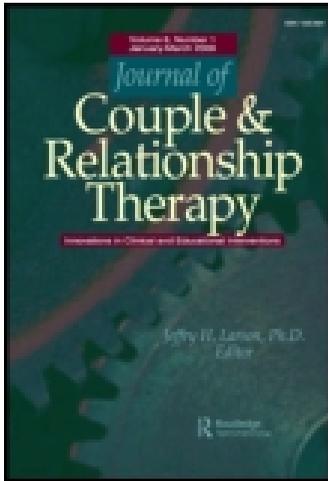


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A Clinician's Guide to Helping Couples Heal from the Trauma of Infidelity

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A Clinician's Guide to Helping Couples Heal from the Trauma of Infidelity

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Infidelity remains one of the most challenging issues encountered by both the couple involved and the clinician working with the couple. This article presents clinicians with a comprehensive frame of reference and practical guide to help organize their own thinking and increase the effectiveness of their clinical work with infidelity. The article begins with a broad definition of infidelity to initiate an analysis of various considerations around understanding the complex phenomenon of infidelity, then considers the role of the clinician in working with issues revolving around infidelity, and finally presents a summary of the tasks, responsibilities and concrete steps to be taken by both the involved partner and the hurt partner individually, as well as by the couple together, to facilitate the process of healing. In addition, Relationship Enhancement therapy is introduced as it serves as the broad therapeutic framework from which this therapist approaches working with all couples, including those dealing with the challenging issues involved in infidelity.

KEYWORDS *infidelity, affair, trauma, healing, forgiveness, marriage, relationship, Relationship Enhancement therapy*

INTRODUCTION

This article aims to provide clinicians a comprehensive frame of reference and practical guide to help organize their own thinking around how to help couples successfully navigate the choppy waters of coming to terms with and hopefully healing from the trauma of infidelity. A survey of marital therapists and family psychologists (Whisman, Dixon, & Johnson, 1997) identified affairs as the second most damaging problem to relationships and the third most difficult problem to treat. Some of the research summarized by Blow

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and Hartnett (2005b) suggests that the majority of married couples who experience infidelity do stay together rather than divorce. On the other hand, simply staying together does not necessarily mean the couple has healed from the infidelity, let alone that they are experiencing a satisfying relationship. One of the aims of this article, then, is to increase the odds of clinicians being able to help couples who have experienced infidelity not simply stay together but instead to experience genuine healing in a manner that permits them to rebuild an engaged and fulfilling relationship.

Following the work of Doherty (2002), who cogently argues there is no such thing as a “value neutral” or “value free” therapeutic stance, the goal of healing and the rebuilding of an engaged and fulfilling relationship would be regarded as the ideal outcome for the majority of couples experiencing infidelity. Adopting this stance nonetheless accepts that there are any number of factors that would understandably lead either partner (or both) to conclude it would be best to end the relationship. Defining the ideal goal of couple therapy with regard to infidelity in this way thus adheres to the important therapeutic principle of respecting client autonomy and self-determination. At the same time, it empowers the clinician to work toward the hoped for goal of genuine healing and reconciliation, recognizing that whether or not that happens in the end lies in the hands of the couple themselves.

We will begin by examining a broad definition of infidelity to clarify and define its parameters. We continue with additional considerations with regard to understanding the complex phenomenon and varieties of infidelity. Then, we will address the role of the clinician when dealing with issues revolving around infidelity, including the task of facilitating a process of forgiveness between the partners. Finally, we conclude by identifying the tasks, responsibilities, and concrete steps to be taken by both the involved partner and the hurt partner individually, as well as by the couple together, to facilitate the process of healing. An initial compilation of synthesized thoughts from the literature on infidelity, together with personal insights gained from my own clinical work with infidelity, and illustrated through three clinical case vignettes, was previously offered in the context of Relationship Enhancement therapy (Scuka, 2005). What follows is a more comprehensive integration of existing research and the clinical literature on infidelity with my own clinical experience to present a systematic crystallization of the issues and the tasks of the therapeutic process when dealing with the challenges surrounding the multifaceted issue of infidelity.

DEFINING INFIDELITY

Blow and Hartnett (2005a) offer the following definition of infidelity, formulated on the basis of a systematic review of the literature:

Infidelity is a sexual and/or emotional act engaged in by one person within a committed relationship, where such an act occurs outside of the primary relationship and constitutes a breach of trust and/or violation of agreed-upon [boundaries or] norms [explicit or implicit] by one or both individuals in that relationship in relation to romantic/emotional or sexual exclusivity. (pp. 191–192)

Following, in part, Blow and Hartnett's analysis (2005a, 2005b), several implications and conclusions can be drawn from this useful definition of infidelity. First, there are three types of infidelity: exclusively emotional, exclusively sexual, and combined emotional/sexual, or romantic, infidelity. Statistics on the prevalence of infidelity and their distribution between the genders are notoriously difficult to pinpoint given the varying time frames used in different studies attempting to determine rates of prevalence, as well as whether the focus is on married couples or committed relationships. Blow and Hartnett (2005b) estimate lifetime prevalence of infidelity as 25% for married men and 15% for married women. In one study, Janus and Janus (1993) found that 44% of divorced men and 40% of divorced women reported having engaged in at least one extramarital liaison. Glass (2002) estimates that between 30% and 60% of marital therapy cases involve infidelity as either the presenting issue or an issue revealed during the course of therapy. Collectively, these figures point to the reality that infidelity is a major clinical issue that virtually any clinician will encounter frequently in their clinical work.

Despite the uncertainty regarding actual prevalence rates, the following generalizations regarding infidelity seem to be found across a number of studies. (For a summary, cf. Glass, 2002; Blow & Hartnett, 2005b). Historically, men have tended more toward exclusively sexual infidelity while women have tended more toward exclusively emotional infidelity. However, those patterns appear to have shifted, with more men engaging in exclusively emotional infidelity and more women engaging in exclusively sexual infidelity. Not surprisingly, combined emotional/sexual, or romantic, infidelity appears to have been on the rise with both genders. This form of infidelity poses the greatest threat to the primary intimate relationship because of the exponentially increased attraction and involvement, both emotionally and sexually, on the part of the two people engaged in this form of infidelity. It also poses a greater challenge to the therapeutic process because of the intensified level of emotional and sexual attachment involved in the affair relationship, potentially resulting in the involved partner having greater difficulty in ending and emotionally letting go the affair relationship.

In addition, as Glass observes (2003), both the increased presence of women in the workplace since the 1960s and 1970s and, more recently, easy access to the Internet have contributed to an increase in the opportunity for and therefore the prevalence of infidelity. Indeed, widespread and covert access to the Internet also has spawned what has come to be referred to

as “cyber-affairs” and “cyber-sex” (Atwood, 2011), which in the former case may never result in a physical meeting and in the latter case may not even involve a live person. Not surprisingly, these phenomena are more and more at the center of contentious argument in many couple relationships, with the partner engaging in one of these activities often being in denial about the impact of their activity on both their own sense of self as a sexual being and their relationship with their partner.

