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Treating Affair Couples: Clinical Considerations and Initial Findings

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Infidelity can have devastating effects on couples' relationships. Not only are couples typically confused and uncertain about how to proceed, but couple therapists also report that treating infidelity is one of their greatest clinical challenges. In the current article, we present a conceptual model of response to infidelity with a corresponding infidelity-specific, couple-based intervention. This intervention incorporates interventions from cognitive-behavioral, insight-oriented, trauma-based, and forgiveness approaches to working with couples. In addition to this intervention created specifically for treating infidelity, we discuss how existing, empirically supported couple therapies such as traditional behavioral couple therapy (TBCT) and integrative behavioral couple therapy (IBCT) approach the treatment of infidelity. Finally, we present preliminary findings from two small treatment studies that provide initial, encouraging findings for the utility of the infidelity-specific intervention as well as TBCT and IBCT for treating infidelity.

Keywords: infidelity; couple therapy; marital therapy; cognitive-behavior therapy

Affairs are relatively frequent marital events in the United States. In recent studies with large representative samples, approximately 22% to 25% of men and 11% to 15% of women indicated that they had engaged in extramarital sex on at least one occasion (Lauman, Gagnon, Michael, & Michaels, 1994). In any given year, it is estimated that between 1.5% and 4% of married individuals will engage in extramarital sex, with about twice as many men as women reporting extramarital sex in the past year (e.g., Laumann et al., 1994). Even more significant for understanding marital disruption, 40% of divorced women and 44% of divorced men reported more than one sexual contact during the course of their marriages (Janus & Janus, 1993). Infidelity is the most frequently cited cause of divorce and doubles the likelihood of divorce (Amato & Rogers, 1997; Atkins, Baucom, & Jacobson, 2001).

Despite the prevalence of this problem, many therapists are unable to adequately conceptualize infidelity or develop a treatment plan for this problem (Whisman, Dixon, & Johnson, 1997). At present, it is not clear whether the field needs an intervention specifically developed to treat infidelity or whether existing couple therapy approaches can adequately assist couples experiencing such problems. The purpose of this article is to discuss these two possible approaches to treating infidelity, along with presenting preliminary data regarding the efficacy of these types of interventions. Because it is a newer intervention developed specifically to treat infidelity, we will focus primarily on an approach developed by Gordon, Baucom, and Snyder (Baucom, Gordon, & Snyder, 2005; Gordon & Baucom, 1998; Gordon, Baucom, & Snyder, 2004) to help couples recover from an affair, integrating treatment strategies from cognitive-behavioral couple therapy, trauma interventions, forgiveness interventions, and insight-oriented couple therapy. In addition, we will discuss the application of behavioral and integrative behavioral couple therapy to this specific clinical problem. Initial findings will be presented regarding the utility of these two approaches for treating infidelity—an infidelity-specific treatment and general couple therapy.

Extramarital Affairs as Interpersonal Trauma: Conceptual and Treatment Implications

Both clinical observations and empirical investigations demonstrate that the discovery of an affair can have an overwhelming and devastating impact on a couple.[1] Injured partners often report intense emotions that vacillate between rage toward the participating partner and inward feelings of shame, depression, overwhelming powerlessness, victimization, and abandonment (e.g., Abrahms Spring, 1996; Brown, 1991; Gordon et al., 2004; Lusterman, 1998; Pittman, 1989; Reibstein & Richards, 1993). Taken as a whole, many of these emotional, cognitive, and behavioral responses parallel the criteria for post-traumatic stress disorder. Therefore, conceptualizing the response to an affair as a reaction to an interpersonally traumatic event aids in the formulation of these difficult cases and the conduct of treatment (e.g., Baucom et al., 2005; Glass & Wright, 1997; Gordon & Baucom, 1998).

Literature on traumatic responses suggests that people are most likely to become emotionally traumatized when an event violates basic assumptions about how the world and people operate (e.g., Janoff-Bulman, 1989). Several important assumptions that individuals commonly hold about intimate relationships may be violated by an affair (e.g., that partners can be trusted, that the relationship is a safe place). The trauma literature also suggests that when these basic beliefs are violated, the injured person can significantly lose a sense that the future is predictable and experience a loss of control. Hence, an extramarital affair is not merely a very negative event; instead, the injured person often experiences the shattering of core beliefs essential to emotional security. Common statements reflecting such turmoil include, "I don't know you; you aren't the person I thought you were, and our relationship isn't what I thought it was" or "This just makes no sense; I can't understand how you could do this; I thought I could trust you." Given this unpredictability and ruptured trust, the injured person typically cannot move forward with the relationship, even if the affair has ended. As long as injured partners do not have a clear sense of why the affair occurred, they cannot trust their partners not to hurt them again; in the absence of this understanding, the participating partners are likely to be seen as malicious people whose very faces or voices may serve as stimuli for painful emotions such as anxiety, confusion, anger, depression, and shame.

Given the conceptualization of affairs as interpersonal trauma, the literature on both the traumatic response and interpersonal forgiveness can be helpful when considering how to conceptualize and organize an effective treatment. Treatments that arise from trauma theories generally assist clients in focusing more clearly on the trauma, expose them to the memories of the trauma,

and help them reconstruct their basic schemata about how the world operates and regain a new sense of control over their outcomes (e.g., Resick & Calhoun, 2001). Interestingly, these themes are echoed in newly developed forgiveness-based interventions, which are therapeutic approaches beginning to gain greater attention in mainstream psychological literature. Studies have indicated that forgiveness-based interventions aimed at helping the individual cognitively reframe the interpersonal betrayal and gain a greater understanding of why the trauma occurred are effective in increasing participants' levels of forgiveness and in improving their levels of both individual and dyadic psychological functioning (e.g., Freedman & Enright, 1996; Worthington, in press).

Similar to the trauma-based approaches, in most theories of forgiveness the primary focus of the process is on developing a changed understanding or attributions for why the betrayal occurred and reconstructing a new meaning for the event (e.g., Enright & the Human Development Study Group, 1991; Gordon & Baucom, 1998; Rowe et al., 1989). Despite some differences, most theories of forgiveness are fairly consistent in their definitions of the end state of forgiveness, indicating three common elements: (1) gaining a more balanced view of the offender and the event; (2) decreasing negative affect toward the offender, potentially along with increased compassion; and (3) giving up the right to punish the offender further.

To date, both the trauma and forgiveness literatures have primarily emphasized interventions targeting individuals. Left largely unaddressed are how best to conceptualize the recovery process and what specific interventions to pursue when dealing with interpersonal trauma from a couple perspective. To this end, it is useful to turn to two empirically supported couple therapy approaches: cognitive-behavioral couple therapy and insight-oriented couple therapy.

