

Treating Infidelity and Comorbid Depression: A Case Study Involving Military Deployment

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Sexual infidelity has a high prevalence in both representative community and treatment-seeking samples, and has been identified by experienced therapists as one of the more difficult couple problems to treat. Disclosure or discovery of infidelity triggers a broad range of adverse relationship and individual consequences, including increased risk of major depression and suicidality in either one or both partners. We describe an integrative approach for promoting recovery from infidelity, drawing on empirically supported treatments for couple distress as well as empirical literature regarding recovery from interpersonal trauma and relationship injuries. Using an exemplar case study involving military deployment, we feature three stages of intervention emphasizing containment of initial emotional trauma, understanding factors contributing to vulnerability to an affair, and strategies for helping partners to move on emotionally, either together or separately. The integrative treatment approach described here is the first treatment designed specifically to assist couples' recovery from an affair to garner empirical evidence of its efficacy.

Keywords: couple therapy, infidelity, depression, military, deployment

Sexual infidelity occurs with high frequency, both within the general U.S. population and among treatment-seeking samples. Evidence suggests that among military couples, particularly those experiencing separations due to deployment, rates of infidelity are significantly higher. The adverse consequences of infidelity—including increased symptoms of depression and suicidality—have been well established in both civilian and military samples. Effective couple-based interventions promoting recovery from infidelity need to address both relationship functioning and individual functioning in both partners, particularly attending to factors placing partners at increased risk for physical harm to themselves or each other. In this article, we describe an empirically supported integrative approach for treating infidelity. Using a clinical case involving military de-

ployment, we feature specific components of this three-stage intervention model and highlight their relevance to addressing comorbid depression.

The Prevalence and Impact of Infidelity

Representative U.S. community surveys, such as the General Social Survey (GSS) and National Health and Social Life Survey (NHSLs), indicate a lifetime prevalence of extramarital sex of approximately 12% to 15% for women and 23% to 25% for men (Laumann, Gagnon, Michaels, & Michael, 1994; Wiederman, 1997). Broadening infidelity to encompass emotional as well as sexual affairs approximately doubles these rates (Glass & Wright, 1992). Moreover, anecdotal evidence suggests that this gender gap in sexual infidelity has narrowed during the past 15 years, with rates for women rising. Infidelity is the most frequently cited cause of divorce (Amato & Previti, 2003), doubling its likelihood compared with couples who have not experienced an extramarital affair.

Although data on the incidence of infidelity among couples in which one or both partners serve in the U.S. Armed Forces are limited, the

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available evidence suggests comparable or higher rates compared with civilian samples. First, military couples are characterized by a number of factors that place them at higher risk for infidelity. Soldiers tend to enlist young and marry young; just 1% of the civilian population aged <20 years is married, compared with nearly 14% of military members in the same age-group, and marriage at a young age is a strong predictor of subsequent infidelity (Allen et al., 2005; Atkins, Baucom, & Jacobson, 2001). Moreover, in the past decade, these marriages have been tested by the longest and most recurrent deployments in the history of the volunteer military. Among combat-exposed troops, the high incidence of stress-related mental health problems evidenced 3 to 4 months after returning from deployment (estimated by the Army's surgeon general at 30%) further strains couples' relationships and renders them more vulnerable to infidelity (Monson, Fredman, & Adair, 2008; Sayers, Farrow, Ross, & Oslin, 2009).

Spouses of service members express strong concerns regarding the incidence of marital infidelity in their husband's or wife's unit. In a survey of spouses of active-duty members of the U.S. Army, nearly two thirds of respondents whose spouses had been deployed since September 2001 believed that infidelity was common (Kaiser Family Foundation, 2004). Sampling a group of male Vietnam veterans, Gimbel and Booth (1994) found that 25% of the veterans reported having sexual relations outside of marriage with at least three different people during at least one of their marriages. This stringent operationalization of infidelity (≥ 3 sexual partners other than one's spouse) likely yields more conservative estimates of infidelity in the military when compared with typical surveys asking respondents whether they had "ever had sex with someone other than your spouse while married." Data from the 1992 NHSLs for 345 veterans and 1,963 nonveterans indicated that 32% of veterans reported extramarital sexual relationships, compared with 17% of nonveterans; however, it was not clear from these data when the infidelity had occurred or whether serving in the military played any role in the higher rate of infidelity (London, Allen, & Wilmoth, 2011). Moreover, even less is known regarding rates of infidelity among civilian spouses of service members (whether deployed

or not), although data suggest that concerns about sexual infidelity by one's civilian partner are a significant source of stress among military personnel (Bray et al., 2010). Among military couples seeking marital therapy from U.S. Army family life chaplains, approximately 50% to 60% seek assistance with issues of infidelity, a rate strikingly higher than for the percentage of civilian couples in marital therapy (approximately 15%) (Atkins, Eldridge, Baucom, & Christensen, 2005).

The adverse individual as well as relationship consequences of infidelity are well documented. For persons recently learning of their partner's affair, research demonstrates a broad range of negative emotional and behavioral effects including partner violence, depression, suicidal ideation, acute anxiety, and symptoms similar to posttraumatic stress disorder (PTSD; Cano & O'Leary, 2000; Charny & Parnass, 1995; Glass & Wright, 1997; Gordon, Baucom, & Snyder, 2004). Concerns about infidelity have been shown to be significantly associated with general psychological symptoms among military spouses (Adler, Bartone, & Vaitkus, 1994). Among persons having participated in an affair, similar reactions of depression, suicidality, and acute anxiety are also common effects, particularly when disclosure or discovery of infidelity results in marital separation or threats of divorce (Glass, 2003; Spanier & Margolis, 1983; Wiggins & Lederer, 1984). The vulnerability of service members to acute relationship difficulties has garnered national attention, particularly in light of increases in soldiers' suicide rates for each of the past 5 years; indeed, the U.S. Army estimates that approximately 50% to 65% of suicides among active-duty soldiers in recent years were precipitated by the breakup of an intimate relationship (Suicide Risk Management & Surveillance Office, 2008).