The second implication of Blow and Hartnett’s definition is that the act of infidelity occurs within the context of a committed relationship. There are two subsidiary points to observe here. First, the experience of infidelity is not limited to married couples, but also applies to any nonmarital but ostensibly monogamous committed relationship. Infidelity may even be experienced in the context of a so-called “open marriage” or relationship where, by prior explicit agreement, certain outside relationships are regarded as acceptable, but others are not. Another point worth noting, to counter a potential line of rationalization or self-justification, is that a partner in a nonmarital committed relationship who is involved with a third party cannot attempt to excuse or justify involvement with the third party by appealing to the fact that the two partners in the committed relationship are not married.

The second subsidiary point is that the category of infidelity would not apply to a nonmarital intimate relationship that had not been explicitly defined as a committed or exclusive dating relationship. This would be the case even though it is quite possible—and understandable emotionally—that one person in an intimate relationship might feel betrayed if the other person engaged in a sexual relationship with a third party. This reflects the potential ambiguity that may exist between two people engaged in an intimate dating relationship who have not taken the step of explicitly defining the nature of their relationship. It also points to why it is crucial for that ambiguity to be eliminated by a couple explicitly defining the nature of their intimate relationship as a committed relationship, or explicitly agreeing that dating other people is acceptable. This will become clearer as we proceed to the next point.

The third implication is that the act of infidelity constitutes a violation of the boundaries around the primary intimate relationship because of one partner’s involvement with a third party in a manner that is experienced by the other partner as a betrayal of the primary relationship, a breach of trust and a violation of relationship norms. The subjective experiences of feeling betrayed, of trust having been breached, of profound devastation, shock and hurt, and the consequent loss of trust are almost universal features of the experience of the hurt partner when faced with the involved partner’s infidelity.¹ The additional point, not quite made fully explicit by Blow and Hartnett, is that the violation of agreed-on norms that the hurt partner also experiences may be with reference to either explicitly made or implicitly assumed norms that define and are presumed to govern the

committed relationship. Those implicitly assumed norms that have not been made explicit may constitute the greatest slippery slope within an intimate, presumably committed relationship that indirectly makes it easier for one partner (or both) to engage in infidelity. In American culture, there is a widespread *implicit* assumption that a committed relationship involves “romantic/emotional or sexual exclusivity.” Part of the problem, however, is too often that assumption remains implicit and couples fail to make it explicit. One obvious implication relative to premarital counseling is that the issue of emotional and sexual exclusivity should be explicitly raised and the couple should be encouraged to talk about it in an open manner. This, of course, would also provide an important opportunity to help the couple understand and define their agreement around what would constitute emotional infidelity, a cyber-affair or cyber-sex, since so many people are in self-serving denial about those being forms of infidelity.

The final point is that infidelity may be engaged in by one partner or both in a committed relationship. In my clinical experience, those cases where both partners in a committed relationship have engaged in infidelity pose the greatest challenge to the therapeutic process. The reason is one partner (or both) might feel inhibited from holding the other partner accountable for their infidelity because of one's own infidelity. This form of psychological disempowerment on the part of one partner can then result in the other partner not having to fully face and come to terms with their infidelity, thereby potentially diminishing the effectiveness of the therapeutic process. Conversely, one partner (or both) might take a stance of judgmental self-righteousness toward the infidelity of the other partner, resulting in a self-justifying form of denial that effectively discounts the need for that person to face and come to terms with their own infidelity. I have encountered cases where both partners have engaged in infidelity and each of these stances was adopted by one of the partners, to the profound detriment of the therapeutic process.

ADDITIONAL CONSIDERATIONS IN UNDERSTANDING INFIDELITY

The Trauma Model of Infidelity

Glass (2002) deserves the most credit for developing a model for understanding the subjective experience of infidelity as akin to the experience of a trauma (without a person necessarily meeting the criteria for a formal diagnosis of posttraumatic stress disorder). (Gordon, Baucom, & Snyder [2004], Lusterman [2004, 2011], and Baucom, Snyder, & Gordon [2009] all follow in Glass's footsteps in this regard). The notion of infidelity being experienced as a kind of trauma applies especially to the subjective experience of the hurt partner. However, it can also be experienced as a kind of trauma by the involved partner. Expanding on Glass's lead (2002, 2003), the subjective

experience of the hurt partner is generally characterized by feelings of betrayal given a sense of boundaries around the primary relationship having been violated; a breach of trust, as much with regard to an almost inevitable pattern of secrecy and lies as with the infidelity itself; emotional turmoil and confusion; disbelief; anger; resentment; disillusionment; fear; helplessness; depression; hopelessness; and a profound sense of loss. The losses include those of innocence, emotional safety, and trust (Glass, 2002, 2003), as well as self-respect and a sense of purpose (Spring, 1996). As Lusterman (2011) observes, sharing the basic ideas of the trauma model of infidelity can be very useful in helping couples normalize the complexity and emotional intensity of their experience.

As Dean (2011) observes, adding a useful complementary perspective to the notion of a trauma-like response, the experience of infidelity may also lead to a grief-like response in the form of “grieving the idea of what the relationship was and what it represented” (p. 15). In addition, a common theme I have observed in therapy with regard to the hurt partner’s sense of loss is the unnerving experience of feeling as though one has not the foggiest idea who this person is to whom one had pledged oneself in a committed relationship. Conversely, as Spring (1996) observes, the hurt partner may come to have serious doubts about their own sense of self: “I no longer know who I am” (p. 13). All these felt losses can lead to a further sense of loss with regard to the future feeling utterly uncertain, insecure, and frightening.

The involved partner can also experience a profound sense of loss, including a sense of loss about oneself, such as, “How did I ever allow myself to do this to my partner?” Or, “Who in the world *am* I? I never thought I could or would do such a thing.” Feelings of guilt and/or shame may come to be experienced as an unshakeable burden by the involved partner. There may also be a sense of loss for the involved partner with regard to the future feeling uncertain, especially concerning whether the hurt partner will ever be able to forgive and allow the involved partner a continued place in his or her life. Conversely, the involved partner may experience a sense of loss with regard to the termination of the relationship with the third party, particularly in cases of emotional infidelity or romantic love. Any or all of these losses can therefore be experienced by the involved partner as a kind of trauma as well.

The Role of Secrecy, Lies, and Self-Deception

One universal feature of infidelity is that it involves a drain of time and energy away from the primary intimate relationship, with inevitable negative impacts on that relationship, as well as on the family when children are present. Because on some level the involved partner knows that the hurt

partner would not approve of the activities being engaged in, infidelity in virtually all instances involves secrecy and the desire to preserve secrecy. The felt need to preserve secrecy in turn leads the involved partner into a pattern of lying, and it is the lying as much as or even more than the emotional and/or sexual infidelity itself that makes the loss of trust on the part of the hurt partner so deep and profound. Indeed, the pattern of secrecy and lies that also characterize emotional infidelity is one of the key means of helping to puncture the denial and rationalizations an involved partner often exhibits when the hurt partner, either on their own or in therapy, attempts to get the involved partner to see that their deep emotional involvement with a third party clearly involves both a boundary violation and a drain of time and energy away from the primary intimate relationship. The same points, of course, can also be made relative to partners engaged in cyber-sex or a cyber-affair (cf. Atwood, 2011).