Cognitive-behavioral couple therapy (CBCT) builds on skills-based interventions of behavioral couple therapy targeting couple communication and behavior exchange by directing partners' attention to explanations they construct for each other's behavior and to expectations and standards they hold for their own relationship and for relationships in general (Epstein & Baucom, 2002). The structured, directed strategies offered within cognitive-behavioral interventions provide focus and direction to couples at a time when they are particularly needed.

Before couples can explore the meaning of an affair for their relationship or reestablish trust and intimacy, they first need assistance in containing the emotional turmoil and destructive exchanges that often characterize initial responses to the disclosure or discovery of an affair. Partners frequently need assistance in communicating feelings in a constructive manner and reaching intermediate decisions about how to set boundaries regarding involvement with the outside affair person, how much information to share with children or extended family, and how to interact with each other. Moreover, in exploring factors that placed their relationship at risk for an affair, couples frequently need to improve their ability to negotiate basic changes in how they interact and manage daily challenges of their relationship. Cognitive-behavioral couple therapy is particularly well-suited to these therapeutic objectives; however, CBCT's general focus on the present and the future also leaves important gaps in dealing with such couples. Many couples report that they cannot merely move forward and put the affair behind them; they need some way to process the trauma that has occurred and some way to make sense of the past.

Insight-oriented couple therapy (IOCT) offers therapeutic strategies designed specifically to help partners understand current relationship struggles from the perspective of partners' developmental histories. In IOCT, previous relationships, their affective components, and strategies for emotional gratification and anxiety containment are reconstructed with a focus on identifying for each partner consistencies in their interpersonal conflicts and coping styles across relationships (Snyder, 1999). Hence, insight-oriented strategies in couple therapy offer the potential of helping partners gain a better understanding of both their own and each other's developmental histories, the role that their respective pasts have played throughout their marriage, and how individual and relationship dynamics influenced by their pasts may have served as potential risk factors contributing to the participating partner's extramarital affair.

These revelations of vulnerability can help the partners develop more empathy and compassion for each other. Furthermore, as will be demonstrated, as this increased understanding and insight occur, it is placed within a cognitive-behavioral framework of developing a well-balanced set of attributions and resulting narrative for the event, along with a focus on what changes are needed in the relationship for the future. Thus, an effective couple intervention for extramarital affairs might draw upon cognitive-behavioral interventions integrated with insight-oriented approaches to provide a treatment strategy that balances the past, present, and future with an increased emphasis on affect and developmental factors.

Overview of Infidelity-Specific Treatment Model

Gordon and Baucom (1998) developed a stage model of forgiveness that parallels a response to trauma including three major stages in the forgiveness process: (1) dealing with the impact; (2) a search for meaning, or understanding of why the affair occurred; and (3) recovery, or moving forward. The treatment builds on this model of forgiveness and integrates cognitive-behavioral, insight-oriented, forgiveness-based, and trauma-based approaches to relationship difficulties. The treatment model includes three phases of treatment, each of which is directly tied to a stage from the authors' forgiveness model.

Given that the first stage of dealing with an affair involves addressing the impact of the event, the treatment components for Stage 1 are primarily cognitive-behavioral and directly target problems that arise from the immediate impact of the affair (e.g., emotional dysregulation, depression, the need to express feelings of anger and hurt, and damage control where necessary). The goal of the second stage is to help the couple explore both proximal and distal factors that contributed to the participating partner's decision to engage in the affair; consequently, treatment strategies in Stage 2 of the therapy are more insight-oriented and incorporate cognitive restructuring strategies, particularly with regard to attributions for the affair. Finally, in Stage 3, the couple is encouraged to (1) address the issue of forgiveness, (2) consolidate what they have learned about each other, (3) reexamine their relationship, and (4) decide how or whether they wish to continue their relationship in the future. At this time, the couple begins work on either improving their relationship in the here and now or initiating termination procedures. The components and challenges of each stage of treatment are described in further detail later in this article. Although this stage model is presented in a linear fashion, our experience is that some individuals demonstrate a mixture of symptoms from various stages at a given time and might return to earlier stages after progressing through a later stage (e.g., reexperiencing Stage 1 phenomena after a flashback later in the process). Thus, the clinician should use the following recommendations as guidelines for treatment that can be adapted flexibly to meet a given couple's needs.

Stage 1: Addressing the Impact of an Affair

Assessment

The first stage of the treatment encompasses assessment and management of the affair's impact. Using common assessment strategies for couples (Epstein & Baucom, 2002; Snyder, Heyman, & Haynes, 2005), basic aspects of couple functioning relevant to all couples should be assessed (e.g., satisfaction, communication skills, and commitment level). Furthermore, a conjoint session focused on gathering information about the couple's relationship history should be conducted, with specific attention paid to events and experiences leading up to the affair. In addition, the therapist should gather information about what the injured partner knows about the affair, how the affair came to light, and how the couple is currently dealing with its impact, looking at both strengths and weaknesses in the couple's current functioning.

Individual assessment sessions, one for each partner, also are beneficial. In addition to further information about the status of the affair and each person's current commitment to the primary couple relationship, the focus of the individual session is on obtaining an individual history for each partner, paying particular attention to aspects of his or her development that may have influenced actions surrounding the affair. Examples of these issues may be patterns in past relationships, beliefs about marriage, and parental history and attitudes toward marriages. These sessions also allow the therapist to explore hidden agendas (e.g., the participating partner's goal of leaving the marriage) and assess further for any potentially problematic areas, such as suicidality or violence. Therapists should be careful about setting boundaries of confidentiality for these sessions as they may be left holding secrets confided by one member of the couple that can be detrimental to the therapeutic alliance. This problem can be avoided by informing the partners that information raised in individual sessions may need to be addressed in the conjoint sessions, but the therapist will always discuss how and when to do this with the individual first.

Therapeutic Components of Stage 1

After completing the assessment, the therapist should have a good understanding of how the couple is functioning. The therapist should then provide the couple with (1) the therapist's initial conceptualization of what may have led up to the affair, (2) a summary of what problems the couple is currently facing in their relationship and why they are experiencing these problems, and (3) a treatment strategy. Then the couple should be given an explanation of the stages of the recovery process and the response to trauma conceptualization described in the introduction. In addition to assessment and feedback, the first stage of therapy has five basic components: (1) boundary setting, (2) self-care techniques, (3) time-out and venting techniques, (4) emotional expressiveness skills and discussion of the impact of the affair, and (5) coping with flashbacks.

Boundary Setting. When a couple feels out of control and in crisis, providing healthy boundaries can help to create some sense of normality and predictability. Because their own relationship has become dysregulated, the therapist's guiding the couple in setting boundaries or limits on how the partners interact with each other can be helpful. The injured partner often is greatly distressed about the outside person who had an affair with the participating partner. This intrusion of a third party into their lives is a major factor creating anxiety and a lack of safety. Therefore, setting strong and clear boundaries on interactions with the outside, third person is very important.