Both the prevalence and adverse consequences of relationship problems among military couples have generated growing concern. For example, between 2001 and 2007, the divorce rate in the Army more than doubled (Defense Manpower Data Center, 2009). In a survey of more than 2,200 Operation Enduring Freedom (OEF) soldiers, approximately 6% of noncommissioned officers were planning separation or divorce at the beginning of their deployment, but by the 15-month point, the percentage tripled to >20%. Among enlisted

ranks, the percentage planning separation or divorce also tripled during 15 months, from 10% to >30% (Office of the Army Surgeon General, 2006).

Although the Army has responded with various programs to strengthen couples and families (e.g., the Deployment Cycle Support program and the Strong Bonds program), none of these programs is designed specifically to reduce known adverse individual and relationship consequences of infidelity or specifically strengthen the couple's resistance to future affairs. A recent study showed that married Army couples with a history of infidelity receiving a well-established marriage education program did not reach the same levels of marital satisfaction after intervention as did couples without a history of infidelity, although they did achieve comparable levels of communication skills (Allen, Rhoades, Stanley, Markman, & Loew, 2012).

An Integrative Approach for Promoting Recovery Following Infidelity

Although infidelity is reported by couples as a leading cause of divorce, and couple therapists describe infidelity as among the most difficult problems to treat (Whisman, Dixon, & Johnson, 1997), until recently there has been almost no empirical study of interventions for couples dealing with affairs. To date, the only intervention designed specifically for couples struggling with issues of infidelity to be empirically evaluated and supported as efficacious is an integrative approach designed by Snyder, Baucom, and Gordon (Baucom, Snyder, & Gordon, 2009; Gordon et al., 2004; Snyder, Baucom, & Gordon, 2007).

This intervention for couples struggling with issues of infidelity builds on strengths of two empirically supported treatments for couple distress, specifically, cognitive-behavioral couple therapy (CBCT) and insight-oriented couple therapy (IOCT). CBCT is a skills-based approach emphasizing communication skills (e.g., emotional expressiveness and problem-solving) as well as behavior-change skills (e.g., constructing independent or shared behavior change agreements), with additional emphasis on cognitive processes (e.g., relationship beliefs and standards, expectancies, and interpersonal attributions) that moderate the initiation, main-

tenance, or impact of these relationship skills (Epstein & Baucom, 2002). IOCT is a developmental approach emphasizing the identification, interpretation, and resolution of conflictual emotional processes in the couple's relationship related to enduring maladaptive interpersonal patterns established in previous relationships (Snyder & Mitchell, 2008). Although theoretically grounded primarily in these two approaches to couple therapy, the specific interventions comprising our treatment are fully congruent with a broad range of alternative theoretical approaches fostering change in couples' problem-solving interactions (e.g., solution-focused therapy) and emotional responsiveness (e.g., emotion-focused therapy).

In addition to integrating empirically supported components from cognitive-behavioral and insight-oriented couple treatments, the affair-specific intervention outlined here also builds upon the empirical literature regarding recovery from interpersonal trauma and recovery from relationship injuries. Specifically, infidelity is viewed as a traumatic event to the relationship that dramatically disrupts partners' assumptions about themselves and their relationship, causing both emotional and behavioral upheaval related to perceived loss of control and unpredictability of their future. Among other individual symptoms, reactions to infidelity frequently include intrusive and persistent rumination about the affair, hypervigilance to relationship threats and the partner's interactions with others, vacillation of emotional numbing with affect dysregulation, physiological hyperarousal accompanied by disrupted sleep or appetite, difficulties in concentration, and a broad spectrum of symptoms similar to those exhibited in PTSD.

Consistent with conceptualization of infidelity as an interpersonal trauma, this affair-specific intervention for couples also draws on literature regarding recovery from interpersonal injury, including an emerging empirical literature on stages and processes of forgiveness. Similar to trauma-based approaches, across diverse conceptualizations of recovery from interpersonal injury a crucial component involves developing a changed understanding of why the injury or betrayal occurred and reconstructing a new meaning for the event. Preliminary evidence concerning interventions aimed at promoting recovery from interpersonal injury—

heretofore developed almost exclusively from an individual- rather than couple-based perspective—indicates that such interventions can facilitate a more balanced appraisal of the injuring person and event, decreased negative affect and behaviors toward the offender, and increased psychological and physical health (Gordon, Baucom, & Snyder, 2005).

Detailed guidelines for clinical assessment and intervention—along with extended case examples and representative dialogues between therapist and partners—have been provided in a published clinician's guide (Baucom et al., 2009). This clinician's guide also describes how to integrate a self-help book designed for couples involved in extramarital affairs (Snyder et al., 2007) into treatment as a supplemental resource. We organize our treatment for affair couples into three stages: (1) dealing with the initial impact; (2) exploring context and finding meaning; and (3) moving on. Descriptions of each of these three stages follow.

Stage I: Dealing With the Initial Impact

The first stage of this intervention addresses the affair's impact. The first goal involves assessment of individual and relationship functioning to identify immediate crises requiring intervention (e.g., suicidality or physical aggression) and develop a shared intervention plan outlining each participant's responsibilities. After this assessment and formulation, initial interventions assist partners in articulating desired boundaries or guidelines for interaction between themselves and with others. For example, partners often need to negotiate how much time to spend together or apart; whether to sleep together or to maintain sexual relations; what further contact, if any, the participating partner will have with the outside affair person; and what information to share with potential interested parties (e.g., children, in-laws, or friends). Even couples with a history of effective problem-solving skills often find it difficult to resolve basic boundary issues because of the emotional turmoil after an affair, without assistance.

