
Treating Infidelity: Clinical and Ethical Directions



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This article addresses clinical and ethical directions in treating clients coping with infidelity. Developing competence in this domain requires familiarity with empirical research regarding infidelity, individual and cultural differences involving nonmonogamy, and assessment and intervention skills related to treating infidelity. Practical directions will entail distinguishing among responsibilities to individual partners versus their relationship and managing related potential conflicts of interest with other involved parties. Confidentiality assumes increased complexity when confronting undisclosed infidelity in couple therapy and when a client engaging in high-risk behaviors for contracting STDs or testing seropositive for HIV has not informed his or her partner(s). Finally, we discuss therapists' need to concretely articulate their values that influence treatment of infidelity. © 2005 Wiley Periodicals, Inc. *J Clin Psychol/In Session* 61: 1453–1465, 2005.

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Treating clients coping with infidelity presents special clinical and ethical challenges. Among these challenges are ensuring professional competence, inherent conflicts of interest when dealing with multiple clients, policies and limitations regarding confidentiality, and responsibility for clarifying implicit values. Therapists confronting the challenges of treating infidelity may turn to ethical codes of conduct articulated by the American Psychological Association (APA, 2002), the American Association for Marriage and Family Therapy (AAMFT, 2001), or other professional associations. Additional resources include

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publications on special difficulties in interpreting and implementing ethical principles when working with couples and families (e.g., Gottlieb, 1996; Margolin, 1982, 1986; Marsh & Magee, 1997; O'Shea & Jessee, 1982). In this article, we highlight the practice challenges unique to treating infidelity.

Ensuring Professional Competence

Knowledge Base

Working with individuals coping with infidelity requires familiarity with information regarding common antecedents, correlates, and consequences of affairs. As Allen and colleagues note (Allen & Atkins, 2005, this issue; Allen et al., 2005), such knowledge enables clinicians to examine ways in which nomothetic findings apply to a particular individual or couple in constructing a comprehensive formulation of how an affair has developed. Similarly, knowledge of infidelity research can help therapists to normalize certain experiences and challenge faulty attributions. For example, by recognizing that injured partners frequently struggle with symptoms similar to posttraumatic stress disorder (PTSD) both immediately following and oftentimes long after an affair has become known, therapists can promote more specific coping skills and tolerance in partners for these experiences (Gordon, Baucom, & Snyder, 2005, this issue). Similarly, as suggested by Pittman and Wagers (2005, this issue), familiarity with physiological processes accompanying an affair may help to place the subjective experience of a new sexual relationship in broader perspective and forestall long-term decisions based on transient emotional states.

Widespread but inaccurate beliefs about affairs may be prevalent not only among the general public, but also among experienced clinicians. Therapists may err in diverse ways. They may, for example, believe that the prevalence of infidelity conveys its implicit acceptability and hence underestimate its potential adverse effects, or they may assume that the negative consequences of an affair are irrevocably toxic and destined to culminate in divorce or enduring relationship distress. Moreover, when uninformed of empirical findings regarding the prevalence of infidelity or its correlates, therapists may be more likely to draw on their own personal experiences as a perspective for responding to affairs of their clients. Indeed, an early survey of clinical members of AAMFT (Knapp, 1975) found that therapists who had experienced some type of extramarital sex or described themselves as personally "in favor" of outside sexual experiences were more accepting in their attitudes toward clients involved in sexually open marriages, secret affairs, and "recreational swinging" than were therapists who described themselves as "uncertain about" or "against" extramarital sex themselves.

Familiarity With Individual Differences

Principles of ethical conduct published by the APA (2002) emphasize that therapists should be aware of and respect cultural, individual, and role differences—including those based on gender, ethnicity, culture, religion, and sexual orientation—and that they should strive "to eliminate the effect on their work of biases based on those factors" (p. 1063). Just as therapists are vulnerable to conceptualizing infidelity from the perspective of their own relationship history, they may be even more susceptible to implicit norms of their respective cultures (both personal and professional).

Respect for individual differences in nontraditional relationships and variations in views regarding nonmonogamy does not require the therapist to wholly reject a culture's

expectations or implicit values. Rather, culturally sensitive therapy involves delineating features of an individual's behavior that are congruent and incongruent with his or her social context across multiple levels including expectations in the current relationship, extended family and support system, subculture bounded by ethnicity or sexual orientation, and broader cultural or societal milieu. After placing an individual's behavior within the appropriate social context, the therapist can then begin to explore the adaptive and maladaptive aspects of that behavior. Therapists may err in either direction—either by underestimating the impact of culture and incorrectly attributing dysfunction to a pattern that is normative in that couple's culture or by overestimating the impact of culture and failing to recognize relationship processes that are dysfunctional for a particular couple or family within that culture (Margolin, 1986).