First, the couple's own relationship must be targeted to create a sense of safety in the relationship and minimize further negative effects on the couple. A major problem confronting many couples dealing with the impact of an affair is the fact that the negative emotions engendered by the betrayal may flood into many aspects of their functioning. Even areas within the marriage that were not problematic prior to the affair are likely to be affected by the increase in negativity in the marriage. For example, a couple who once prided themselves on their ability to parent well together may find themselves arguing bitterly in front of their children. Given that the couple is likely to experience intense and frequent conflict, they are likely to need immediate assistance from the therapist in setting limits on their negative interactions. For some couples, this involves making agreements about when, how often, and what aspects of the affair they will discuss. Otherwise, some couples report that they spend hours each day discussing the affair, often repeating the same conversations, typically resulting in negative, hurtful interactions.

Using directed problem-solving or decision-making strategies (Epstein & Baucom, 2002), the therapist should help the couple develop their own limits and boundaries for this problematic stage. It is important to emphasize that some of these solutions might be temporary ones primarily designed for so-called damage control. The participating partner may have to agree to some behaviors that would not be typical in a marriage but that are needed in the short term to help the injured partner regain a sense of control or safety and to demonstrate the participating partner's

remorse for the affair. For example, if a common cause of arguments is a wife's anxiety regarding her husband's whereabouts, then her husband may agree to be zealous in checking in with his wife until some trust or security has been reestablished.

Second, in order for the injured partner to feel safe enough to engage in the therapeutic process, it is important for the participating partner to set strong boundaries on interactions with the outside third party. This is most easily obtained if the participating partner agrees to end the relationship with the third person with no further contact. This absolute termination, however, is sometimes difficult to create for a variety of reasons. Some participating partners are unwilling to terminate all interaction with the outside person when the affair is discovered; sometimes logistics makes it impractical to have no interactions, at least immediately (e.g., when the participating partner and third person work together); and at times, the outside person continues to contact the participating partner, despite being told not to do so. Because rebuilding trust is a crucial part of the therapeutic process, the therapist encourages the participating partner to be honest in stating what boundaries he or she is willing to set with the outside person at present and how that will be carried out, along with agreements for how the injured partner will be informed of contact with the outside person. It is extremely important that the couple eventually set limits together on interactions with the outside partner, however, particularly if the outside partner insists on intruding into the relationship. From our experience, it is clear that continued interactions with the outside partner can have the effect of retraumatizing the injured partner and eroding the progress that the couple is able to make.

Self-Care Guidelines. As noted earlier, the emotional and cognitive sequelae of affairs often involve feelings of anxiety, depression, shame, and lowered self-esteem. Consequently, another major target for this stage of therapy involves helping both partners to take better care of themselves in order to have more emotional resources to use as they work through the aftermath of the affair. The current treatment offers basic self-care guidelines that encompass three areas: (1) physical care, including such aspects as eating well, sleep, decreased caffeine, and exercise; (2) social support, with careful attention paid to what is appropriate to disclose to others and what is not; and (3) spiritual support, such as meditation, prayer, and talking with spiritual counselors if consistent with the partner's belief system.

Time-Out and Venting Techniques. In light of the intense negative interactions between the partners at this stage in the process, most couples need strategies that allow them to disengage when the level of emotion becomes too high. Time-out strategies are introduced, and partners are instructed on how to recognize when one needs to be called and how to do so effectively. In addition, instead of using time-outs to fume and plan a counterattack, the partners are instructed in how to use the time-outs constructively; for example, to vent their tension through nonaggressive physical exercise or to calm themselves through relaxation strategies.

Discussing the Impact of the Affair. A common need for an injured partner is to express to the participating partner how she or he has been hurt or angered by the affair. It is likely that this need serves both a punitive and a protective function. By its punitive qualities, this discussion serves as a way to communicate that what happened was wrong and to ensure that the participating partner also feels as much discomfort as possible as a result of his or her actions. Often these interactions between the partners are rancorous and complicated by feelings of anger and guilt on the part of the participating partner. Frequently, the participating partner also has feelings of bitterness about an earlier hurt or betrayal in the marriage, which interferes with his or her ability to sympathize with the injured partner's feelings of betrayal. As a result, the injured partner is not likely to feel heard and may increase demands or comments, precipitating a negative interaction cycle between the partners.

The current treatment seeks to interrupt this cycle through three means. First, the couple is taught to use appropriate emotional expressiveness skills for both speaker and listener to help the injured person be more effective in communicating feelings and the participating partner to be

more effective in demonstrating that she or he is listening (Epstein & Baucom, 2002). Second, the couple is given a careful conceptualization of why this step is necessary. The participating partner must understand that his or her own perspective of the affair will most likely not be effectively understood by the injured partner unless the injured partner is first able to experience that the participating partner truly understands and is remorseful for the effect of his or her actions on the injured person and the relationship. Finally, the injured partner is encouraged to write a letter exploring his or her feelings and reactions to the affair, which is first given to the therapist. After feedback from the therapist, the letter is then revised and read to the participating partner. This process allows injured partners to explore their reactions in a calmer manner and then enables them to take time to express their feelings in ways that are not attacking or abusive and are more likely to be heard by the participating partner.

Coping With Flashbacks. A final but critical component in Stage 1 is the explanation of so-called flashback phenomena and the development of a plan for how to cope with them. As noted earlier, the reaction to an affair strongly parallels the traumatic response, and both partners are likely to encounter reexperiencing phenomena. For example, a wife may discover an unexplained number on a telephone bill, which may then remind her of the unexplained telephone calls during the affair and trigger a flood of affect related to her husband's affair. If the husband is not aware of this sequence of events, his wife's emotions may appear inexplicable, which in turn may cause him to question the progress they may be making in recovering from the affair. In working with couples, we explain the concept of a flashback in this context and how to address such experiences. For example, the therapist may explain:

> *When one person has had an affair it tends to make the other person extremely sensitive and reactive to things that directly or even indirectly remind them of the traumatic event. That's why a strange number on the phone bill or being at a restaurant where your partner ate with the other person can so easily set you off. What we think may be happening is that the person has started to associate certain experiences, memories, objects, and so forth with the traumatic event. This kind of association happens to us every day. Have you ever smelled something and then immediately were reminded of a past experience? Like smelling chalk dust and immediately thinking of elementary school? "Innocent" objects, smells or sounds may immediately remind a partner of an affair and then produce strong emotional reactions to it. We call these kinds of experiences flashbacks. Does this make sense in terms of what you're describing has been happening?*

We often provide a handout with a set of guidelines for addressing flashbacks. Within these guidelines, couples are taught to differentiate between upsetting events that reflect current inappropriate behavior versus events that trigger feelings, images, and memories from the past. See Snyder, Baucom, and Gordon (in press) for a detailed description of how to handle flashbacks.