The role of secrecy and lies points to another key, but not frequently noted, characteristic of many involved partners' participation in infidelity, namely, the central role of self-deception. This likely is not the case with serial philanderers, who tend to be very self-conscious in their disdain of social conventions and/or exhibit an extreme sense of entitlement, and who actively pursue opportunities for sex more or less wherever they are able to find them. But for an involved partner for whom their infidelity was a one-time experience, even if on a sustained basis but with a single person, self-deception often is a crucial component in how that person first allowed him or herself to become involved in an emotional or sexual affair.

Glass (2003) has provided an eloquent account of how for these involved partners, the slide down a "slippery slope" into infidelity is a gradual step-by-step process of choices made, where the relationship with the third party often begins fairly innocently as a friendship or a collegial work relationship, but how it then gradually evolves into something different through a series of shifts where the conversation becomes more intimate and/or the flirting becomes more suggestive, until the involved partner becomes fully immersed in an emotional and/or sexual affair. None of this is to minimize or deny that the act of infidelity in the end remains a decision and a choice. More accurately, this kind of infidelity involves a series of discrete decisions and choices in that at each point along the way the involved partner had alternative choices that could have been made to avoid sliding further down that "slippery slope" into infidelity. As Weiner-Davis (2008) aptly puts it, affairs do not "just happen," as some involved partners would like to rationalize, and have their partners believe. In the end, affairs are the byproduct of discrete decisions and choices.

The apparent psychology of this dynamic, given my work to assist numerous involved partners come to terms with how they allowed themselves to cross the Rubicon into infidelity, is that they almost invariably engaged in various forms of self-deception. (For a classic study of self-deception, cf.

Fingarette, 1969). Self-deception involves multiple and complex psychological processes that render acceptable in a person's mind a course of action that on some level the person recognizes is problematic and may have negative consequences; yet, the person does it anyway because the person convinces him or herself it is "okay" because of the pleasure or perceived gain derived from the choice and behavior. Self-deception could thus be described as a bifurcated psychological process whereby a person's choices and behavior happen "half-unawares, half-aware," but where the accent falls decidedly on the "half-unaware" portion of the spectrum in that the mind in effect suppresses the "half-aware" portion to make it possible for the person to proceed with the problematic behavior. The discrete tactics of self-deception include suppression, rationalization, compartmentalization, minimization, denial, and/or self-justification. Infidelity in the form of a gradual slide down a slippery slope as described above almost invariably involves many, if not most, of these tactics of self-deception. An important part of the task in working with this kind of involved partner—often in individual sessions—is to help that person unravel, step by step, the discrete decisions and choices by which they permitted themselves to continue down the slippery slope into deeper and deeper involvement with the affair person.

Emotional Versus Sexual Infidelity

Sexual infidelity is relatively easily defined, ranging classically from kissing (which represents the key shift from emotional to sexual infidelity), mutual fondling or sexual stimulation, to oral sex or sexual intercourse, but more recently also including phone sex, the use of Internet porn, and "sexting." Emotional infidelity, however, is a more slippery concept and harder to pin down. This is particularly the case for the partner involved in emotional infidelity since there is a strong motivation to engage in denial even in the face of the hurt partner's strong feelings and concerns regarding the relationship with the third party. The title of Glass's book *Not Just Friends* (2003) nicely captures the counter post to the denial and rationalization often offered by the involved partner in a situation involving emotional infidelity, where the response to the concerned partner often is "We're just friends," when the reality is there is much more to the relationship than just being friends. Glass (2002) describes emotional infidelity as involving emotional intimacy, secrecy, and sexual chemistry, with Internet-based relationships representing a particularly salient and contemporary prototype of this form of infidelity. In the latter instance, the email correspondence or chat room trolling is kept secret from the partner and typically involves sharing emotional intimacies (often around the marriage or committed relationship) and/or sexually explicit fantasies or titillating suggestiveness. (For an extended analysis of issues surrounding Internet infidelity, cf. Hertlein & Piercy, 2006; Atwood,

2011). An additional feature of emotional infidelity is that over time the affair relationship typically becomes more emotionally intimate than the primary committed relationship and takes on the character of a privately shared world into which no one else is admitted, except perhaps for very close confidants.

Assessing Specific Cases of Infidelity

As already indicated, infidelity can take on a wide variety of forms. Blow and Hartnett (2005a, 2005b) suggest the following relevant questions be posed in any attempt to assess, and then develop an approach to dealing with, a specific case of infidelity. Was the infidelity an emotional connection, a one-night stand, a short term sexual affair, a long-term sexual relationship, recurrent sexual infidelity with the same person, serial sexual infidelity with different people, or romantic love? Did the infidelity occur within the context of a marriage, an engagement, a committed relationship, or a dating relationship? Was the primary intimate relationship heterosexual, gay, lesbian, bisexual, or open? Was the infidelity relationship heterosexual, gay, lesbian, bisexual, or open? What was the length of the infidelity? Glass (2002) suggests the following important considerations also be explored: whether the affair is on-going, or whether it has ended; the state of sexual intimacy between the committed partners before disclosure/discovery, and what it has been since; the “individual, relational and contextual influences that created the vulnerability for infidelity”; situational events during the preceding 2 years; and individual and relationship strengths and resources (pp. 491–492).

Two additional important considerations are whether the infidelity was self-disclosed by the involved partner or whether it was discovered by the other partner, and whether sexual infidelity resulted in the birth of a child. (The latter consideration appears to have been given little attention in the literature, but clinical experience has shown that this introduces exponential complications into the working-through process). Weeks, Gambescia, and Jenkins (2003) suggest that the answers to these kinds of questions will affect both the assessment of and treatment approach to each individual case of infidelity. The answer to some of these questions may also affect prognosis for healing and reconciliation. For example, a one-night stand or short-term affair that is voluntarily disclosed by the involved partner will tend to be easier for the couple to work through toward healing and reconciliation than serial infidelity over the course of many years that is discovered by the other partner.

Finally, contrary to some traditional views of infidelity, Glass's research (2002) indicates that infidelity is *not* correlated with marital or relationship unhappiness or dissatisfaction. A not insignificant percentage of

people involved in infidelity indicate they engaged in infidelity despite having a happy marriage. (That said, Glass & Wright [1985] also note that emotional infidelity does tend to be associated with relationship dissatisfaction, and that this is especially true of women; cited by Blow & Hartnett [2005b, p. 222]). Some of the *personal vulnerability factors* that may help explain why an individual who is not unhappy in their primary intimate relationship might nonetheless engage in infidelity include depression; poor self-esteem; external life events such as the loss of a job or the illness or death of a family member; parental divorce or personal divorce; the unconscious multigenerational transmission of patterns of infidelity; a sense of sexual entitlement; or an “addiction” to fantasy, excitement, novelty, or the “forbidden.” From their small research study, Gordon et al. (2004) observe the following *individual vulnerability factors* as increasing the risk of infidelity: fear of abandonment, fear of conflict, approval seeking, and self-absorption. In addition, they cite the following *relationship vulnerability factors* as potentially increasing the risk of infidelity: emotional distance, problems with communication, problems with emotional or sexual intimacy, interpersonal “conflicts over autonomy and control,” problems with in-laws, and pregnancy or birth of a child (p. 226).