Because of frequent negative interactions between partners during this initial stage of recovery, most couples need a strategy that allows them to disengage when their level of emotion becomes too high. Consequently, both "time-out" and appropriate "venting" strategies are

presented, with partners instructed on when and how to implement these strategies effectively.

After some degree of stabilization has been achieved, the couple can begin to examine the affair's impact on themselves and their relationship. Couples are taught to use appropriate emotional expressiveness skills for both speaker and listener to promote more effective communication regarding the affair's impact. In addition to facilitating discussion of the affair's impact within sessions, supervised letter writing is used as a means for helping partners to explore and exchange their feelings in a more reflective manner.

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

Finally, because common reactions to affairs include acute anxiety, depression, and shame, partners are provided with specific strategies to facilitate physical self-care (e.g., sleep, diet, exercise), engaging social support while maintaining appropriate boundaries, and spiritual support if consistent with the partners' belief system. The supportive nature of these sessions also aids in strengthening rapport with each partner.

Overall, the fundamental goals of Stage I interventions are to establish boundaries regarding the outside person, restore basic patterns of couple or family interaction and reduce intense negative interactions, and promote an explicit recognition of the affair's impact on the injured partner and the couple's relationship. When these goals have been met, the treatment can proceed to examining factors that contributed to the affair.

Stage II: Exploring Context and Finding Meaning

The second stage of this intervention involves exploring factors that contributed to the affair's occurrence and evaluating both their ongoing effects and potential response to inter-

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

Factors from each of these domains are explored as potential contributors to the course of an extramarital affair, including (a) preexisting and enduring vulnerabilities, (b) initial approach behaviors (e.g., flirtatious behavior outside the couple's own standards), (c) implicit or explicit decisions to engage in or maintain the affair, (d) disclosure or discovery of the affair (e.g., participating partner's feelings of guilt, injured partner's increased vigilance), and (e) the couple's immediate and potential long-term response (e.g., capacity for emotional self-regulation and containment of intense couple conflict). In discussing these various factors, individual responsibility is placed on the partner involved in the affair, but a careful assessment of the context within which the individual decided to have an affair is important. It is essential to differentiate between understanding the context for the affair versus "blaming the victim" for the affair.

An overriding objective during Stage II of this intervention involves deriving a comprehensive explanatory formulation of the affair that facilitates a realistic appraisal regarding potential reoccurrence of this traumatic experience and aids in creating a new understanding of the couple's relationship, both as it functioned before the affair and its current dynamics. The injured partner's recovery of perceived relational security is critical to his or her ability to move beyond the hurt, anger, and anxiety that typify their initial response to an affair. A second goal is to promote the participating part-

ner's tolerance for the injured partner's continued emotional reactivity and persistent "need to know" why the affair occurred. Partners often have conflicting timelines for recovery, with participating partners preferring to "move on" and put the affair behind them well before their injured partners feel emotionally prepared to do so. Unless this difference is understood and normalized, and the participating partner's engagement in exploring the context is facilitated, a couple's long-term recovery after some initial stabilization of affect is frequently compromised. Third, examination of contributing factors promotes initial problem-solving processes and provides the couple with an opportunity to evaluate their ability to initiate changes critical to the long-term viability of their relationship.

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

In sum, the fundamental goals of Stage II involve examining a broad spectrum of factors that potentially contributed to the affair, identifying specific actions that each partner would need to pursue to reduce or eliminate these risk factors, and evaluating initial success in the couple's efforts to implement these strategies, at both individual and relationship levels. A shared understanding of risk factors and initial assessment of partners' ability to restore a secure and loving relationship provide the foundation for Stage III interventions promoting informed decisions about how to move forward, either together or separately.

Stage III: Moving on

The final stage of this intervention begins by integrating information obtained in previous

sessions in preparing to reach an informed decision about how to “move on.” An integrative summary provided to the couple, along with letters written by each partner to the other, are used to converge on a comprehensive formulation regarding factors contributing to the affair’s occurrence. Similar to the cognitive processing therapy for PTSD, any remaining questions or fears about their relationship are addressed, and reconstructed beliefs about the relationship are evaluated. Once this goal is achieved, handouts and written exercises are used to promote partners’ evaluation and discussion of their relationship’s viability, its potential for change, and partners’ commitment to work toward change based on what they have learned about themselves and each other. Partners explore the process of moving on by examining the meaning of this construct, as it relates to both their personal and relationship values and belief systems.

For many couples, this process involves examining personal beliefs about forgiveness. We advocate a view of forgiveness as a process whereby partners pursue increased understanding of themselves, each other, and their relationship to free themselves from being dominated by negative thoughts, feelings, and behaviors. This process is distinguished from a view of forgiveness as excusing or forgetting that the affair occurred, or requiring a decision to reconcile and remain in the couple’s relationship. An important aspect of this conceptualization of forgiveness is that it does not stipulate that partners must reconcile for forgiveness to occur. Rather, forgiveness is conceptualized as meaning that negative feelings no longer dominate their lives or control their actions toward their partner, and that the affair event has been resolved to such an extent that the injured partner no longer carries its negative effects into other relationships. The forgiveness process also allows for the possible development of warmer and more positive feelings toward the participating partner.

Thus, partners’ beliefs about forgiveness are explored, along with their apprehensions or fears regarding moving on. Potential risks and benefits of moving on emotionally are examined, including research on adverse consequences of sustained anger on individuals’ physical and emotional health as well as relationships with others. If the couple decides during this stage to continue their relationship, in-

terventions aid the couple in identifying areas of their relationship that require additional assistance and provide them with strategies to address these difficulties. Alternatively, if the couple decides to separate or pursue divorce, additional sessions help partners plan how to pursue this goal in a manner that is least hurtful to them and others they care about (e.g., children and extended family), and that promotes a process of moving on emotionally and rebuilding healthy, but separate, lives.