Stage 2: Examining Context

Therapeutic Components

Exploring Factors Potentially Contributing to the Affair. After the emotional chaos or emotional distance from Stage 1 has been addressed, then the second stage of the treatment focuses on helping the couple explore and understand the context of the affair; that is, developing a realistic, well formulated set of attributions for the infidelity. This is a crucial part of the therapy and typically occupies the greatest amount of time. Given that basic assumptions about both partners and their relationship have been disrupted by the affair, the couple cannot move forward until they have a more complete and thoughtful understanding of why the affair occurred. Such attributions or explanations set the stage for helping the couple decide whether they want to maintain their relationship, what needs to change, or if they should move forward by ending their relationship.

The factors discussed in Stage 2 include: (1) aspects of the relationship such as difficulty communicating or finding time for each other; (2) external issues such as job stress, financial difficulties, or conflicts with in-laws; (3) issues specific to the participating partner such as his or her beliefs about marriage or his or her social development history; and (4) issues specific to the injured partner such as his or her developmental history or his or her relationship skills. This last point is likely to be most difficult for the couple, given that it may appear to be blaming the victim. At this point, the couple needs to understand an important distinction between contributing to the context of the affair versus responsibility for engaging in the affair. In this treatment, participating partners are always held responsible for their choices to have the affair, but it is important to understand the context within which they made that decision (Allen et al., 2005).

These sessions exploring the context of the affair typically are conducted in two ways. Depending on the couple's level of skill and their motivation to listen to and understand each other, these sessions can take the form of structured discussions between the partners as they attempt to understand the many factors that potentially contributed to the affair. The therapist intervenes as necessary to highlight certain points, reinterpret distorted cognitions, or draw parallels or inferences from their developmental histories that the couple is not able to do themselves. If the couple's communication skills are weak, if either partner is acutely defensive, or if they are having difficulty understanding each other's positions, however, then the therapist may structure the sessions so that they are more similar to individual therapy sessions with one partner, while the other partner listens and occasionally is asked to summarize his or her understanding of what is being expressed.

The therapist also looks for patterns and similarities between what the partners have reported in their individual histories and the problems they are reporting in their own relationship. It is in this exploration that the treatment borrows most heavily from insight-oriented approaches. Understanding how past needs and wishes influence an individual's choices in the present is a critical element to understanding why the individual chose to have an affair or how the injured partner has responded to this event. Often, the decision to choose an affair as a possible solution to present problems is influenced by strategies that have worked in the past or by developmental needs that were not met in the past. For example, a woman who was repeatedly rejected sexually in early adolescence and young adulthood, and consequently sees herself as unlovable and undesirable, may be particularly vulnerable to choosing a sexual affair to solve her feelings of rejection and abandonment in her marriage. Directing both members of the couple to explore these influences helps them gain a deeper understanding of each other's vulnerabilities and may help promote a greater level of empathy and compassion between them.

Stage 3: Moving On

Therapeutic Components

Summary and Formulation of the Affair. The therapist's first task in this stage is to help the couple integrate the disparate pieces of information they have gleaned in Stage 2 into a coherent story explaining how the affair came about; that is, to develop an integrated and rich set of attributions for the affair. This task is critical because understanding how the affair came about is central to developing a new set of assumptions about each person and the relationship.

This task of putting together what they have been discussing in Stage 2 can be accomplished in several ways. First, the therapist can explain to the couple that this is the next task and ask each partner to prepare for the next session by trying to "put it all together," including a focus on the (1) relationship issues, (2) environmental issues, (3) individual issues related to the participating partner, and (4) individual issues related to the injured partner that contributed to the context within which the affair

occurred. The couple and therapist then discuss their fullest understanding at the next session. As an alternative, each partner can be asked to write a letter for the next session (similar to the task in Stage 1 described earlier) in which each person describes now in a fuller and less angry manner what he or she understands to be these relevant factors. As a result of such issues arising from the discussion of the affair, the therapist and the couple discuss what aspects of their relationship may need additional attention and how this can be accomplished in order to help them avoid future betrayals. In this respect, the therapy begins to move from a focus on the past to a focus on the present and future of the relationship. At this point, the interventions are likely to resemble the frequently used strategies employed in cognitive-behavioral couple therapy in which the couple focuses on their current and future relationship (Epstein & Baucom, 2002).

Discussion of Forgiveness. Four basic aspects of forgiveness are discussed with the couple: (1) a description of the forgiveness model, (2) common beliefs about forgiveness, (3) consequences of forgiving and not forgiving, and (4) addressing blocks to forgiving and moving on. Gordon et al.'s (2004) three-stage forgiveness model is presented to the couple, and then the therapist draws parallels between this process and the work that the couple has just completed. Discussion then centers on the couple's reactions to this model and their own particular beliefs about forgiveness. For example, often couples report difficulty with forgiveness out of mistaken beliefs that forgiving their partner is weak or is equivalent to saying that what happened is acceptable or excusable. Addressing this belief by exploring whether one may forgive and yet also appropriately hold the partner responsible for his or her behaviors may then result in the couple developing a new conceptualization of forgiveness that feels more possible for them to achieve. Thus, in this phase of treatment, the therapist engages in helping the couple with cognitive restructuring of their standards, assumptions, and expectancies surrounding forgiveness.

Exploration of Factors Affecting Their Decision to Continue Their Relationship. In this final stage of treatment, couples are encouraged to use what they have learned about each other to decide whether their relationship is a healthy one for them or not. In other words, forgiveness does not require reconciliation. Thus, couples who have successfully negotiated the forgiveness process may still decide to dissolve their relationship based on their new understandings of themselves. In these cases, couples are ideally able to separate without intense anger and resentment toward each other. To this end, couples are encouraged to ask themselves separately—and then to discuss together within the sessions—a series of questions that the therapist designs to help them evaluate their relationship. These questions focus on whether each partner is willing and able to make individual changes needed to preserve the relationship and help it be rewarding, whether as a couple they can work together effectively as a unit for the family, and whether they are willing to make needed changes in interacting with the outside world (e.g., patterns at work, interacting with other people) that might be related to the affair.

At times when reaching the end of Stage 2, partners may conclude that critical factors contributing to the affair cannot be resolved and may determine that the best decision for them is to end this relationship and move on separately. When either partner concludes after careful consideration of all the relevant information that continuing their relationship is not in their best interests, we work to help them dissolve the relationship in a manner that is least hurtful to the two of them and to others involved in their lives, including children, other family members, and friends.