THE CLINICIAN'S ROLE

Adopting a Specific Therapeutic Model for Working With Infidelity

One significant development in the theory of therapy over the past 15 years has been the increased recognition of the importance of “common factors” that help explain the effectiveness of therapy in ways that transcend any specific model (cf. Sprenkle & Blow, 2004). These include the therapeutic alliance, which involve empathy, warmth, trust, and caring; the client's confidence in the therapist; the therapist's ability to generate hope; and the therapist's ability to promote emotional and behavioral self-regulation and cognitive mastery. Conversely, it also has been increasingly recognized that the effectiveness of therapy in practice is dependent on each clinician working systematically from a specific model because of the coherence it lends to the therapeutic process (again, cf. Sprenkle & Blow).

Relationship Enhancement (RE) therapy has provided this therapist a systematic, integrated model for working with couples and families. RE therapy therefore has served as the broad therapeutic framework from which I approach working with couples dealing with the complex issue of infidelity, while bringing to my work with these couples insights gained from the literature and research on infidelity as well as my own clinical experience with the issue. RE therapy was first developed by Bernard G. Guerney, Jr. in the 1960s and 1970s (Guerney, 1977). RE therapy combines a standardized

psychoeducational skills—teaching component with a broadly experiential, structured dialogue process that aims to plumb the depths of the clients' emotions and concerns in a manner designed to facilitate reconnection and healing. The core skills taught are the Empathic skill, Expressive skill, Discussion or Dialogue skill, and Problem-solving skill. In addition, Conflict Management skill and emotional self-regulation skills are taught. (For a systematic presentation of how these skills are taught to couples, cf. Scuka, 2005). The practical relevance of this psychoeducational component of RE therapy, as well as the crucial role that the couple's dialogue process plays in the course of healing, will become apparent as we proceed. That said, there is no assumption here that using the RE therapy model is necessary to following and using what is described.

The general sequence of sessions within RE therapy is as follows. First, there is a joint session with the couple designed to provide each partner the opportunity to share their perspective on the relationship and, at the end of the session, for the therapist to explain the nature of the RE therapy process. During this first joint session, each partner is asked to reply to three questions: What do you see as the strengths in this relationship? What do you see as the primary issues of concern? What are your hopes and goals for this relationship? Second, an individual appointment is scheduled with each partner to follow up on certain important individually oriented questions regarding depression and anxiety, alcohol or substance abuse, how the couple deals with arguments and fights—which also allows for inquiring about the possibility of violence in the relationship—and the state of sexual intimacy between the couple. Each partner is also invited to share any other concerns that may or may not have been addressed in the first joint session. Then, typically, two joint sessions are devoted to teaching Conflict Management skills and the Empathic skill. With a brief introduction to the Expressive skill and the structured dialogue process in the following session, the rest of the therapeutic work then involves the couple dialoguing directly with one another about whatever issues need to be worked through. Additional individual sessions may be scheduled as deemed appropriate in support of the joint couple's work.

Conceptualizing Phases of Infidelity Treatment

While the focus and flow of infidelity treatment will inevitably be fluid because of the uniqueness of each couple and their specific circumstances, it nonetheless can be useful to have a general frame of reference for conceptualizing the phases, or broad themes, of infidelity treatment. Glass (2002) conceives of the three phases as trauma recovery, developing a narrative or "story" of the infidelity or affair, and mastering the meaning of the infidelity to facilitate healing. The first phase is focused on establishing safety,

fostering hope, and managing traumatic symptoms. The second phase includes the work of helping the involved partner understand how he or she permitted themselves to engage in infidelity, as well as the impact of the infidelity on the hurt partner and the relationship. The third phase is focused on rebuilding the relationship and working toward forgiveness.

Gordon, Baucom, and Snyder (2004) also conceptualize a three-stage model for the treatment of infidelity. Stage 1 is termed "Dealing with Impact." Stage 2 is called "Exploring Context and Finding Meaning." Stage 3 is called "Moving On." The first stage is focused on facilitating "stabilization" and exploring the impact of the infidelity on each partner and their relationship. The second stage, broadly speaking, coincides with Glass's second phase. The third stage is focused on coming to terms with the infidelity, working toward forgiveness, and either working to rebuild the relationship or making a decision to divorce.

In the nature of the case, the clinician will need to be aware of all of these broadly conceived phases or stages of infidelity treatment throughout their clinical work with each couple. However, they are not rigid one, two, three sequential time frames, but broadly conceived aspects of infidelity treatment that will shift in and out of focus as the therapy process unfolds. Broadly following Glass's three phase model, we now turn to identifying and describing discrete aspects of the clinician's role and tasks with regard to infidelity treatment.

Explaining Confidentiality

One important aspect of the clinician's role is that the clinician must, as an ethical obligation, explain at the very beginning of the first joint session their personal policy with regard to issues of confidentiality in their couple therapy work. There is a significant divide in the various clinical professions as to whether or not to grant confidentiality to each partner in the context of couple therapy. There are legitimate reasons on each side of this divide for the respective position taken on this issue. (For a discussion of the rationale of each position, including perceived benefits and costs, cf. Scuka, 2005, pp. 71–75). Despite this divergence, Glass (2002) notes there is relative agreement that it would be unethical for a clinician to conduct couple therapy in a situation where infidelity has been disclosed to the clinician but is not known by the other partner and the involved partner refuses to have it disclosed—the point being that the therapist then would become triangulated. While recognizing that each clinician must come to terms with this issue for himself or herself, the general approach within RE therapy, and embraced by this clinician, is that there will not be confidentiality between the two partners in the context of couple therapy. The clarification that is offered to couples about this is that the privacy of certain thoughts

can be respected, but what the clinician cannot permit to have happen is, in effect, to become the keeper of a secret around something that would be of material relevance to the partner with regard to the relationship or marriage.

Fostering Trust, Confidence, and Hope

The clinician's primary *process* objective in any couple therapy, as opposed to the content objective of learning about the particulars of a specific case, is "to instill in the couple a sense of trust and confidence in the clinician" (Scuka, 2005, p. 66). This is accomplished in a number of ways, including the clinician's ability "to show equal, nonjudgmental, and empathic understanding to both members of the couple," and in a manner that "leaves each person *feeling* understood and accepted as a person." This obviously applies to each member of any couple but is especially relevant in cases of infidelity with regard to the involved partner's need to not feel judged. Another dimension of the clinician's ability to engender trust and confidence is his or her ability "to generate and instill hope that [the couple's] issues can be addressed in a manner that holds out the promise for healing and reconciliation in the relationship" (p. 67). Yet another way the clinician generates trust and confidence is in his or her ability "to maintain productive control over the therapy process in a manner that allows both parties to feel emotionally safe" (p. 66). Each of these objectives is a crucial aspect of the clinician's role with regard to cases of infidelity and of necessity comes into play from the beginning of the first joint session with the couple.