Martell and Prince (2005, this issue) note that because sexual nonmonogamy is more common in gay male relationships than in heterosexual couples, the context of the gay couple's agreement with one another about outside sexual activity is crucial in understanding its impact. From this perspective, although the proximal culture among gay couples may be more accepting of nonmonogamous relationships, for a given couple the impact may be defined by such expectations as those concerning single versus repeated sexual exchanges with the same outside person, secrecy versus openness of these exchanges, emotional versus sexual involvement, and use of protection against contracting sexually transmitted diseases (STDs). Similarly, the utilitarian approach advocated by Linquist and Negy (2005, this issue) increases the burden of therapists to become knowledgeable about the individual and social contexts in which extramarital relationships occur when evaluating potential costs and benefits.

Assessment and Intervention Skills

Therapists helping clients with infidelity need to acquire skills relevant to assessment and intervention. Given the prevalence of extramarital affairs among couples seeking treatment, inquiring about emotional or sexual involvement with someone outside the couple's relationship should comprise a standard component of the initial evaluation. Indeed, preliminary findings (Atkins, Eldridge, Baucom, & Christensen, 2005) indicated that, among couples in therapy, those in which a partner failed to reveal a secret affair during the course of treatment had poorer outcomes than those couples in which an affair was revealed either prior to or during therapy. Therapists will vary in their preference for (a) initial assessment by interview versus self-report measures, (b) inquiry in individual versus conjoint sessions, and (c) introducing discussion of outside relationships with general questions about "other significant persons in the couple's relationship" versus specific queries regarding extramarital affairs. Whisman and Wagers (2005, this issue) note that, at a minimum, therapists need to ascertain whether an individual (or partner) has engaged in a sexual or emotionally intimate relationship with someone outside of marriage, whether that relationship is ongoing, and whether there have been occasions of sexual intercourse without protection against STDs. Moreover, nomothetic findings regarding emotional and behavioral difficulties accompanying the discovery of a partner's affair (e.g., depression, suicidality, anxiety, PTSD) suggest the need for assessment procedures targeting these concerns. Therapists also need to be familiar with any legal mandates in their jurisdiction regarding the duty to warn in cases of clients testing seropositive for HIV or other STDs, and they need to inform clients ahead of time of confidentiality policies regarding this or related issues (as discussed further below).

The literature is replete with descriptions of treatments for clients coping with infidelity, but only two studies (both emphasizing couple-based treatments) have demonstrated

empirical support for clinical interventions in this domain. In the first study, Atkins and colleagues (2005) examined treatment outcomes for 19 couples reporting an affair by one of the partners participating in a randomized trial of integrative behavioral couple therapy (IBCT) versus traditional behavioral couple therapy (TBCT) in which 134 couples were recruited on the basis of relationship discord, rather than specifically for affairs. Results showed that infidelity couples (7 of whom received IBCT and 12 of whom received TBCT) began treatment more distressed than did couples not reporting infidelity, but that couples for whom there had been an affair also improved at a greater rate during the course of therapy than did couples not dealing with infidelity. In the second study, Gordon, Baucom, and Snyder (2004) reported findings from a replicated case study of an integrative approach designed to assist couples recovering from an extramarital affair. At termination, the majority of participants in the study reported less emotional and marital distress, and individuals whose partner had participated in the affair reported greater forgiveness toward their partner. In an era of evidence-based practice, therapists treating couples recovering from an affair are advised to be competent in the evidence-based methods emphasized in these studies or other treatments garnering empirical support in future research.