In a preliminary evaluation of this intervention—originally designed to be delivered in 25 sessions across 6 months—the majority of couples showed significant reductions in PTSD symptomatology, depression, and marital distress; individuals whose partner had engaged in the affair reported greater forgiveness toward their partner (Gordon et al., 2004). Treatment effect sizes on these outcome criteria were comparable with those of other empirically supported marital treatments and were significantly greater than the average effect sizes for wait-list controls across marital treatment-outcome studies (Baucom, Hahlweg, & Kuschel, 2003). Couples responding less favorably to treatment were those for whom (a) the quality of the relationship before the affair was poor, marked by sustained high negativity or emotional withdrawal, and/or (b) one or both partners exhibited significant individual psychopathology involving deficits in emotional or behavioral regulation (e.g., borderline or antisocial personality disorder).

A Case Study Involving Military Deployment

Cathy and Mike, aged 30 and 33 years, sought couple therapy approximately 6 months after Cathy learned that Mike had been sexually unfaithful during a 9-month deployment to Afghanistan in support of OEF. Mike’s mission in Afghanistan had been primarily in a noncombat role. His affair with Nancy, who also served in a noncombat role in Mike’s battalion, began approximately halfway into their deployment and continued for approximately 5 months until their unit returned to the United States. According to Mike, the affair had been primarily physical in nature with little emotional depth, and it ended almost immediately following their de-

ployment after both Mike and Nancy returned home to their respective spouses.

Cathy had noticed Mike's emotional detachment after his deployment and initially attributed this to common family reintegration challenges familiar to military couples (Snyder & Monson, 2012). However, when Mike's aloofness persisted and he seemed less interested in sexual intimacy than had been their norm, Cathy became concerned and began questioning Mike about reasons for both his emotional and physical distance. After a few weeks of continued marital strains, Mike disclosed his affair (which by now had ended), and emotional chaos in the couple's relationship ensued. Cathy felt emotionally devastated and found it difficult to make it through each day. In the evenings, she questioned Mike relentlessly about his affair, particularly about how he "could have done such a thing" to their family. Mike had no satisfactory explanation and the more Cathy escalated in her emotional intensity, the further he withdrew. Finally, Cathy took their three young children (aged 4, 7, and 8 years) to live with her parents in another state. Six weeks later, remaining deeply ambivalent, she agreed to return to Mike to give their marriage another chance.

By the time they sought couple therapy, Cathy and Mike had restored a stable, but devitalized, marriage. They rarely mentioned Mike's previous affair, but its effects weighed heavily on their relationship. Both partners went about their own work during the day, and in the evenings or on weekends, they tended to their children or various responsibilities in their home. There was little emotional warmth—none of the shared visioning of the future they had done so frequently in the past, and little depth to discussions of their daily experiences. Sexual intimacy was infrequent—with intercourse approximately once every 2 weeks and little other touching in-between—and lacked the passion they had enjoyed previously. They acknowledged collaborative coparenting, and they handled family logistics reasonably well, including managing their finances and arranging family outings. But they had lost their sense of friendship. Disagreements about minor issues festered beneath the surface because any serious relationship discussions threatened to bring up unresolved issues regarding Mike's affair. Although expressing commitment to keeping their

family together as best they could, both partners acknowledged doubts about their ability to tolerate and sustain their marriage in its present form over the long run.

Assessment and Stage I Interventions

After the initial session, both Mike and Cathy completed the Marital Satisfaction Inventory—Revised (MSI-R; Snyder, 1997), a multidimensional measure composed of 150 true–false items and 13 nonoverlapping scales designed to identify relationship functioning, overall and in specific domains such as affective and problem-solving communication, leisure time together, finances, sexual intimacy, and interactions regarding children, in addition to measures of role attitudes and family-of-origin distress. Considerable research has been conducted regarding the psychometric underpinnings of the MSI-R and scales' relation to treatment outcome. Test–retest reliability coefficients for the MSI-R scales average .79, and standard errors of change (based on normalized *T* scores) average 6.00, such that changes in scores over time exceeding 12 *T* score points can be considered significant at $p < .05$.

The couple's descriptions of their relationship on the MSI-R reflected remarkably similar evaluations of their marriage (see Figure 1). Both partners reported high levels of global relationship distress (GDS) and complained of not feeling cared for or understood by the other (AFC), although Cathy's distress was somewhat greater than Mike's in both these respects. Both partners reported difficulties in resolving differences between them (PSC), and both expressed moderate levels of dissatisfaction with their sexual relationship (SEX). By contrast, consistent with their presentation during the initial clinical interview, Cathy and Mike each denied any concerns regarding verbal or physical aggression (AGG), difficulties in managing money (FIN), or negotiating couple or family activities (TTO). They reported collaborative coparenting (CCR) and general satisfaction with their respective experiences as parents (DSC); both expressed a somewhat nontraditional, egalitarian approach to roles in the home (ROR), consistent with Cathy's leadership in the family related to Mike's recurrent deployments.