Providing Realistic Expectations, Normalizing Perspectives, and Emotional Support

Given the almost invariably traumatic nature of the impact of infidelity on the hurt partner, and the relationship, the first phase of infidelity treatment will typically, following Glass (2002), include three important tasks on the part of the clinician. The first involves helping the couple have realistic expectations with regard to the therapy process. It is not uncommon for therapy to last anywhere from 1 to 2 years for the couple to reach a solid place relative to the ongoing process of healing, especially with regard to cases of sexual infidelity or romantic love. This may involve helping the couple have realistic expectations for their relationship during this challenging period by helping them negotiate parameters and boundaries for them as a couple, such as spending time together and sexual intimacy, as well as boundaries between them and other people.

Second, the clinician often will need to provide normalizing perspectives to help the couple understand their own experience, as well as cognitive restructuring to help them avoid remaining stuck in counterproductive thought processes that could reinforce depression, anxiety, or patterns of implicit character assassination of the partner that interfere with the process of healing. Introducing the notion of infidelity having a traumatic impact, especially on the hurt partner but also on the involved partner and the relationship, can be an effective strategy to help the couple normalize the extremely complex and confusing thoughts and emotions that they are experiencing in the wake of infidelity.

Third, the clinician often will need to provide necessary emotional support to both the hurt partner and the involved partner. For the hurt partner, this often will involve helping that person deal with the overwhelming emotions and/or obsessive preoccupation with the details of the infidelity. For the involved partner, it may involve helping that person come to terms with the loss of the relationship with the third party and/or excessive feelings of guilt and/or shame that are keeping them stuck and unavailable to deeper levels of the therapeutic process.

Teaching Good Relationship Skills

The first phase of infidelity treatment will almost certainly involve the clinician needing to teach the couple good communication skills to facilitate the work of healing and to promote open, honest communication to help rebuild trust. As Glass (2002) puts it, “The [hurt] partner practices expressing pain without attacking, and the involved partner practices empathic listening. Compassionate communication leads to a healing process” (p. 497). This is one reason why the RE therapy model is an ideal format for working with issues of infidelity, because a core component of that model is to systematically teach couples core communication skills in the context of a rigorously structured dialogue process designed to keep communication safe while facilitating the couple to go as deep as possible into exploring and hopefully resolving their difficult issues. (Cf. Scuka, 2005, for three clinical vignettes, and Scuka, 2012, for a recent case example, illustrating the use of the RE therapy model with cases involving infidelity).

In addition to teaching good communication skills, it also is important to systematically teach the couple conflict management skills, as is done in RE therapy, so they know how to self-regulate emotion, interrupt a negative interaction cycle, or, as necessary, take a structured time out that has been taught to them in the form of a “relationship contract” (Scuka, 2005, pp. 105–118). Another aspect of teaching “emotional intelligence” is that the involved partner often will need to be helped to learn how to tolerate the hurt partner’s intense and unpredictable emotions

regarding the infidelity and, at a deeper level, to be able to genuinely connect empathically with the pain the hurt partner is experiencing relative to the infidelity.

Fostering Self-Understanding, Mutual Understanding, and a Path Toward Forgiveness

Once the above described tasks of the first phase of infidelity treatment have been largely accomplished, the work then shifts to the heart of the infidelity treatment. A crucial part of the work in the second phase is for the involved partner to be helped to understand how he or she permitted themselves to make the choice to engage in infidelity. This will also include helping the involved partner uncover personal vulnerabilities that may have been some of the contextual factors rendering that person more susceptible to engaging in infidelity. Often, this delicate but vitally important work is best done in individual sessions, with the net results of that work being brought back into joint sessions. (This kind of individual session, as well as other kinds of individual sessions designed to provide individual support to either or both partners, are regarded as part of the couple therapy work). There are two reasons why this part of the work is so important. First, the involved partner coming to understand the path by which they allowed themselves to engage in infidelity serves a prophylactic purpose to reduce the likelihood of a recurrence of infidelity. Second, this increased self-understanding on the part of the involved partner is an important component of the hurt partner being able to have increased trust and confidence that the involved partner is unlikely to engage in infidelity again.

The converse task in the second phase often will involve helping the hurt partner develop compassion for the involved partner, which in effect is the necessary precondition for the possibility of forgiveness. This does not mean that the hurt partner excuses the infidelity, but rather that the hurt partner comes to understand the involved partner's vulnerabilities as part of their partner being an imperfect human being. In my own experience, this is most effectively accomplished by gently helping the hurt partner understand their own imperfection as a human being, often by helping the hurt partner come to terms with their contribution to difficulties in the primary intimate relationship when that is part of the context of—though not an excuse for—the partner's infidelity. Perel (2009) brings a useful counterbalancing perspective to working with the hurt partner when that person remains stuck in a position of angry rage and/or judgmental rejection of the efforts of the involved partner to re-earn trust and work toward reconciliation by asking the hurt partner how they may have betrayed the relationship with their partner in ways other than by engaging in infidelity. Spring (2004) offers useful perspective on some of the factors that may contribute to a person's

“refusal to forgive,” with a view to helping that person work through their mental or emotional obstacles to forgiveness.

The clear implication of these observations is that forgiveness is a process that proceeds in gradual and discrete steps, not a one-time decision (Enright, 2001). From one point of view the work of forgiveness can be viewed as part and parcel of the second phase of infidelity treatment. However, from another point of view, the work of forgiveness also represents the culmination of the third phase of infidelity treatment relative to the ideal goal of healing and reconciliation between the couple. The clinician’s task is to facilitate this process of forgiveness by (a) working with the hurt partner to work through reservations and potential mental and emotional obstacles to forgiveness; (b) working with the involved partner to help that person understand how he or she can work toward rebuilding trust and demonstrating care and concern for the needs of the hurt partner as well as commitment to their relationship; and (c) working with the couple together on a joint process of healing and reconciliation that involves both the demonstration of remorse and the seeking of forgiveness by the involved partner, and acknowledgment by the hurt partner of the involved partner’s efforts to rebuild trust, resulting ideally in the granting of forgiveness. Case (2011) presents one of the most useful models of forgiveness, with carefully and systematically delineated concrete steps for each person to take as part of an interpersonal process of apology and forgiveness. Worthington (1998) also presents a model of forgiveness as an interpersonal process.

It should be stressed that depending on other issues in the couple’s relationship, the process of forgiveness may well operate in both directions, with each person seeking and granting forgiveness for a variety of reciprocal betrayals and hurts. Spring (1996) also notes the likely need for self-forgiveness on the part of either or both partners. For example, the hurt partner may need to forgive themselves for “contributing to [their] partner’s dissatisfaction” with the relationship, while the involved partner may need to forgive themselves for “inflicting chaos on [their] children, family and friends” (pp. 242–244)—to which I would add the likely need for the involved partner to forgive oneself for betraying one’s own values as well as one’s commitment to their partner.