Defining the Client and Managing Conflicts of Interest

Clarifying which persons are clients is inherently more difficult in couple or family therapy than in individual treatment, and these difficulties are magnified when treating individuals or couples dealing with infidelity. The APA (2002) ethics code states that, "When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person" (pp. 1072–1073). Determining "who the client is" constitutes an essential prerequisite to subsequent decisions regarding informed consent and confidentiality. Efforts to delineate client boundaries become more problematic when these boundaries shift over the course of treatment—for example, when shifting from individual to conjoint couple therapy. Even under advantageous circumstances—for example, when two partners present simultaneously for couple therapy and agree to identify their relationship as the "client"—conflicts of interest may be unavoidable. Margolin (1986) asserted that, "The marital therapist must ensure that, at a minimum, improvement in one spouse does not occur at the long-range expense of the other" (p. 624). This criterion for ethical treatment may be difficult to achieve, particularly with couples in which partners differ in mental or physical health, or when caring for one partner requires accommodations with adverse consequences for the other. Therapists confront inherent conflicts of interest in addressing competing needs of individual partners, their relationship, or other vested parties not participating in the therapy (e.g., children of parents contemplating divorce). For example, how does one balance a parent's right not to share information regarding an affair with their partner who is not involved in treatment against concerns regarding adverse consequences for a child who has been led by that parent to share in the secret?

Gottlieb (1996) outlined four stances one can adopt in couple or family therapy in navigating respective responsibilities: (a) pledging primary loyalty to each family member as if they were being treated as individuals, thereby intending that the treatment serves the best interest of each family member; (b) being responsible only to the system and refusing to align with any individual, thus targeting the couple relationship or family

system as the beneficiary regardless of the impact on any one individual; (c) declaring loyalty to all, but shifting alliances between individuals or subsystems during treatment sessions as determined by the therapist's judgment about the greater good of the individuals and the relationship or family; or (d) adhering exclusively to the stated therapeutic goals of the family, independent of the therapist's own judgment regarding the relative merits of these goals. Adhering to any one stance in the face of shifting goals or needs of one individual may be not only difficult, but also ineffective treatment. Unfortunately, there are no outcome studies attesting to the differential effectiveness of any of these four stances.

Consider the following case: A couple sought treatment from one of the authors (DKS) following the husband's discovery that his wife was having an affair. The couple explained that they had agreed from the outset of their relationship to have a sexually open marriage, with the provision that each partner would be fully informed of the other's sexual exchanges with outsiders and that outside sexual relationships would never become "emotional." In this case, the husband became irate and cited his wife's affair after learning that she had pursued sexual relations with the same man on several occasions over 6 months and had weekly phone conversations in which they discussed their personal lives. In initial sessions, the wife professed remorse for violating the couple's prior agreement and agreed to suspend the outside relationship. However, as treatment progressed, she expressed increasing despair over her lack of emotional fulfillment and disclosed her ambivalence about staying in the marriage. In subsequent sessions she gained awareness of, and was able to articulate, both shame and enduring resentments of the couple's own emotional and sexual relationship. Although the husband then tentatively agreed to a monogamous relationship at her request, he subsequently expressed resentment over the altered terms of their explicit marriage contract and renewed his attacks on her emotional infidelity. After several months of sorting through conflicting individual and relationship needs in therapy, the wife filed for divorce. In working with this couple, the therapist struggled to define the client. An initial agreement to accept the couple's working definition of a shared relationship value espousing a sexually open marriage became untenable as the partners progressively diverged in their respective needs. Ultimately, when confronted with conflicting goals of the two partners, the therapist aligned himself with the partner expressing needs and values more consistent with his own beliefs—a common resolution pursued by therapists and fraught with its own ethical dilemmas (Margolin, 1982).

When working with individuals coping with infidelity, therapists are obligated to convey as soon and as fully as possible their conceptualization of who comprises the client and their stance regarding therapeutic neutrality, as components of informed consent to treatment. Therapists need to remain vigilant to real or perceived emerging conflicts of interest, and to ensure that multiple roles and professional responsibilities are clarified as often as necessary (Gottlieb, 1996).

Handling Issues of Confidentiality

Managing confidentiality often presents unique challenges. When a recent or ongoing affair is disclosed to the therapist by one partner but remains unknown by the other, treatment of the couple by that therapist may become difficult if not impossible. In this section, we address principles of confidentiality in work with couples and families, and then apply these principles in specific situations involving infidelity.

Principles of Confidentiality

Ethical guidelines adopted by the APA and AAMFT emphasize that policies regarding confidentiality should be discussed at the outset of treatment and thereafter as new

circumstances may warrant. Gottlieb (1996) identified four approaches to handling confidentiality when working with couples or families: (a) treat information disclosed individually as confidential; (b) set a policy that no information is to be confidential; (c) agree that certain information will be kept confidential as a matter of personal privacy; or (d) agree to keep certain information confidential temporarily with the understanding that it will be disclosed at a later date. The implications of these approaches vary considerably when confronting an undisclosed affair. One of the most difficult confidentiality situations occurs when one spouse reveals an affair and the other has made "no affairs" the condition for continuing the marriage. Although cogent arguments can be made for handling such situations differently depending on the circumstances of the affair, one overarching principle finds repeated affirmation throughout discussion of ethical issues in the literature: The most difficult predicament for the therapist would be if she or he failed to convey a policy on confidentiality ahead of time (Margolin, 1982).