Both partners also completed the Patient Health Questionnaire (PHQ-9), a well-validated

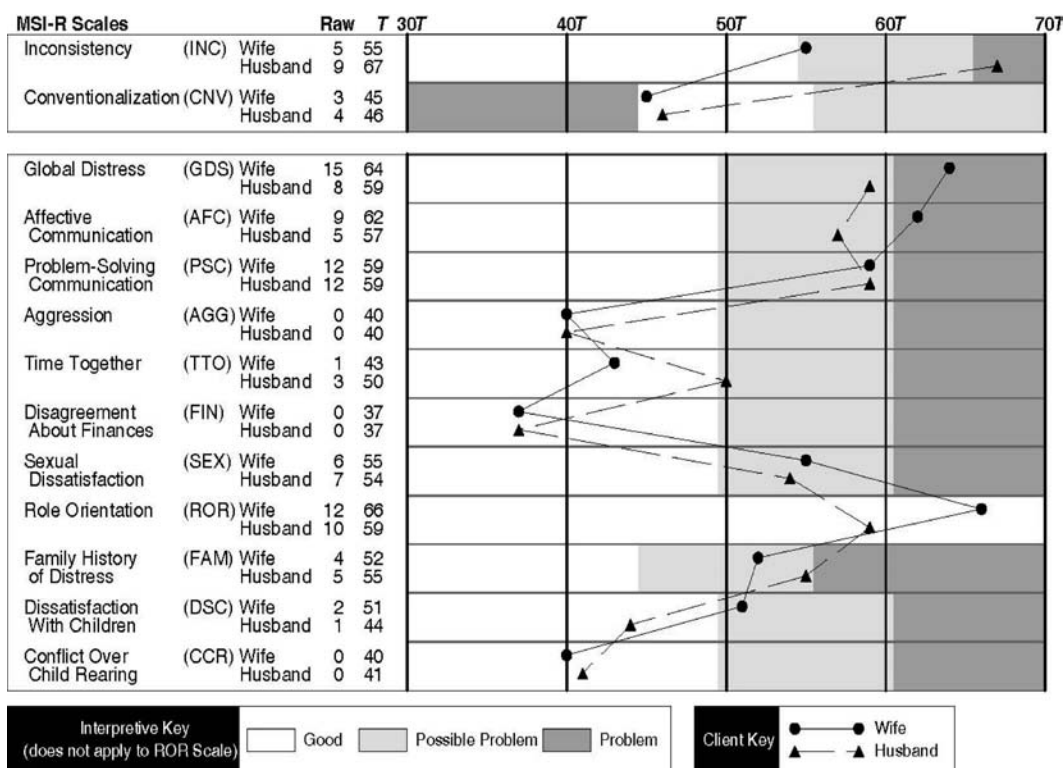


Figure 1. Pretreatment profiles on the Marital Satisfaction Inventory—Revised (MSI-R).

measure of depression composed of nine items corresponding to the *DSM-IV* diagnostic criteria for major depression (Kroenke, Spitzer, & Williams, 2001). Scores on the PHQ-9 range from 0 to 27 and have a test–retest reliability of approximately 0.84 and standard error of change of 2.15, such that changes in scores over time exceeding 4 points can be considered significant at $p < .05$. Cathy's score of 14 on this measure placed her in the mild to moderate range of symptomatology for major depression, including feelings of hopelessness and disrupted sleep, appetite, and concentration. Cathy denied any suicidal ideation, but acknowledged that her depression was making it difficult to take care of things at work or at home. By contrast, Mike reported virtually no depressive symptoms, consistent with both his presentation in clinical interview and complaints from Cathy that Mike "rarely experienced or discussed feelings." However, despite obtaining a raw score of only 2 on the PHQ-9, Mike acknowledged on this measure that on several occasions in the

past 2 weeks he had thoughts that he would be better off dead and had considered ending his life.

Both Mike's suicidality and Cathy's level of depression demanded immediate intervention. Mike acknowledged his access to lethal weapons by virtue of his military service, but pledged not to harm himself primarily because of his concerns about its adverse impact on their children. Moreover, he recognized that—although not *feeling* depressed—his suicidal thoughts must reflect a level of despair he was experiencing in a "nonemotional" way. He agreed to using couple therapy in part as a means for learning how to recognize and label feelings—not only his own, but also Cathy's—in ways that might initially be uncomfortable for him but ultimately could facilitate more informed choices about his own behaviors and responses to Cathy. Feedback to Cathy based on her PHQ-9 score emphasized ways that she had tried to suppress her reactions to Mike's affair to stabilize their family, and the toll this strategy

was exacting on her both emotionally and physically. Cathy agreed to set aside some time during the week for self-care and to restore some important friendships she had avoided during the past 6 months out of embarrassment from Mike's affair.

In the initial stage of recovery after disclosure or discovery of an affair, most couples struggle with high levels of emotional and behavioral dysregulation. They often have difficulty with even basic decisions involving childcare, daily household tasks, whether to remain in the same home or bedroom, and how to manage emotional or physical closeness. Helping such couples to manage conflict, use time-outs effectively, and engage in constructive discussion of affair-related topics is crucial. However, other couples—particularly those for whom discovery of the affair was months (or sometimes years) earlier—often settle into a stable, but unsatisfying, routine of daily life that ignores residual emotional barriers stemming from the relationship betrayal. Those couples often need assistance with reengaging in difficult discussions of the affair aimed at explicating its adverse impact on the injured (betrayed) partner's views of him- or herself, toward the participating (betraying) partner, and their relationship.

Such was the case regarding initial interventions with Mike and Cathy, where Cathy believed that Mike had never really understood or acknowledged how his affair had profoundly impacted her. Mike had apologized but then wanted to "move on" without further discussion; for Cathy, this left everything "unsettled" and was unacceptable. Couple therapy initially emphasized guided discussions in session in which Cathy described how Mike's affair had influenced how she felt toward Mike and herself. Mike listened attentively, but had remarkable difficulty reflecting Cathy's feelings, either using her own language or empathic phrasing of his own. Mike's alexithymia—his inability to understand, process, or describe emotions—became painfully obvious to both partners. After several sessions devoted to this process, their therapist instructed Cathy to write a letter to Mike describing the impact of his affair on her emotionally, and then to read this aloud to him in the subsequent session. After that exchange, Mike was asked to respond to Cathy with a letter of his own, capturing as best he could what he understood to be the impact of his affair

on her and then to read this aloud in the following session. The impact of this sequence of interventions on Cathy was immediate and profound. For the first time since her discovery of Mike's affair, she felt understood by him in a meaningful, empathic, and caring way. For the first time since his return from Afghanistan, she felt hopeful again for their marriage.