General Considerations in Responses to Affairs and Implications for Treatment

Each couple presents their own unique challenges when affairs occur. The clinician, however, should be attuned to some frequent complicating factors when working with couples surrounding infidelity.

Psychopathology

As with most couple treatments, a high level of psychopathology is a poor prognostic indicator for successful recovery (Snyder & Whisman, 2003). This problem may be particularly true when the participating partner engages in affairs because she or he has antisocial or narcissistic traits and believes he or she is above social norms and mores. Such thinking communicates to the injured partner that the participating partner is at risk for additional affairs, particularly if she or he is not remorseful or is inordinately defensive about the current affair. In this instance, a goal of treatment is to ensure that the injured partner becomes fully aware of this pattern of behavior and is able to make a good decision about whether to continue the relationship.

Individual psychological problems among injured partners also complicate treatment. Some injured partners have preexisting difficulties with affect regulation. These cases become difficult due to the need to contain negative affect because it can dominate the session and the couple's life outside of treatment. If the injured person generally struggles with regulating negative feelings, the strategies described in Stage 1 of treatment can be useful for these situations. For couples in which one or both partners have long-term, extreme difficulties with affect regulation, we have developed a couple-based intervention to address such difficulties (Kirby & Baucom, 2006).

Comfort With Affect

Not all affair couples present with chaotic, emotionally charged, negative interactions. Indeed, we have often found avoidance of conflict to be a major relationship characteristic associated with the development of an affair. Not surprisingly, this same general reluctance to address conflict often continues after the discovery of the affair. Such couples might easily agree to forgive each other, particularly if the affair has ended, without addressing the critical issues described in this treatment. Strategies to address this discomfort with affect are discussed regarding Stage 1 interventions. It may also be important to address the developmental source of this problem in Stage 2 of therapy, however, particularly if avoidance of conflict is a major contributor to the affair. Often, these individuals have had either direct or vicarious experiences with intense emotions in the past that had frightening or devastating outcomes. Thus, a major therapeutic task would be exploring these fears and the consequences of continued avoidance and creating an explicitly safe environment for the expression of negative affect.

Level of Commitment

A higher level of commitment to the relationship may lead couples to work harder in treatment and to be more willing to engage in emotional risk-taking within therapy; however, an initial ambivalence about the relationship is not necessarily a prognostic indicator of treatment failure. Ambivalence at the beginning of treatment does not preclude the couple's ability to try to improve and understand their relationship in order to come to a good decision about whether to continue with the marriage and in fact is often quite understandable in light of the presenting issue. It is often helpful to frame this ambivalence as such in order to normalize these feelings.

On the other hand, as the treatment progresses, one may find that the issue of commitment in the treatment of infidelity is related to a developmentally based fear of intimacy or feelings of being trapped in a stable relationship. Attachment theorists describe a pattern of attachment that is characterized by approach-avoidance (e.g., Hazan & Shaver, 1987). Individuals with this pattern may need intimate relationships and seek them out yet fear them to such an extent that they find it difficult to feel safe in long-term intimate relationships. Affairs may then serve as a means to create a safe level of distance from their partners (Allen & Baucom, 2004). In this case, the participating partner may need adjunctive individual treatment targeted toward this issue before the couple's relationship is able to recover.

Differences in Affair Patterns

Reactions to a one-night stand may be quite different from the same person's reactions to the discovery of a long-term emotional and sexual extramarital involvement, and various types of affairs have different implications for the continuation of the couple's relationship. In addition, empirical research by Glass and Wright (1985) found that affairs in which there is both emotional and sexual involvement are more predictive of couple dissatisfaction than either of these types alone. Affairs in which both types of involvement are present are likely to be more disruptive to the relationship and require a greater amount of time and processing for the couple to adequately address pertinent issues.

Similarly, a history of repeated affairs has implications for treatment. If the injured partner has been through the process several times before, the participating partner's expressions of remorse and protestations of good behavior may ring hollow. Not surprisingly, it will be more difficult for the injured partner to take the emotional risks required to rebuild trust and intimacy in the relationship. Indeed, it may be the therapist's task to help the injured partner realistically evaluate if she or he should even take those risks; that is, to facilitate realistic expectancies for the future. Injured partners in such situations may still be able to go through the recovery process, but they may need to evaluate the potential risks and benefits of staying in a relationship with a partner who is vulnerable to engaging in extramarital affairs on a repeated basis.

Finally, in extending this model to couples for whom the affair is ongoing, interventions during Stage 1 of the treatment 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. Often, participating partners are reluctant to end an affair that has been ongoing for some time and that provides emotional as well as physical intimacy, particularly if the marital relationship is currently dominated by emotional distance or conflict. Demanding that the participating partner terminate the outside affair relationship immediately and completely may prematurely precipitate that partner's decision to end both the therapy and their marriage. At the same time, it is important that the therapist clearly communicate that any continuation of the outside relationship on either an emotional or sexual level will preclude the couple's ability to recover stability in their own relationship and evaluate whether they can restore trust and intimacy in the long term. Hence, in situations involving an ongoing affair, the therapist should work to (1) promote the participating partner's agreement to limit or suspend involvement with the outside person on an intermediate basis, (2) construct a tentative timeline for reaching a more permanent decision about whether to end the outside relationship, and (3) assist both partners in defining specific ground rules for how they will interact with each other, as well as with others outside their relationship, during the interim.

Traditional Behavioral Couple Therapy and Integrative Behavioral Couple Therapy

The previous discussion describes an intervention that was developed specifically for the treatment of infidelity, incorporating interventions from cognitive-behavioral couple therapy, insight-oriented couple therapy, trauma intervention models, and forgiveness approaches to interpersonal transgressions. It is also possible that intervening with infidelity can be handled within the context of existing couple therapy approaches. In most couple therapy treatment studies, infidelity is addressed using the typical therapeutic format, without employing special conceptualizations or interventions for infidelity. Thus, it is important to consider whether traditional behavioral couple therapy (TBCT) or evolutions of TBCT such as integrative behavioral couple therapy (IBCT; Jacobson & Christensen, 1998) are effective in treating affairs without the special considerations described previously in the infidelity-specific intervention of Gordon, Baucom, and Snyder.

TBCT (Jacobson & Margolin, 1979) was developed using behavioral and social-learning theory, and the focus of therapy is on teaching the couple behavioral skills such as communication and problem-solving to address their relationship problems. When applied to infidelity, TBCT teaches couples to communicate about their concerns regarding the affair and to become behaviorally specific about what needs to change. The couple then problem-solves regarding what individual and couple behavior changes surrounding the affair need to occur to make the relationship more satisfying. This is a similar logic to what would occur with almost any relationship concern from a TBCT perspective.