Handling Undisclosed Infidelity in Couple Therapy

Many couple therapists would concur with the view expressed by Whisman and Wagers (2005, this issue) that ongoing infidelities known by the therapist but not disclosed to the nonparticipating partner undermine the clinician's ability to conduct couple therapy. A common stance, consistent with the approach advocated by Whisman and Wagers, is to inform participants in the initial session that anything revealed outside of conjoint sessions becomes a part of the couple therapy and, *at the discretion of the therapist*, may be disclosed in subsequent sessions involving both partners. The qualifier regarding the therapist's discretion permits clinical judgments concerning the potential consequences for all participants of sharing or withholding specific information on either an interim or permanent basis. For example, different clinical decisions may be reached in situations in which (a) a brief infidelity occurred 10 years earlier in the marriage with someone unknown to the other partner, (b) an equally brief infidelity occurred 2 months earlier with a friend of the other partner during the couple's 2-week trial separation, or (c) one partner describes the recent development of an extramarital affair and expresses uncertainty about whether to continue that affair or—if deciding to end it—whether to disclose it to the other partner.

Even when all participants have been informed from the outset regarding limitations to confidentiality and have explicitly consented to these constraints, individuals frequently devise creative ways of disclosing an affair to the therapist outside of conjoint sessions and then requesting or demanding that this information be kept confidential. In such situations, the therapist has several options. One course is to insist that the individual disclose this information to the other partner and, if the individual refuses, to disclose that information oneself in a subsequent conjoint session or in an individual session with the other partner if the first individual refuses to participate. Another course would be to consent to treat that information as confidential on an interim basis, but to insist that the person disclose the affair to the other partner within a specified time period and to offer individual sessions on an interim basis to assist in working toward that goal. If the person having the affair refuses to disclose this to the other partner then, similar to guidelines recommended by Martell and Prince (2005, this issue), the therapist may require the person having the affair to tell the other partner that he or she has elected to discontinue couple therapy. If the individual refuses, the therapist may assert his or her own conclusion in a conjoint session that the first partner is insufficiently committed to couple therapy (without disclosing the reasons for this appraisal) and refuse to continue as the couple's therapist. A final course of action is that the therapist may elect to honor the

individual's request to treat information about an ongoing affair as confidential—although most couple therapists would likely regard such a stance as inherently problematic, if not untenable.

Confidentiality When Changing Therapy Format

Managing confidentiality becomes particularly difficult when changing the therapy format—when transitioning from individual, couple, or family therapy to an alternative arrangement. Such changes in treatment format require explicit communication among all participants regarding implications for changes in how confidentiality will be handled. For example, when transitioning from couple to individual therapy, the therapist and partners need to agree on whether information obtained during the individual therapy may be shared with the other partner and whether this agreement will be renegotiated if couple therapy is resumed with that therapist in the future. A more frequent dilemma occurs when transitioning from initial individual treatment to couple therapy, because policies regarding confidentiality in individual therapy may not be tenable when establishing a therapeutic alliance with both partners, particularly if infidelity has been revealed in the individual sessions with the presumption that this would not be disclosed in the future to the other partner.

Because of potential conflicts of interest, many therapists decline to transition from individual therapy to conjoint treatment if more than a few initial individual sessions have occurred. Therapists differ in their approach to this dilemma. Lusterman (2005, this issue), for one, notes that when affair-involved clients present initially for individual therapy, he sees them alone until they arrange a moratorium on the affair, at which point he initiates conjoint couple therapy. An alternative approach is to agree to couple therapy contingent on one or more initial individual sessions with the other partner and then transitioning to conjoint sessions with the explicit agreement that the affair will be disclosed within the first few sessions of couple therapy. Still another approach is to avoid changing therapy format altogether, and to refer individuals or couples to another therapist.