Stage II Interventions

Stage II interventions are essential for restoring injured partners' sense of relationship security and intimacy. Until the full range of factors contributing to vulnerability to an affair are understood and addressed, the relationship feels unsafe for the injured partner.

Like many participating partners, Mike's initial explanation for his affair was superficial and, at best, incomplete. He acknowledged his feelings of separation from Cathy and aloneness during his deployment. He described efforts not to think about her and their children in order to "miss her less," but the same strategy reduced the boundaries to his becoming physically intimate with someone else. He attributed his affair to "not really thinking" about what he was doing, but attempted to reassure Cathy that he had learned from this and would not betray her again. For Cathy, this explanation was insufficient. Although recognizing the strains of deployment, she reminded Mike that many (probably most) deployed service members remain sexually faithful to their nondeployed spouses; moreover, she noted that she had not even considered emotional or physical involvement with another man during their separation. Mike's pledging to be faithful in the future also failed to reassure her because he had promised fidelity when they had first married, and that promise had already been broken.

A recurring theme during these discussions—and a persistent frustration for Cathy—was Mike's inability to recognize and process his own feelings. He had never been emotionally communicative in their marriage; his struggles in this regard extended beyond limitations in expressive language to include a more basic lack of awareness of his own mood states and emotional impulses. These limitations rendered Mike more susceptible to seeking out experiences without understanding why, and without being able to reflect on his emotional needs in a

more intentional way to consider alternatives and consequences.

A turning point occurred several months into the couple therapy when the partners agreed to complete the Revised NEO Personality Inventory (NEO PI-R; Costa & McCrae, 1992) as a means for considering enduring differences in their basic cognitive and emotional styles. The NEO can sometimes facilitate a broader perspective for individuals regarding stable psychological dispositions, without imposing a conceptual model rooted in psychopathology. In their responses to this inventory, both Mike and Cathy obtained scores that affirmed important similarities in their overall “calmness” and ability to cope with stress, their compassionate and cooperative style, and their conscientiousness (see Table 1). However, consistent with their differences in affective style evident in therapy

sessions as well as their relationship history, the NEO reflected how dramatically different the two partners were in their interpersonal and expressive styles. Specifically, Mike’s scores affirmed his “introverted and serious” style and discomfort in many interpersonal contexts, as well as his preference for dealing with situations in a “traditional and practical” way that emphasized reason over feelings. By contrast, Cathy’s scores emphasized her “outgoing and high-spirited” style, her need to be around people, and her preference for dealing with situations in “imaginative” ways guided by intuition and emotional processing.

Seeing their enduring differences in personality style so dramatically captured by this assessment released Cathy from trying to convert Mike to her own ways of experiencing life affectively. Previously she had felt angry to-

Table 1
Measures of Individual Functioning for Cathy (Injured Partner) and Mike (Participating Partner)

Construct	Measure: Score	Interpretation (range and description)
Results for Cathy (injured partner)		
Pretreatment depression	PHQ-9: 14	Mild to moderate depression
Posttreatment depression	PHQ-9: 0	Minimal or no depression
Neuroticism	NEO PI-R (N): 72	Average: Generally calm and able to deal with stress, but you sometimes experience feelings of guilt, anger, or sadness
Extraversion	NEO PI-R (E): 128	High: Extraverted, outgoing, active, and high-spirited. You prefer to be around people most of the time
Openness	NEO PI-R (O): 140	Very high: Open to new experiences. You have broad interests and are very imaginative
Agreeableness	NEO PI-R (A): 145	High: Compassionate, good-natured, and eager to cooperate and avoid
Conscientiousness	NEO PI-R (C): 137	High: Conscientious and well organized. You have high standards and always strive to achieve your goals
Results for Mike (participating partner)		
Pretreatment depression	PHQ-9: 2	Minimal or no depression. (But endorsed item: “Thoughts I would be better off dead, or of hurting myself—Several days during the past 2 wk.”)
Posttreatment depression	PHQ-9: 1	Minimal or no depression
Neuroticism	NEO PI-R (N): 69	Average: Generally calm and able to deal with stress, but you sometimes experience feelings of guilt, anger, or sadness
Extraversion	NEO PI-R (E): 87	Low: Introverted, reserved, and serious. You prefer to be alone or with a few close friends
Openness	NEO PI-R (O): 66	Very low: Down-to-earth, practical, traditional, and pretty much set in your ways
Agreeableness	NEO PI-R (A): 135	High: Compassionate, good-natured, and eager to cooperate and avoid
Conscientiousness	NEO PI-R (C): 128	Average: Dependable and moderately well organized. You generally have clear goals but are able to set your work aside

Note. PHQ-9 = Patient Health Questionnaire depression scale; NEO PI-R = Revised NEO Personality Inventory; N = neuroticism; E = extraversion; O = openness; A = agreeableness; C = conscientiousness.

ward Mike because she had assumed that he experienced the same kinds of feelings that she did but deliberately withheld them from her. She now proposed a different formulation that left her less angry but still disillusioned, namely, that she had the capacity to experience feelings, but Mike did not. Their therapist offered a more nuanced formulation—that Cathy could experience, access, and label her feelings on a more continuous basis, whereas Mike experiences his own feelings more rarely and episodically, usually only in particularly painful or stressful times, has difficulty labeling or expressing them, and then quickly moves past them. Both partners accepted the therapist’s alternative formulation and agreed to work toward some “common middle ground” for discussing feelings.