Christensen and Jacobson (2000; Jacobson & Christensen, 1998) developed IBCT to build on behavioral couple therapy by emphasizing emotional acceptance. IBCT is centered around a case formulation of the presenting problems of the couple. This formulation emphasizes the vulnerabilities in each partner, the differences between partners that often trigger each other's vulnerabilities, the often frustrating interaction patterns in which partners engage as they try to negotiate their differences, and the often polarizing impact that these interactions have, making the problems worse rather than better. IBCT includes a core assumption that there are genuine differences in all couples that are not easy to change and that partners' emotional reactions to these differences—based in part on each one's vulnerabilities—are as problematic, or more so, than the differences themselves. Therefore, interventions focus on a balance between active change in partners' behavior and the achievement of acceptance between partners regarding their differences and the resultant behavior.

In addition to the use of typical behavioral interventions described previously to promote behavior change, IBCT employs three major strategies to promote acceptance: empathic joining, unified detachment, and tolerance building (Christensen & Jacobson, 2000; Jacobson & Christensen, 1998). During empathic joining, the IBCT therapist elicits vulnerable feelings (e.g., sadness) that may underlie partners' observed negative emotional reactions (e.g., anger) about an area of concern, encourages expression and elaboration of these vulnerable feelings, and communicates empathy for these understandable reactions. As a result, the therapist attempts to build empathy between the partners for each other. During unified detachment, the therapist helps the couple step back from the problem and assume a more descriptive and less evaluative stance toward the problem. For example, the therapist may engage the couple in an effort to describe (without evaluating) the common sequence that they go through, to specify the triggers that activate each other and escalate negative emotions, to create a name for their problematic pattern, and to consider variations in their interaction pattern and factors that might account for these variations. In tolerance building, the therapist helps the couple remember the positive aspects and benefits of their individual differences as well as the negative implications of their differences. The therapist might encourage the couple to engage deliberately in a problematic interaction around their differences in the session or at home so they can become more aware of their pattern, become less sensitized to it, take it less personally, and become more tolerant of it.

IBCT therapists working with a couple in which there has been infidelity would begin, as with any couple, by gathering information in order to understand the struggles of the couple and to generate a formulation of these struggles. There is no assumption that couples who have had an affair will inevitably have certain kinds of experiences or go through certain necessary stages. Although many couples may go through the stages described in the previous model, there is no a priori assumption of stages in IBCT. Affairs may not be traumatic for some couples, and their issues about them can be quite varied. For example, in one couple the husband's emotional reaction to the discovery of his wife's affair was tempered by his awareness of his own affairs, and his primary concern was that her affair not be a precursor to her leaving him. In another instance, a wife assumed that her husband probably had sexual dalliances but was primarily concerned that he "not bring any diseases home." Of course, IBCT therapists ensure that a couple's initial

presentation does not mask more serious concerns. For example, a wife may assume a cavalier stance toward her husband's indiscretions because she does not feel entitled to complain or fears that any complaints could lead to his abandoning her.

Once IBCT therapists have generated a formulation of their couple's difficulties, they use the previously mentioned strategies to address the emotional vulnerabilities and reactions in each partner and to de-escalate the polarizing interaction that occurs. For example, if a wife has been traumatized by her husband's affair and the injury is particularly painful because of her own history of previous men who have betrayed her, the IBCT therapist would use empathic joining to help her voice her pain and assist her husband in hearing it. IBCT therapists would also be sensitive to the pain of the husband, however, but without detracting from the primacy of her pain or establishing any so-called equality of pain between the two. If this particular couple engaged in a common but frustrating interaction pattern in which the wife pushes to talk about the affair whereas the husband avoids those discussions with vague entreaties to "move on," IBCT therapists would use unified detachment to help the couple recognize the usual triggers for the pattern, to understand the mutual sequence of behavior in the pattern, to understand how it separates them, and to achieve some emotional distance from the pattern. A goal of empathic joining would be a stronger intimate connection between the two partners; a goal of the unified detachment would be to reduce the friction that damages that intimacy.[2]

Preliminary Empirical Findings Regarding Interventions for Couples When Infidelity Has Occurred

As can be seen, there is overlap between the IBCT approach and Gordon et al.'s (2004) infidelity-specific intervention for addressing infidelity. At the same time, IBCT was developed as a more general approach to relationship distress and therefore does not have the elaborated interventions specific to addressing infidelity in Gordon et al.'s model. At present, no large-scale randomized trials have been conducted that evaluate either Gordon et al.'s intervention or TBCT or IBCT for infidelity or that directly compare these interventions. Two preliminary studies, however, have been conducted that shed some light on the utility of these interventions for assisting couples experiencing infidelity.

The methodological details of these two investigations are provided elsewhere. For their infidelity-specific intervention, see Gordon et al. (2004), and for the treatment outcome investigation involving TBCT and IBCT, the reader is referred to Atkins, Eldridge, Baucom, and Christensen (2005) and Christensen et al. (2004). Briefly, for Gordon et al.'s infidelity-specific treatment, married couples were recruited through television stories, radio interviews, and newspaper ads. To be eligible for the investigation, couples must have experienced an extramarital affair within the past year that had since ended. Thus, couples were selected specifically because of their distress regarding infidelity. Nine couples were assigned consecutively to the infidelity-specific intervention that could continue for up to 26 sessions. No comparison control group was established in this investigation; the study was designed as a series of replicated case studies.

A group of 19 couples reporting infidelity from Christensen et al.'s (2004) randomized clinical trial comparing TBCT with IBCT for treatment of generalized relationship distress was identified from the larger sample of 134 couples in this trial. The broader goal of that investigation was to compare the relative efficacy of IBCT and TBCT for relationship discord; within that context, couples were randomly assigned to one of these two treatments. Whereas couples were selected because of the presence of relationship distress and not for infidelity, 19 of the couples in the study had experienced a previous affair, were engaged in infidelity when treatment began, or initiated an affair while treatment was under way. As described by Atkins et al. (2005), these

19 couples were selected from the larger sample for evaluation of the effects of couple therapy on distressed couples experiencing infidelity. Because of the small sample size, couples receiving either IBCT or TBCT were combined to evaluate the effects of treatment. As in the Gordon et al. (2004) investigation, couples could receive up to 26 sessions.