Addressing the Duty to Warn

When individuals engage in sexual relations with multiple partners without protection against STDs, the risk of contracting an incurable or potentially fatal disease increases not only for themselves, but also for their partners. Knowledge of a client's high-risk sexual behaviors presents complex legal and ethical dilemmas for mental health professionals. These dilemmas have received increased attention in recent years as they relate to HIV and the "duty to warn" (e.g., Burkemper, 2002; Knapp & VandeCreek, 1990; Melchert & Patterson, 1999; Schlossberger & Hecker, 1996). We summarize here some of the central issues highlighted in this literature. We also note at the outset that both case law and statutory mandates vary from state to state and are rapidly evolving; hence, therapists are strongly encouraged to pursue legal consultation through their professional association or other resources to ensure familiarity with laws governing practice in their jurisdiction.

Every mental health professional has at least rudimentary awareness of the *Tarasoff v. Regents of the University of California* (1976) case, but misunderstanding of either specific details of that ruling or its relevance to duty to warn in cases of HIV are prevalent. In this case, the Supreme Court of California ruled that:

When a psychotherapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another he incurs an obli-

gation to use reasonable care to protect the intended victim against such danger; discharge of such duty may require the therapist to take one or more of various steps, depending on the nature of the case, including warning the intended victim or others likely to apprise the victim of the danger, notifying the police or taking whatever steps are reasonably necessary under the circumstances. (p. 334)

Both individual authors and professional associations have argued (in part based on the *Tarasoff* ruling) that when a provider of mental health services (a) becomes aware of a client's HIV-positive status, (b) knows of an identifiable third party whom the provider has compelling reason to believe is at significant risk for infection, (c) has reasonable belief that the third party has no reason to suspect that he or she is at risk, and (d) finds that the client either refuses to inform the third party or cannot be trusted to notify the third party, then that provider is either permitted to notify appropriate authorities (American Psychiatric Association, 1993; American Psychological Association, 1991) or, if the authorities take no action, may be ethically compelled to notify the endangered third party (American Medical Association, 1988).

Others have argued opposing perspectives, citing the ethical mandate to preserve the client's right to confidentiality as well as distinctions between the specific situation precipitating the *Tarasoff* ruling and cases of HIV-positive clients. For example, Schlossberger and Hecker (1996) asserted that the distinction between legally permitted and legally forbidden dangers is critical to reaching decisions regarding the duty to warn. They noted that when Tatiana Tarasoff was threatened and then killed by a co-student, Prosenjit Poddar, Poddar posed a danger to her that violated her legal rights. Schlossberger and Hecker stated that, by contrast, in many states persons do not have a legal right to be informed of their sexual partners' HIV status, and they asserted that "*the therapist has no duty to intervene when clients pose dangers that society, through law, grants them the right to pose*" (p. 32, italics in original). In their view, unless state law requires HIV-positive individuals to inform their partners, therapists have no legal duty to warn. (Some states have since made it illegal for a person to risk infecting another with HIV; Burkemper, 2002.) Schlossberger and Hecker also distinguished between physician and nonmedical allied health providers, asserting that because prevention of infectious or contagious disease is not a fiduciary duty of psychotherapists, a therapist's failure to warn third parties about a client's HIV status does not constitute negligence.

In a more recent consideration of these issues, Melchert and Patterson (1999) noted that all states allow any person to make "good faith disclosures" regarding individuals' HIV status to a local, state, or federal department of health. However, at the time their article appeared, Montana was the only state that specifically protected mental health professionals from liability in making good faith disclosures to third parties at risk for HIV infection, and only Texas gave protection to all persons against liability for disclosing this information to the spouse of an HIV-positive individual. Moreover, Melchert and Patterson noted that no state *required* health care professionals to warn third parties and that "very few states . . . offer legal protection against any civil or criminal liability that psychotherapists might incur as a result of breaking confidentiality to warn third parties about their risk for HIV infection" (p. 181).

Melchert and Patterson (1999) proposed a decisional matrix regarding duty to warn third parties about a client's HIV-positive status based on whether (a) the client is currently engaging in high-risk behaviors (unprotected sexual intercourse or unclean needle sharing); (b) the client has been tested for HIV and, if so, whether results were seropositive; and (c) the client's sexual (or needle-sharing) partners are aware of HIV test results. In only two situations did the authors advocate breaking confidentiality: when the client is engaging in high-risk behaviors, has tested HIV-positive, his or her partners are unaware

of test results, and interventions aimed at getting the client to disclose his or her HIV status to at-risk third parties have failed; and when regardless of HIV status, the client is engaging in high-risk behaviors and has expressed an explicit intent to infect others. Therapists' considerations of these guidelines need to integrate statutory regulations in their jurisdiction.