As part and parcel of the process of fostering mutual understanding and a path toward forgiveness, the couple will almost certainly be faced with also addressing other issues in the relationship independent of the infidelity. This work is likely to begin during the second phase of the infidelity treatment and continue during the third phase of the treatment as the couple continues to work at improving their relationship. This will include the issues, concerns, and desires of both the hurt partner and the involved partner. As the work shifts more and more to dealing with other issues in the relationship, preoccupation with the infidelity issue tends to recede. This is a

significant indicator that progress is being made in the overall work toward the ideal goal of healing and reconciliation.

Attending to the Couple's Sexual Intimacy as Needed

One of the things that has become increasingly well understood in the field is that improvement in a given couple's relationship at an emotional and/or functional level will not automatically or necessarily translate into an improvement in that couple's sexual functioning (McCarthy & Thestrup, 2008). Therefore, it is important that the clinician be attuned to and inquire about the nature and quality of sexual intimacy in a couple where infidelity has occurred. Some couples who experience infidelity actually experience a resurgence and revitalization of their sexual intimacy. Other couples fall into a state of being non-sexual. Often times this is predominantly influenced by the hurt partner due to fear of sexually transmitted disease (STD), self-image or self-esteem issues, and/or a self-protective emotional withdrawal from the relationship given the profound sense of anger, hurt, and betrayal. Other times, it may be influenced more by the involved partner's profound sense of guilt and not feeling worthy. In either case, the clinician needs to be prepared to assist the couple in dealing constructively and compassionately with the couple's challenges around sexual intimacy. Issues surrounding sexual intimacy may need to be addressed in the first phase of infidelity treatment, or could emerge, or reemerge, as a focal point of attention in either the second or third phases of infidelity treatment. One excellent resource for both the clinician and the couple regarding the revitalization of sexual intimacy is McCarthy and McCarthy's book *Rekindling Desire* (2014).

Using a Balanced Conceptual Framework

Finally, it is important that the clinician have a clear conceptual framework for understanding—and in turn being able to explain to the couple—that the work of healing must find “the appropriate balance between . . . an assumption of responsibility framework and a contextual factor framework” in order for that work to be successful (Scuka, 2005, p. 265). In practice, this means operating, on the one hand, with a framework that stresses individual existential responsibility for choices made, especially with regard to the involved partner's decisions vis-à-vis the infidelity, while also acknowledging that both partners likely contributed to the conditions and issues that constituted part of the context and backdrop to the infidelity. As Fife, Weeks, and Gambescia (2008) observe, “both partners share responsibility for the quality of the relationship” (p. 318). Identifying contextual factors such as

relationship vulnerabilities therefore can help both the involved partner and the hurt partner better understand the context within which the infidelity occurred, while in no way justifying it. (Other contextual factors include either partner's personal vulnerabilities, familial factors, external events, or life stressors). Balancing these two frames of reference facilitates being able to balance the necessary infidelity recovery work with the need to work on other relevant issues in the relationship. The practical relevance of this dual frame of reference for doing infidelity recovery work will become clearer as we turn to our final set of considerations in facilitating a process of healing from infidelity.

TASKS AND RESPONSIBILITIES OF EACH PARTNER TO FACILITATE THE PROCESS OF HEALING

While the role of the clinician can be essential to a successful outcome of couple therapy in cases of infidelity, ultimately the success of the therapy is dependent upon the good will and genuine effort of both partners to engage in and further a process of interpersonal healing and reconciliation. As Spring (1996) observes, each partner must take responsibility for their own part in the healing process. To facilitate that process, Blow and Hartnet (2005b) observe that "couples need a map from which they can work to understand the process of recovery" (p. 230). In order to provide couples and clinicians with such a map, we conclude this Clinician's Guide with a delineation of, first, the tasks and responsibilities of both the involved partner and the hurt partner to facilitate the process of healing between them and, second, the concrete steps to be taken by both the involved partner and the hurt partner individually, as well as by the couple together, to facilitate the process of healing. The task and responsibilities, as well as the concrete steps to be taken by each partner, are formulated to complement one another and to provide the basis for a balanced approach to working with cases involving infidelity.

While extended commentary could be provided on each of these items, they are presented here in summary form (a) out of consideration for the limitations of space, (b) to provide a ready reference guide to clinicians when they are working with cases of infidelity, and (c) to prompt reflection on the part of each clinician regarding the demands and the needs of this complex but in the end immensely satisfying piece of clinical work. The tasks and responsibilities, as well as the concrete steps, have been formulated on the basis of the existing research and literature, as well as this author's own clinical experience. In addition, clinical experience has shown that the concrete steps marked with an asterisk (*) are essential ingredients that constitute preconditions for genuine healing to occur in a relationship

sundered by infidelity. These items could also be regarded as hypotheses for testing in empirical studies to determine to what extent meeting or failing to meet these conditions correlates with healing in a relationship impacted by infidelity or with the termination of the relationship. Finally, the concrete steps are presented as though they are written directly to the involved partner or hurt partner themselves. In this way, they can also be used as a handout with clients to help anchor them in the process of healing that is being undertaken through the therapy. If per chance both members of the couple have engaged in infidelity, then both sets of individual steps would apply to each partner as relevant.

One important caveat should be noted by clinicians. The Tasks and Responsibilities and Concrete Steps represent a summary of how an ideal couple's therapy process would go and what would be involved along the way for the ideal outcome of healing and reconciliation to occur. However, how that process unfolds for any given couple may contain within it many diversions and detours along the way that will involve the clinician exercising good clinical judgment in the moment and along the long road toward the hoped for ideal outcome. This will include, especially in the early stages of the process for some couples, the clinician needing to engage in what Doherty (2011) calls "Discernment Counseling" and what Glass (2002) calls "Ambivalence" therapy. The initial purpose of the therapy then becomes to help either or both partners sort through their ambivalent feelings and concerns with regard to the possibility of healing and reconciliation in the relationship, leading either to a decision to commit to a process of therapy to explore what might be possible between the couple, or to a pre-emptive decision to move toward separation and termination of the marriage or relationship.

For example, with regard to the first concrete step to be taken by the involved partner identified below, that person may not be prepared to terminate all contact with the third party immediately. In those cases, the clinician must first be empathic with the involved partner to give that person the time and space to explore their feelings, concerns and reservations. At the same time, the clinician also needs to be clear, from a strictly psychoeducational point of view, that healing and reconciliation in the primary relationship are unlikely to occur unless contact with the third party is definitively terminated, because the involved partner would both fail to create the necessary emotional safety the hurt partner needs while also risking re-traumatizing the hurt partner by having further contact with the affair person. Whether termination of the relationship with the third party happens clearly is up to the involved partner. But in those cases where this does not eventually happen, it almost certainly, in my clinical experience, impedes progress in the therapy or undermines it altogether, resulting in termination of the primary relationship.