Whereas both of these investigations included a large number of outcome measures, for current purposes we will focus on a small set of measures to provide some indication of the extent to which the interventions promoted change in both relationship and individual functioning. Both investigations included the Global Distress Scale of the Marital Satisfaction Inventory–Revised (Snyder, 1997), and it serves as the overall index of marital adjustment in this report. To assess overall individual psychological symptomatology, Gordon et al. (2004) used the Brief Symptom Inventory (Boulet & Boss, 1991), whereas Atkins et al. (2005) used the Current Symptoms subscale of the Compass Outpatient Treatment Assessment System (Sperry, Brill, Howard, & Grissom, 1996). To assess depression, Gordon et al. used the Beck Depression Inventory (Beck, Rush, Shaw, & Emery, 1979), whereas Atkins et al. used the Depression subscale of the Compass.[3]

Because of the small sample sizes in these two investigations, inferential statistics to assess changes in functioning from pretest to posttest were inappropriate. A standardized unit of change from the beginning to the end of couple therapy was employed, however: the intragroup effect size. It reflects the level of change at posttest relative to pretest, as measured in standard deviation units. The effect size is defined as the difference between the mean posttest score and the mean pretest score, divided by the pooled standard deviation. Effect sizes were calculated for each treatment condition, corrected for small sample bias (Hedges & Olkin, 1985). Whereas most couple treatment outcome investigations present findings separately for males and females, for current purposes it seemed more appropriate to differentiate the effects of treatment for the participating and injured partners. That is, we note whether there were different patterns of results for the person who had the affair versus his or her injured partner.

The intragroup effect sizes are presented in Table 1. With regard to marital functioning, in both the Gordon et al. (2004) and the Atkins et al. (2005) studies, the injured partners demonstrated notable improvement; however, effects for the participating partners were different. In the Gordon et al. study, the participating partners showed almost no changes in marital satisfaction, whereas the participating partners showed large changes in the Atkins et al. study. In interpreting these findings, it is important to recall the different purposes of these two investigations and the selection criteria. In the Atkins et al. study, couples were selected because they were maritally distressed, and the treatment focused on the alleviation of relationship discord. Consistent with more detailed analyses presented by Atkins et al. regarding this treatment's efficacy, the current findings indicate that IBCT and TBCT are effective in improving marital distress for discordant couples who also are experiencing infidelity. On the other hand, Gordon et al. selected couples on the basis of a recent affair and not for the presence of marital discord per se. Whereas the injured partners were maritally distressed at the beginning of treatment, the participating partners were not as maritally distressed, perhaps accounting for their lack of change on marital satisfaction over the course of treatment.

The pattern of findings for the two investigations is different when individual psychological distress is examined. In the Atkins et al. (2005) study, neither the injured partners nor the participating partners demonstrated notable individual psychopathology at pretest, and there were few changes in either global symptoms or depression over the course of treatment. By contrast, in the Gordon et al. (2004) study, both groups of partners showed more individual symptomatology at the beginning of treatment. This again likely results from the selection criteria for the investigation. Couples sought assistance in the Gordon et al. study because of their distress regarding the recent interpersonal trauma of infidelity. Previous findings indicate that couples seeking intervention for such a trauma are likely to be distressed individually (Beach, Jouriles, & O'Leary, 1985; Cano & O'Leary, 2000). The findings detailed here indicate that the infidelity-

TABLE 1. INTRAGROUP EFFECT SIZES FOR TREATING INFIDELITY

	Injured Partners		Participating Partners	
Measure	Gordon et al. (2004) — Trauma-Specific Intervention	Atkins et al. (2005) — IBCT and TBCT	Gordon et al. (2004) — Trauma-Specific Intervention	Atkins et al. (2005) — IBCT and TBCT
Global marital distress	0.70	0.79	0.08	1.02
Global individual symptoms	1.13	0.20	0.24	−0.10
Depression	0.38	−0.01	0.61	0.24

specific intervention was particularly useful in alleviating global psychological symptoms for the injured partners. In addition, it is noteworthy that there was a medium effect size in decreasing depression among the participating partners as well. It is common to focus upon the individual distress experienced by the injured partner surrounding infidelity, yet the findings remind us that the participating partner might well also be in notable distress.

Given the small sample sizes, the different selection criteria and foci of the two investigations, and that the infidelity-specific and IBCT/TBCT interventions were not directly compared in a randomized controlled investigation, it is inappropriate to consider the relative efficacy of these different approaches. Instead, these findings provide only initial glimpses of issues to take into account when treating couples with infidelity. First, the presenting complaints of couples or reasons for seeking couple-based interventions might be important. Some couples will have suffered a recent affair and are seeking treatment to help them through the pain of that experience. Although the sample size is small in the Gordon et al. (2004) study, the findings indicate that the participating partners might not be as maritally distressed in that context, whereas the injured partners are much more likely to be distressed about the relationship following the affair. In such instances, a strong focus on the affair is appropriate, recognizing that both partners might be suffering individual distress as well; the more that one or both partners shows symptoms of trauma, the more the infidelity-specific intervention likely will be useful.

Another group of couples seeks couple-based interventions because they are more generally maritally distressed, with a previous or current affair as part of their relationship context. Elsewhere, Atkins et al. (2005) report that this same sample of couples begins treatment more maritally distressed than couples without an affair. These couples with an affair actually demonstrated more change in response to treatment than couples without an affair. Consequently, treating couples who are seeking treatment for marital distress more broadly and who have experienced or are experiencing infidelity as part of that picture is possible with existing empirically supported interventions such as IBCT and TBCT.

Given that (1) Gordon et al.'s (2004) infidelity-specific intervention (which also attends to broader relationship issues) has not been evaluated for couples seeking treatment of marital discord more broadly, along with a history of infidelity; and (2) IBCT and TBCT have not been evaluated among couples specifically targeting assistance for infidelity, however, it is premature to recommend differential treatments for these various groups of couples. At this point with existing data, the results are generally promising and provide the clinician with suggestions for how to address the trauma of infidelity in a more focal manner as well as how to attend to broader relationship and individual distress.

As we noted at the beginning of this article, infidelity is one of the most distressing and complex problems that couples and couple therapists experience. Whereas we still have a great deal to learn both clinically and empirically, we offer the current article as a way to understand and conceptualize infidelity, along with suggestions for helping couples through this extremely difficult time in their relationship.

Notes

1. Throughout this discussion, the term *participating partner* is used to describe the person having the affair, and *injured partner* is the term used to describe the person not having the affair, while recognizing that both partners may be injured considerably by what has occurred.

2. See the treatment manual for IBCT (Jacobson & Christensen, 1998) or the guide for couples (Christensen & Jacobson, 2000) for further information about how IBCT deals with affairs as well as other couple problems.

3. Further details of these widely used measures (along with pretest and posttest descriptive statistics for the samples on these measures) are provided in the original descriptions of these investigations noted previously.

References

Abrahms Spring, J. (with Spring, M.). (1996). *After the affair: Healing the pain and rebuilding trust when a partner has been unfaithful.* New York: Harper Collins.

Allen, E. S., & Baucom, D. H. (2004). *Adult attachment and patterns of extradyadic involvement.* Manuscript submitted for publication.

Allen, E. S., Atkins, D. C., Baucom, D. H., Snyder, D. S., Gordon, K. C., & Glass, S. P. (2005). Intrapersonal, interpersonal, and contextual factors in engaging in and responding to extramarital involvement. *Clinical Psychology: Science and Practice, 12,* 101–130.