As Mike felt less pressured to adopt Cathy’s emotional style, he was more willing and somewhat more able (albeit to a limited degree) to expand his emotional language and attend to his own feelings. The couple practiced short exchanges in session focused on discrete emotional experiences, with Mike acquiring a repertoire of a dozen or so words to capture the valence and intensity of his feelings (e.g., sad, happy, excited, calm, restless, satisfied). His willingness to engage in 5- to 10-minute discussions each evening that extended beyond “factual disclosures” to include limited emotional expressiveness, and Cathy’s willingness to embrace those exchanges without demanding more protracted discussions on an emotional level, gradually facilitated a steadier flow of somewhat more comfortable and satisfying emotional connections for both partners.

During the course of these discussions, Cathy was able to express to Mike her continuing feelings of vulnerability and her wish for explicit agreements involving Mike’s closer attention to his own feelings and adherence to boundaries protecting their relationship. Their therapist invited Mike to develop a list of specific “warning indicators” that he could use in future situations that would help him recognize when he was transitioning along the “slippery slope” toward inappropriate feelings and interactions with other women. In the subsequent session, Mike returned with a list of indicators such as exchanging text messages after hours that are only partially work-related; having lunch as a group, but finding reasons to stay

behind afterward with a woman; sharing personal details in conversations with a woman that are not work-related; frequent touching during interactions; or frequent flirting. The specificity of these indicators went well beyond Mike’s initial formulation earlier in the therapy that he “simply didn’t think about what he was doing.” His list of warning signs reassured Cathy that he could now recognize and interrupt interactions that increased his vulnerability to crossing the line into unfaithful behaviors. During this same time, Cathy recognized that Mike was working hard to regain her trust by volunteering throughout the day where he was and whom he was with, fulfilling simple commitments in their day-to-day interactions at home, and initiating discussions that he admittedly found less crucial and less satisfying emotionally than Cathy. His intentions and efforts at change helped her to adopt more reasonable expectations about the kinds of emotional discussions they could have as a couple and to embrace these when they occurred.

Stage III Interventions

After achieving a broader understanding of factors that had placed Mike at risk for infidelity during deployment, and achieving specific agreements aimed at reinforcing appropriate boundaries, the couple’s frequency and depth of emotional and physical connection improved significantly. In anticipating Mike’s future deployments or extended training exercises, they proposed specific strategies for staying emotionally connected and “keeping intimacy alive” during those separations. They identified an approaching weekend marking their 10th wedding anniversary, and planned a trip out of town without their children for renewing their vows and celebrating the work they had accomplished during couple therapy.

Shortly after this trip, they learned that Mike’s unit was about to redeploy in 2 months. Mike’s former affair partner was no longer a part of his battalion, and this helped to mitigate some of Cathy’s initial panic. More importantly, however, anticipation of Mike’s upcoming redeployment increased the couple’s efforts to practice their new communication patterns, working toward a level of emotional expressiveness that was tolerable and sustainable for each of them, and trying out strategies for stay-

ing connected during predeployment training exercises. During the next-to-last session, both partners once again completed the PHQ-9 to assess their level of depressive symptoms. In this reassessment, Cathy's score dropped from 14 to 0, exceeding the criterion for reliable change on this measure. Mike's score dropped from 2 to 1, and his only symptom reflected concerns about overeating, which he attributed to disruption of his usual exercise routine rather than to depression.

In their final session, both partners expressed recovery of trust and intimacy in their marriage, and optimism that they could withstand the individual and relationship challenges characterizing the military deployment cycle.

Summary

Sexual infidelity has a high prevalence in both representative community and treatment-seeking samples, and has been identified by experienced therapists as one of the more difficult couple problems to treat. Disclosure or discovery of infidelity triggers a broad range of adverse relationship and individual consequences, including increased risk of major depression and suicidality in either one or both partners. Effective treatment requires an integrative approach that (1) recognizes the traumatic impact of an affair, (2) builds relationship skills essential to initial containment of trauma and effective decision making, (3) promotes partners' greater understanding of factors within and outside themselves that increased their vulnerability to an affair and influence their recovery, and (4) addresses emotional, cognitive, and behavioral processes essential to forgiveness and moving on, either together or separately. The integrative treatment approach described here is the first treatment designed specifically to assist couples' recovery from an affair to garner empirical evidence of its efficacy. Additional evidence is emerging in support of abbreviated adaptations of the intervention tailored to contextual constraints of the military environment and implementation by a broad range of service providers.