Articulating the Therapist's Values

Psychotherapists have the responsibility to be aware of their own values, to examine how these values potentially influence their practice in ways that may be discrepant from their clients' values, and to inform clients of the therapist's values in a manner that allows clients to make informed decisions to initiate or continue in therapy or to consider alternative sources. This mandate applies to all forms of treatment—whether individual, couple, or family—but merits special consideration when treating individuals coping with infidelity.

Personal and Cultural Values

Therapists' assumptions and standards for intimate relationships are strongly influenced by their individual history and the various cultures (familial, religious, ethnic, or societal) to which they have been exposed. One cannot reasonably presume to practice from a "value-free" perspective; indeed, efforts to do so likely reflect an inherent set of implicit values regarding autonomy, noncontingent acceptance, and similar ideals.

Personal values involve those judgments or evaluations that are not explicitly prescribed or proscribed by the clinician's professional discipline. The codes of ethics adopted by mental health professions do not specifically advise against (or endorse) infidelity, sexually "open," or other nonmonogamous relationships. Whereas some argue that failure to assert an explicit stance challenging infidelity comprises an abdication of professional responsibility (cf., Pittman & Wagers, 2005, this issue), others argue that adopting a predetermined position regarding the merits of nonmonogamous relationships reflects a personal rather than professional value (cf., Linquist & Negy, 2005, this issue). Nothing in ethical guidelines prohibits therapists from having or interjecting personal values; rather, the guidelines indicate that therapists should be explicit in identifying personal values and acknowledging the manner in which such values may inadvertently or intentionally influence treatment.

Nearly half of couple and family therapists would support extramarital sex in at least some circumstances (Knapp, 1975), and their attitudes on this subject covaried with therapists' own personal sexual attitudes and histories. Some therapists actively discourage extramarital relationships or require that extramarital affairs be ended prior to initiating couple therapy (cf., Lusterman, 2005, this issue), whereas others encourage outside sexual relationships in limited circumstances, even if not as a general policy. Even when an extramarital affair may be psychologically healthy or advantageous for one partner, the other partner in the primary relationship may experience adverse effects even if uninformed of the affair (e.g., through diminished attention from the participating partner). Hence, either supporting or challenging the affair could present a dilemma of conflicting interests, depending on the model adopted by the therapist. When therapists confront conflicts in values among different family members, they are likely to support those values more consistent with their own personal beliefs—either implicitly or directly (Margolin, 1982). Margolin concluded that,

“It is inevitable that a family therapist’s values regarding the emotionally charged issues of divorce, extramarital affairs, and sex roles will influence how that person conducts therapy and, ultimately, affect the course of his or her clients’ lives. . . . Thus, the therapist must guard against becoming such a strident advocate of any one position that she or he cannot evaluate the needs of a particular family” (p. 799).

Applying these guidelines to the couple described earlier who espoused a sexually open marriage but presented with infidelity after the wife became emotionally involved with an outside partner, we believe one could advocate any one of the following responses as ethically responsible:

- Therapist A: “I don’t have much experience in dealing with sexually open marriages, but I’m willing to work with you toward that goal for your relationship if that is what you would like. In the course of working together, I want to ensure that we’re able to examine in what ways this is working or not working, and what would have to change in order for this to work well for both of you.”
- Therapist B: “I don’t believe that I can work with you effectively toward maintaining a sexually open marriage because that goal would be substantially discrepant from my own personal values. I’m expressing this not as a negative judgment about your own lifestyle, but rather as an acknowledgement of my own personal values that could potentially render me less effective as your therapist. I would like to refer you to one of my colleagues in the community who I believe could be more effective than I in helping you with your concerns.”
- Therapist C: “I need you to know that, if we were to work together, I could not support your goal of maintaining a sexually open marriage. In my professional experience, it is not an arrangement in which most committed relationships can succeed. I would be willing to work with you toward developing a monogamous relationship that works well for both of you. If that is not your goal in working with me, then I would be glad to refer you to one of my colleagues in the community whom I believe could be more effective in helping you toward your stated goals.”

Professional and Scientific Values

Distinguishable from personal values are those that are specifically espoused by one’s profession. Professional codes of ethics for mental health professionals, for example, specifically prohibit therapists from having sexual intimacy with clients or using their professional relationships with clients to further their own interests. The five principles in the APA (2002) code of ethics (i.e., beneficence/nonmaleficence, fidelity/responsibility, integrity, justice, and respect for people’s rights and dignity) may also be cited as professional values governing ethical conduct—although such general principles may yield contradictory yet ethically defensible interpretations in any given situation.