Amato, P. R., & Rogers, S. J. (1997). A longitudinal study of marital problems and subsequent divorce. *Journal of Marriage and the Family, 59,* 612–624.

Atkins, D. C., Baucom, D. H., & Jacobson, N. S. (2001). Understanding infidelity: Correlates in a national random sample. *Journal of Family Psychology, 15,* 735–749.

Atkins, D. C., Eldridge, K. A., Baucom, D. H., & Christensen, A. (2005). Infidelity and behavioral couple therapy: Optimism in the face of betrayal. *Journal of Consulting and Clinical Psychology, 73,* 144–150.

Baucom, D. H., Gordon, K. C., & Snyder, D. K. (2005). Treating affair couples: An integrative approach. In J. L. Lebow (Ed.), *Handbook of clinical family therapy* (pp. 431–463). New York: Wiley.

Beach, S. R., Jouriles, E. N., & O'Leary, K. D. (1985). Extramarital sex: Impact on depression and commitment in couples seeking marital therapy. *Journal of Sex and Marital Therapy, 11*(2), 99–108.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy and depression.* New York: Guilford.

Boulet, J., & Boss, M. W. (1991). Reliability and validity of the Brief Symptom Inventory. *Psychological Assessment, 3,* 433–437.

Brown, E. (1991). *Patterns of infidelity and their treatment.* New York: Brunner/Mazel.

Cano, A., & O'Leary, K. D. (2000). Infidelity and separations precipitate major depressive episodes and symptoms of nonspecific depression and anxiety. *Journal of Consulting and Clinical Psychology, 68,* 774–781.

Christensen, A., Atkins, D., Berns, S., Wheeler, J., Baucom, D. H., & Simpson, L. (2004). Traditional versus integrative behavioral couple therapy for significantly and stably distressed married couples. *Journal of Consulting and Clinical Psychology, 72,* 176–191.

Christensen, A., & Jacobson, N. S. (2000). *Reconcilable differences.* New York: Guilford.

Enright, R. D., & the Human Development Study Group. (1991). The moral development of forgiveness. In W. Kurtines & J. Gewirtz (Eds.), *Handbook of moral behavior and development* (pp. 123–152). Hillsdale, NJ: Erlbaum.

Epstein, N. B., & Baucom, D. H. (2002). *Enhanced cognitive-behavioral therapy for couples: A contextual approach.* Washington, DC: American Psychological Association.

Freedman, S. R., & Enright, R. D. (1996). Forgiveness as an intervention goal with incest survivors. *Journal of Consulting and Clinical Psychology, 64,* 983–992.

Glass, S., & Wright, T. (1985). Sex differences in type of extramarital involvement and marital dissatisfaction. *Sex Roles, 12,* 1101–1120.

Glass, S., & Wright, T. (1997). Reconstructing marriages after the trauma of infidelity. In W. K. Halford & H. J. Markman (Eds.), *Clinical handbook of marriage and couples interventions* (pp. 471–507). Chichester, UK: Wiley.

Gordon, K. C., & Baucom, D. H. (1998). Understanding betrayals in marriage: A synthesized model of forgiveness. *Family Process, 37,* 425–450.

Gordon, K. C., Baucom, D. H., & Snyder, D. K. (2004). An integrative intervention for promoting recovery from extramarital affairs. *Journal of Marital and Family Therapy, 30,* 213–231.

Hazan, C., & Shaver, P. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology, 52,* 511–524.

Hedges, L. V., & Olkin, I. (1985). *Statistical methods for meta-analysis.* Boston: Academic Press.

Jacobson, N. S., & Christensen, A. (1998). *Acceptance and change in couple therapy: A therapist's guide to transforming relationships.* New York: Norton.

Jacobson, N. S., & Margolin, G. (1979). *Marital therapy: Strategies based on social learning and behavior exchange principles.* New York: Brunner/Mazel.

Janoff-Bulman, R. (1989). Assumptive worlds and the stress of traumatic events: Applications of the schema construct. *Social Cognition, 7,* 113–136.

Janus, S. S., & Janus, C. L. (1993). *The Janus report on sexual behavior.* New York: Wiley.

Kirby, J. S., & Baucom, D. H. (2006). *Integrating dialectical behavior therapy and cognitive-behavioral couple therapy: A couples skills group for emotion dysregulation.* Manuscript submitted for publication.

Lauman, E. O., Gagnon, J. H., Michael, R. T., & Michaels, S. (1994). *The social organization of sexuality.* Chicago: University of Chicago Press.

Lusterman, D. D. (1998). *Infidelity: A survival guide.* Oakland, CA: New Harbinger.

Pittman, F. (1989). *Private lies: Infidelity and the betrayal of intimacy.* New York: Norton.

Reibstein, J., & Richards, M. (1993). *Sexual arrangements: Marriage and the temptation of infidelity.* New York: Scribner's.

Resick, P. A., & Calhoun, K. S. (2001). Posttraumatic stress disorder. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders* (3rd ed., pp. 60–113). New York: Guilford.

Rowe, J. O., Halling, S., Davies, E., Leifer, M., Powers, D., & van Bronkhorst, J. (1989). The psychology of forgiving another: A dialogal research approach. In R. S. Valle & S. Halling (Eds.), *Existential-phenomenological perspectives in psychology: Exploring the breadth of human experience.* New York: Plenum.

Snyder, D. K. (1997). *Marital Satisfaction Inventory–Revised.* Los Angeles: Western Psychological Services.

Snyder, D. K. (1999). Affective reconstruction in the context of a pluralistic approach to couples therapy. *Clinical Psychology: Science and Practice, 6,* 348–365.

Snyder, D. K., Baucom, D. H., & Gordon, K. C. (in press). *Getting past the affair: A program to help you cope, heal, and move on—together or apart.* New York: Guilford.

Snyder, D. K., Heyman, R., & Haynes, S. N. (2005). Evidence-based approaches to assessing couple distress. *Psychological Assessment, 17,* 288–307.

Snyder, D. K., & Whisman, M. A. (Eds.). (2003). *Treating difficult couples: Helping clients with coexisting mental and relationship disorders.* New York: Guilford.

Sperry, L., Brill, P. L., Howard, K. I., & Grissom, G. R. (1996). *Treatment outcomes in psychotherapy and psychiatric interventions.* New York: Brunner/Mazel.

Whisman, M. A., Dixon, A. E., & Johnson, B. (1997). Therapists' perspectives of couple problems and treatment issues in the practice of couple therapy. *Journal of Family Psychology, 11*, 361–366.

Worthington, E. L. (Ed.). (in press). *Handbook of forgiveness.* New York: Brunner-Routledge.

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