Approached in this way, the clinician respects both the principle of meeting and beginning where the client is and the principle of respecting client autonomy and self-determination. That said, given that there is no such thing as a “value free” or “value neutral” stance in therapy, and Goldner’s (1999) argument that the clinician inevitably exercises “a kind of moral authority” in his or her work, it also is an unavoidable part of a clinician’s responsibility to help a client understand the potential consequences of their decisions and actions and, as necessary, to encourage the client to come to terms with what their underlying values are and what their ultimate goal is. The aim is to bring the client to a place of being able to make a clear decision for themselves, as well as for other people in their lives who inevitably will be affected by their decisions and actions. This way of understanding and implementing the clinician’s role also follows Yalom (1980) in his existentialist approach to therapy in that an important part of the therapy process involves helping clients come to terms with their “ultimate concerns” in a manner that increases their self-awareness and, it is hoped, their effective decision making.

Tasks and Responsibilities of the Involved Partner to Facilitate Healing

1. To rebuild trust and create emotional safety for the hurt partner by being completely transparent and giving no further reasons for doubts or suspicions regarding one’s behavior.
2. To demonstrate to the hurt partner one’s care, concern and love by way of connecting with, accepting and validating the hurt partner’s emotional experience.
3. To actively work to demonstrate one’s commitment to interpersonal healing and to rebuilding the relationship or marriage.

Tasks and Responsibilities of the Hurt Partner to Facilitate Healing

1. To be open to and acknowledge the involved partner’s efforts to rebuild trust.
2. To work at developing compassion for the involved partner’s imperfection as a human being by recognizing and having compassion for one’s own imperfection as a human being.
3. To work toward forgiveness when the involved partner has demonstrated his or her commitment to interpersonal healing and to rebuilding the relationship or marriage.

CONCRETE STEPS TO BE TAKEN BY EACH PARTNER TO FACILITATE THE PROCESS OF HEALING

Items marked with an asterisk (*) are essential for genuine healing to occur in a relationship impacted by infidelity.

Steps to Be Taken to Facilitate Healing If You Are the Involved Partner

- * 1. All contact with the third party must be definitively cut off. This includes a commitment to your partner—and follow through—that any further contact initiated by the third party will be reported to your partner, and will not be responded to. Understand that for your partner this is an issue of emotional safety and self-protection.
2. If the third party is a co-worker, then absolutely clear and mutually agreed-to boundaries are to be negotiated, but respecting the needs of your partner so as to promote emotional safety.
3. Make yourself accountable by maintaining complete transparency regarding your schedule, whereabouts, and expected arrival times. This is essential to prevent the arousal of new doubts or suspicions. When traveling, a detailed itinerary is to be provided to your partner, including all relevant contact phone numbers.
4. Access to phone records and email accounts, including passwords, are to be provided to your partner if requested. To regard this as an invasion of privacy given your infidelity undermines the task of rebuilding trust since past secrecy was one essential factor facilitating your infidelity.
5. Depending on the nature of the infidelity, get tested for STDs and provide the results to your partner.
- * 6. Assume and acknowledge complete and exclusive responsibility for your decision to engage in the infidelity or affair, without seeking to “justify” the infidelity because of relationship issues you had with your partner.
7. Be prepared to answer all relevant questions posed by your partner regarding the circumstances, frequency of contact and duration of the infidelity or affair. (This does not include details of sexual acts engaged in).
8. Learn to tolerate—and do not respond defensively to—the complex and unpredictable emotions that your partner likely will display during the healing process. Sometimes it will feel like your partner’s emotion “came out from nowhere.”
9. Periodically ask how your partner is feeling and how your partner is doing emotionally in the aftermath of the infidelity or affair so your partner is not always the one having to bring up this emotionally difficult issue. Inquire of your partner how they would like this to be done.

- *10. Work hard to understand your personal vulnerabilities that indirectly may have contributed to your susceptibility to engage in infidelity or an affair. This is in no way to justify your infidelity, but rather is an important step to help you—and your partner—understand how you allowed yourself to make the decision to engage in infidelity or an affair. It also will facilitate you developing a plan of action to prevent a recurrence of infidelity while building trust and confidence in your partner that infidelity is unlikely to recur.
- 11. Work hard to understand and come to terms with any acts of self-deception that were involved in you allowing yourself to take the steps you took while you engaged in infidelity or an affair, and share this self-understanding with your partner.
- *12. Genuinely connect with and feel the pain and hurt of your partner, and demonstrate that through your verbal empathy so that your partner can *feel* understood by you regarding his or her pain over your infidelity.
- *13. Feel genuine remorse for the pain and hurt caused your partner, and convey genuine contrition for having inflicted such pain.
- *14. Apologize to your partner for your infidelity and ask for forgiveness, accepting that the latter will unfold gradually in stages as part of the healing process.

Steps to Be Taken to Facilitate Healing If You Are the Hurt Partner

1. Be definitively clear with your partner that further contact with the third party will not be tolerated. If the third party is a co-worker of your partner, work at negotiating clear and mutually agreed to boundaries. Explain that for you this is an issue of emotional safety and self-protection.
2. Be clear for yourself—and clearly articulate—what boundaries you need to be in place around your relationship or marriage with regard to outside relationships to preserve the emotional and sexual integrity of your relationship. Once again, stress that this is for your emotional safety and self-protection.
3. Be clear for yourself—and clearly articulate—what you need by way of transparency regarding your partner's schedule and whereabouts, as well as any travel itineraries and how access and contact are to be maintained.
4. Decide what you need by way of access to phone records and email accounts to help establish emotional safety for yourself, but accepting that under certain circumstances this is designed to be a time-limited measure until a sufficient level of trust has been restored. Also, having such access does not automatically translate into you actually choosing to access those records.
5. Depending on the nature of the infidelity, request that your partner get tested for STDs and provide you the results.

6. When you wish to talk with your partner about the infidelity, focus on communicating your experience, your feelings, your concerns, and your desires as subjectively and as respectfully as possible.
- *7. When communicating your emotion to your partner, avoid engaging in personal attacks that would induce defensiveness and resentment in your partner, leading your partner either to shut down and withdraw emotionally, or to get drawn into counterproductive counter attacks and arguments.
8. When referring to your partner's behavior, avoid saying or implying that there is something wrong with your partner. Instead, describe the behavior and the impact it has had or is having on you.
9. When asking questions about your partner's infidelity or affair, be careful how much detail you ask for. There is a risk you could deepen your sense of trauma if you were to fixate on minute sexual details as opposed to questions regarding the circumstances, frequency of contact, and duration of the infidelity or affair. Seek extra help if you find yourself obsessing about the details of the infidelity or affair.
- *10. Attempt to understand your partner's vulnerabilities that may have indirectly contributed to his or her susceptibility to engage in infidelity or an affair. This is not asking you to accept any justification for your partner's choices or actions. It is simply by way of helping you make sense of how your partner could have come to allow himself or herself to make such a decision, often times contrary to their better nature.
- *11. As relevant, acknowledge and be open to addressing issues that your partner may have about you and/or the relationship. This is not to accept blame for your partner's infidelity or affair. It is to be fair in acknowledging that your partner also has the right to have certain feelings, concerns, and desires, as well as the right to have those issues addressed.
- *12. Acknowledge and appreciate your partner's efforts to re-earn your trust as well as your partner's efforts to understand the pain and hurt you suffered as a result of their infidelity.
- *13. Be willing to forgive your partner for their infidelity when they have demonstrated their commitment to interpersonal healing and to rebuilding the relationship or marriage.
- *14. Apologize to your partner and ask for forgiveness for actions on your part that were not beneficial to the relationship.