Similarly, one could espouse a particular position in a situation involving infidelity not as an expression of personal belief or value, but rather on the basis of the best available evidence in the research literature. For example, in evaluating the duty to warn when one’s client has tested seropositive for HIV and continues to engage in high-risk sexual behaviors with uninformed third parties, a therapist may draw on research findings regarding rates of nondisclosure among sexually active persons testing seropositive for HIV, rates of HIV transmission in various forms of unprotected sexual intercourse, and probabilities of developing AIDS or other HIV-related illnesses within some defined period following HIV infection.

Citing empirical findings as a basis for therapeutic decisions requires the therapist to accept responsibility for being informed of the most current, representative, and methodologically sound research. Such a stance, however, requires a sufficient body of research from which the therapist can draw. Unfortunately, research on treating infidelity is sorely lacking. From the complex clinical and ethical issues introduced in this issue of *Journal of Clinical Psychology: In Session*, we propose several questions that need to be addressed.

The first of these questions is, "Should therapists tell couples that affairs are inherently damaging or, if not, how can therapists differentiate 'good' from 'bad' affairs?" Contributors to this issue have offered sharply contrasting views—from advocating that "extrarelatinal affairs are neither inherently good nor evil, but are simply a fact of life" (Linguist & Negy, 2005, p. 1427) to the assertion that a partner having an affair "runs the risk of blowing their lives apart" (Pittman, 2005, p. 1415). What data bear on the potential benefits and risks of having an affair? Linguist and Negy assert several "neutral or even relatively healthy motives" (p. 1422) for having an affair, including validation, affection, and increased self-esteem. Does empirical research affirm these benefits? If so, what risks or drawbacks for the participating partner may be revealed? Moreover, what potential benefits or risks exist for the nonparticipating partner? Existing evidence suggests that discovery of an affair results in increased depression in the nonparticipating partner (Cano & O'Leary, 2000); however, there are likely numerous other impacts for the nonparticipating partner as well as the couple's relationship.

A related question is, "Are consensual extra-dyadic relationships inherently detrimental to the individual partners or their relationship?" Martell and Prince (2005) cite empirical findings indicating similar levels of relationship satisfaction in sexually monogamous and nonmonogamous relationships among same-sex couples. If additional empirical research with both gay and lesbian as well as heterosexual couples were to demonstrate that the detrimental effects of affairs were the result of violated trust and expectations, couple therapists might do best to distinguish between the extrarelatinal affair on the one hand and the trust violation on the other.

Additional questions for which empirical findings and practice directions are lacking involve the effects of disclosing affairs during the course of treatment; that is, "Should couple therapists keep the revelation of an affair in an individual discussion a secret from the other partner (if only for a while), or either encourage or insist upon immediate disclosure of that affair?" Different authors take conflicting stances on this question—from revealing all information from individual sessions in subsequent conjoint sessions (e.g., Whisman & Wagers, 2005) to keeping individual sessions confidential to the extent allowed by law (e.g., Lusterman, 2005). Although the latter position has the advantage of likely obtaining more candid information from each partner regarding affairs, the former position has the advantage of reducing the complexity of alliances and facilitating trust. Moreover, preliminary data suggest that couple therapy with affair couples is more effective when the affair is revealed during the course of treatment (Atkins et al., 2005). Evaluating the relative efficacy of different approaches would require empirical findings from studies in which disclosure of affairs was handled differently under controlled conditions.

Summary

Treating clients coping with infidelity presents special clinical and ethical challenges. Few therapists intentionally pursue clinically ineffective interventions or knowingly engage in unethical conduct. Rather, questionable behavior in the treatment of infidelity more likely results from failure to recognize professional competence in this area, potential

conflicts of interest, complex situations involving confidentiality, and the influence of implicit personal values. As O'Shea and Jessee (1982, p. 18) noted in their discussion of ethical issues in family therapy, "Ethical therapist behavior clearly requires more than good intentions, and the values permeating therapeutic efforts must . . . be more than a matter of personal bias and subjectivity." Therapists working with persons coping with infidelity need to remain informed of emerging conceptual, clinical, empirical, and legal developments germane to their practice in this complex domain.

