping with flashbacks	Conjoint session discussion and directed problem-solving
<u>Stage 2. Finding Meaning</u>	
Exploration of factors contributing to the affair	Conjoint sessions emphasizing developmental exploration of contributing factors from the couple's relationship, external context (e.g., work, extended family, pursuit by other), aspects of the participating partner, and aspects of the injured partner
Relationship work	Conjoint session discussion, directed problem-solving, and targeted homework assignments
<u>Stage 3. Moving On</u>	
Summary and formulation of affair	Conjoint session discussion, letter-writing by each partner to the other, therapist formulation, and feedback
Examination of forgiveness and related concepts of "letting go" and "moving on"	Conjoint sessions exploring models of forgiveness, common beliefs about forgiveness, potential benefits and costs of forgiveness, and apprehensions or resistance to moving on
Exploration of factors affecting decision whether to continue the couple's relationship	Conjoint session discussions; directed questioning of ability and commitment to make needed changes
Additional relationship work or preparation for termination	Conjoint sessions involving continued exploration, problem-solving, and targeted homework