Steps to Be Taken to Facilitate Healing by Both Partners Together

1. Accept that healing is a process that takes time—as well as genuine commitment and effort by both of you.
2. Be kind to one another, especially under these very difficult circumstances.

3. Hold on to hope even when at times it may feel hopeless.
4. Learn good relationship and communication skills, either through therapy and/or by attending a weekend workshop for couples that focuses on skills training. (Not all workshops for couples do that).
5. Be patient in listening to one another. Take turns expressing; express yourselves in a subjective and respectful manner, without attacking or criticizing one another; be patient in listening; do not interrupt or talk over one another; listen empathically to understand your partner on his or her terms—most especially when it differs from your perspective; verbally empathize with your partner's perspective so that he or she feels understood by you; wait to be invited to become the expresser before you express your point of view.
- *6. Be open to receiving difficult to hear feedback, and never respond dismissively to your partner's feelings, concerns, or desires.
7. Be willing to talk through all the feelings and concerns of both partners about everything related to the infidelity as well as other issues in the relationship.
8. Negotiate mutually acceptable boundaries with regard to outside relationships, including extended family and friends. This includes balancing the need to preserve privacy regarding issues internal to the marriage or committed relationship with the legitimate need to be able to talk in confidence with a trusted friend or family member about concerns related to the relationship. In the latter case, it is crucial that any such confidant be someone who genuinely is "a friend of the marriage" or relationship.
9. Develop an action plan to nurture your relationship by strengthening its positive aspects and aiming to meet your partner's needs and desires.
10. Attend to sexual intimacy in your relationship. Request assistance in therapy if there are issues related to sexual intimacy that need to be addressed.
- *11. Work together toward mutual forgiveness and reconciliation, and understand that forgiveness is not a single act that happens once, but instead is a process that happens gradually over time.
12. For the involved partner, the process of forgiveness and reconciliation involves: empathic understanding of and compassion for the pain experienced by your partner; genuine remorse and contrition; concerted efforts to re-earn trust by respecting your partner's various needs for emotional safety; apologizing for your act of betrayal; making amends for your infidelity; and asking for forgiveness.
- *13. For the hurt partner, the process of forgiveness and reconciliation involves: acknowledgment of your partner's efforts at healing and reconciliation; surrendering a stance of superiority or self-righteousness; having compassion for your partner's (as well as your own) imperfection as a human being; forgiving your partner for the hurt you have

experienced; accepting your own potential need to be forgiven for your choices and actions that may have contributed to difficulties in the relationship; and apologizing and asking for forgiveness in turn.

CONCLUDING OBSERVATIONS

The challenges in working with infidelity are complex and multifaceted. However, the clinician having a useful roadmap to guide his or her therapeutic work can be instrumental to the success of such work. In addition, the couple having a roadmap that can help them navigate the rough waters and shifting tides of their emotions while they explore the possibility of healing and reconciliation can, at minimum, ease their difficult journey while potentially making all the difference in the world as to the eventual outcome. Such a roadmap helps couples (a) normalize their experience so that they can better understand and have more realistic expectations about the process they are going through, (b) identifies a set of tasks and responsibilities to help clarify what is needed to facilitate a process of healing between them, and (c) delineates a set of concrete steps designed to help the couple more readily achieve the ideal goal of healing and reconciliation. This article has attempted to provide roadmaps for both the clinician and the couple to facilitate the achievement of that ideal goal.

Several additional observations are in order. There is not, to my knowledge, empirical data on whether the issues related to infidelity or the general process of recovery from infidelity are experienced differently by married, engaged, or committed couples on the one hand, or by heterosexual versus gay or lesbian couples on the other. However, it has been this clinician's experience that the broad themes related to the experience of infidelity described in this article are common to married, engaged, and committed couples, regardless of sexual orientation—while acknowledging that the experience of any given couple will be distinctive to that couple. I believe this is true while also acknowledging that sexual boundaries within a gay or lesbian relationship may tend to be more flexible than is the case with most heterosexual couples. However, even gay and lesbian couples who have more flexible sexual boundaries typically have certain limits that govern that flexibility. In addition, it has been this clinician's experience that the tasks, responsibilities, and concrete steps to be taken by both members of the couple to facilitate a process of healing and reconciliation are broadly applicable to married, engaged and committed couples, regardless of sexual orientation. It also has been this clinician's experience that both the broad themes related to the experience of infidelity and the tasks, responsibilities, and concrete steps designed to facilitate healing and reconciliation are largely applicable across different ethnic and cultural groups. Again, this is stated while acknowledging that the experience of any given couple will be distinctive to that couple.

Given the frequently traumatic impact of the experience of infidelity, there is much at stake in its clinical treatment in terms of personal well-being and the quality of the couple's relationship, whether or not healing and reconciliation happen. For the hurt partner, what often is at stake is not simply their sense of security within the relationship or marriage, but their very sense of themselves as a valuable and loveable human being who is deserving of some measure of happiness in life. Likewise for the involved partner, what may be at stake, in the face of the not uncommon feelings of guilt and shame, is their own sense of themselves as a valuable and loveable person. For each of them, what is at stake is their ability to heal emotionally from the impact of the infidelity, and their ability to move on with their lives in constructive ways. For the couple, what is at stake is the kind of relationship they may be able to have post-treatment. Even if the couple were to stay together, merely staying together is not a sufficiently satisfactory outcome. The goal, ideally, is for the couple to experience genuine healing and reconciliation where the couple is able to have a deeper sense of connection and a more fulfilling relationship than they may have had prior to the revelation of the infidelity.

But even if the couple does not remain together, there still is much at stake in terms of personal well-being and the quality of relationship that the two former partners are able to have. At one extreme, there may be an irrevocable alienation that does not permit any contact whatever between them. In the middle, there may be a kind of civil acceptance of the other person and the end of the relationship, with occasional and polite, if not overtly cordial, contact. At the other end of the spectrum, there may be an element of genuine healing, both individually and between the two parties, despite the decision to end the relationship. In this case, each person is able to regard the other person with genuine acceptance and is able to be in the presence of the other person without feelings of resentment and, potentially, even with some feelings of fondness. Which of these outcomes happens obviously will have a profound long-term impact not just on each person's sense of self and emotional well-being, but on other people in each of their lives, most especially any children which the former partners may have had in common. It therefore should be self-evident that there is much at stake on multiple levels in the successful treatment of cases of infidelity, whether or not the two partners remain together.

NOTE

1. There has been extensive discussion in the literature regarding the best terminology to be used to describe the two partners in the primary intimate relationship, the increasing preference being to avoid potentially moralizing and/or perpetrator/victim implications (cf. Johnson, 2011). The term *involved partner* seems to be the most commonly used and straightforwardly descriptive term for the one

partner. The choice of a suitable term for the other partner is more challenging, but I believe the term *hurt partner* is a legitimate choice because it accurately describes the subjective experience of the other partner. I also believe that in context the term hurt partner can be read purely descriptively without imputing to it a perpetrator/victim framework.

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