Select References/Recommended Readings

- Allen, E.S., & Atkins, D.C. (2005). The multidimensional and developmental nature of infidelity: Practical applications. *Journal of Clinical Psychology: In Session*, 61(11), 1371–1382.
- Allen, E.S., Atkins, D.C., Baucom, D.H., Snyder, D.K., Gordon, K.C., & Glass, S.P. (2005). Intra-personal, interpersonal, and contextual factors in engaging in and responding to extramarital involvement. *Clinical Psychology: Science and Practice*, 12, 101–130.
- American Association for Marriage and Family Therapy. (2001). Code of ethics. Alexandria, VA: Author.
- American Medical Association Council on Ethical and Judicial Affairs. (1988). Ethical issues involved in the growing AIDS crisis. *Journal of the American Medical Association*, 259, 1360–1361.
- American Psychiatric Association Commission on AIDS. (1993). AIDS policy: Position statement on confidentiality, disclosure, and protection of others. *American Journal of Psychiatry*, 150, 852.
- American Psychological Association. (1991). Legal liability related to confidentiality and the prevention of HIV transmission. Washington, DC: APA.
- American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060–1073.
- Atkins, D.C., Eldridge, K.E., Baucom, D.H., & Christensen, A. (2005). Behavioral marital therapy and infidelity: Optimism in the face of betrayal. *Journal of Consulting and Clinical Psychology*, 73, 144–150.
- Burkemper, E.M. (2002). Family therapists' ethical decision-making processes in two duty-to-warn situations. *Journal of Marital and Family Therapy*, 28, 203–211.
- 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.
- 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, 1–12.
- Gordon, K.C., Baucom, D.H., & Snyder, D.K. (2005). Treating couples recovering from infidelity: An integrative approach. *Journal of Clinical Psychology: In Session*, 61(11), 1393–1405.
- Gottlieb, M.C. (1996). Some ethical implications of relational diagnoses. In F.W. Kaslow (Ed.), *Handbook of relational diagnosis and dysfunctional family patterns* (pp. 19–34). New York: Wiley.
- Knapp, J.J. (1975). Some non-monogamous marriage styles and related attitudes and practices of marriage counselors. *Family Coordinator*, 24, 505–514.
- Knapp, S., & VandeCreek, L. (1990). Application of the duty to protect to HIV-positive patients. *Professional Psychology: Research and Practice*, 21, 161–166.
- Linquist, L., & Negy, C. (2005). Maximizing the experiences of an extrarelatonal affair: An unconventional approach to a common social convention. *Journal of Clinical Psychology: In Session*, 61(11), 1421–1428.
- Lusterman, D.D. (2005). Helping children and adults cope with parental infidelity. *Journal of Clinical Psychology: In Session*, 61(11), 1439–1451.

- Margolin, G. (1982). Ethical and legal considerations in marital and family therapy. *American Psychologist*, 37, 788–801.
- Margolin, G. (1986). Ethical issues in marital therapy. In N.S. Jacobson & A.S. Gurman (Eds.), *Clinical handbook of marital therapy* (pp. 621–638). New York: Guilford.
- Marsh, D.T., & Magee, R.D. (Eds.). (1997). *Ethical and legal issues in professional practice with families*. New York: Wiley.
- Martell, C.R., & Prince, S.E. (2005). Treating infidelity in same-sex couples. *Journal of Clinical Psychology: In Session*, 61(11), 1429–1438.
- Melchert, T.P., & Patterson, M.M. (1999). Duty to warn and interventions with HIV-positive clients. *Professional Psychology: Research and Practice*, 30, 180–186.
- O'Shea, M., & Jessee, E. (1982). Ethical, value, and professional conflicts in systems therapy. In J.C. Hansen & L. L'Abate (Eds.), *Values, ethics, legalities and the family therapist* (pp. 1–22). Rockville, MD: Aspen.
- Pittman, F.S., & Wagers, T.P. (2005). Teaching fidelity. *Journal of Clinical Psychology: In Session*, 61(11), 1407–1419.
- Schlossberger, E., & Hecker, L. (1996). HIV and family therapists' duty to warn: A legal and ethical analysis. *Journal of Marital and Family Therapy*, 22, 27–40.
- Tarasoff v. Regents of the University of California et al., 551 P.2d 334. (1976).
- Whisman, M.A., & Wagers, T.P. (2005). Assessing relationship betrayals. *Journal of Clinical Psychology: In Session*, 61(11), 1383–1391.

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