References

- Adler, A. B., Bartone, P. T., & Vaitkus, M. A. (1994). *Family stress and adjustment during a peacekeeping deployment*. Paper presented at the meeting of the American Psychological Association, Los Angeles, CA.
- Allen, E. S., Atkins, D., Baucom, D. H., Snyder, D., Gordon, K. C., & Glass, S. P. (2005). Intrapersonal, interpersonal, and contextual factors in engaging in and responding to extramarital involvement. *Clinical Psychology: Science and Practice*, 12, 101–130. doi:10.1093/clipsy.bpi014
- Allen, E. S., Rhoades, G. K., Stanley, S. M., Markman, H. J., & Loew, B. (2012). The effects of marriage education for Army couples with a history of infidelity. *Journal of Family Psychology*, 26, 26–35.
- Amato, P. R., & Previti, D. (2003). People's reasons for divorcing: Gender, social class, the life course, and adjustment. *Journal of Family Issues*, 24, 602–626.
- Atkins, D. C., Baucom, D. H., & Jacobson, N. S. (2001). Understanding infidelity: Correlates in a national random sample. *Journal of Family Psychology*, 15, 735–749. doi:10.1037/0893-3200.15.4.735
- Atkins, D. C., Eldridge, K. A., Baucom, D. H., & Christensen, A. (2005). Infidelity and behavioral couple therapy: Optimism in the face of betrayal. *Journal of Consulting and Clinical Psychology*, 73, 144–150. doi:10.1037/0022-006X.73.1.144
- Baucom, D. H., Hahlweg, K., & Kuschel, A. (2003). Are waiting-list control groups needed in future marital therapy outcome research? *Behavior Therapy*, 34, 179–188. doi:10.1016/S0005-7894(03)80012-6
- Baucom, D. H., Snyder, D. K., & Gordon, K. C. (2009). *Helping couples get past the affair: A clinician's guide*. New York: Guilford Press.
- Bray, R. M., Pemberton, M. R., Lane, M. E., Hourani, L. L., Mattiko, M. J., & Babeu, L. A. (2010). Substance use and mental health trends among U.S. military active duty personnel: Key findings from the 2008 Department of Defense health behavior survey. *Military Medicine*, 175, 390–399.
- 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. doi:10.1037/0022-006X.68.5.774
- Charny, I. W., & Parnass, S. (1995). The impact of extramarital relationships on the continuation of marriages. *Journal of Sex and Marital Therapy*, 21, 100–115. doi:10.1080/00926239508404389
- Costa, P. T., & McCrae, R. R. (1992). *NEO PI-R manual*. Odessa, FL: Psychological Assessment Resources.
- Defense Manpower Data Center. (2009). *Selected manpower statistics*. Arlington, VA: Department of Defense.

- Epstein, N. B., & Baucom, D. H. (2002). *Enhanced cognitive-behavioral therapy for couples: A contextual approach*. Washington, DC: American Psychological Association. doi:10.1037/10481-000
- Gimbel, C., & Booth, A. (1994). Why does military combat experience adversely affect marital relations? *Journal of Marriage and the Family*, 56, 691–703. doi:10.2307/352879
- Glass, S. P. (2003). *Not "just friends": Protect your relationship from infidelity and heal the trauma of betrayal*. New York: Free Press.
- Glass, S. P., & Wright, T. L. (1992). Justifications for extramarital relationships: The association between attitudes, behaviors, and gender. *Journal of Sex Research*, 29, 361–387. doi:10.1080/00224499209551654
- Glass, S. P., & Wright, T. L. (1997). Reconstructing marriages after the trauma of infidelity. In W. K. Halford & H. J. Markman (Eds.), *Clinical handbook of marriage and couples intervention* (pp. 471–507). New York: Wiley.
- 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. doi:10.1111/j.1752-0606.2004.tb01235.x
- Gordon, K. C., Baucom, D. H., & Snyder, D. K. (2005). Forgiveness in couples: Divorce, affairs, and couples therapy. In E. Worthington (Ed.), *Handbook of forgiveness* (pp. 407–421). New York: Routledge.
- Kaiser Family Foundation. (2004). *Military families survey*. Menlo Park, CA: Kaiser Family Foundation.
- Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16, 606–613. doi:10.1046/j.1525-1497.2001.016009606.x
- Laumann, E. O., Gagnon, J. H., Michael, R. T., & Michaels, S. (1994). *The social organization of sexuality: Sexual practices in the United States*. Chicago, IL: University of Chicago Press.
- London, A. S., Allen, E., & Wilmoth, J. M. (2011, August). *Veteran status, marital infidelity, and divorce*. Paper presented at the meeting of the American Sociological Association, Las Vegas, NV.
- Monson, C. M., Fredman, S. J., & Adair, K. C. (2008). Cognitive-behavioral conjoint therapy for posttraumatic stress disorder: Application to operation enduring and Iraqi Freedom veterans. *Journal of Clinical Psychology*, 64, 958–971. doi:10.1002/jclp.20511
- Office of the Army Surgeon General. (2006). *Mental health advisory team (MHAT) IV: Operation Iraqi Freedom 05–07*. Washington, DC: Office of the Army Surgeon General.
- Sayers, S. L., Farrow, V. A., Ross, J., & Oslin, D. W. (2009). Family problems among recently returned military veterans referred for a mental health evaluation. *Journal of Clinical Psychiatry*, 70, 163–170. doi:10.4088/JCP.07m03863
- Snyder, D. K. (1997). *Manual for the marital satisfaction inventory—revised*. Los Angeles, CA: Western Psychological Services.
- Snyder, D. K., Baucom, D. H., & Gordon, K. C. (2007). *Getting past the affair: A program to help you cope, heal, and move on—together or apart*. New York: Guilford Press.
- Snyder, D. K., & Mitchell, A. E. (2008). Affective reconstructive couple therapy: A pluralistic, developmental approach. In A. S. Gurman (Ed.), *Clinical handbook of couple therapy* (4th ed., pp. 353–382). New York: Guilford Press.
- Snyder, D. K., & Monson, C. M. (2012). *Couple-based interventions for military and veteran families: A practitioner's guide*. New York: Guilford Press.
- Spanier, G. B., & Margolis, R. L. (1983). Marital separation and extramarital sexual behavior. *The Journal of Sex Research*, 19, 23–48. doi:10.1080/00224498309551167
- Suicide Risk Management and Surveillance Office. (2008). *Army suicide event report*. Tacoma, WA: Madigan Army Medical Center.
- Whisman, M. A., Dixon, A. E., & Johnson, B. (1997). Therapists' perspectives of couple problems and treatment issues in couple therapy. *Journal of Family Psychology*, 11, 361–366. doi:10.1037/0893-3200.11.3.361
- Wiederman, M. W. (1997). Extramarital sex: Prevalence and correlates in a national survey. *The Journal of Sex Research*, 34, 167–174. doi:10.1080/00224499709551881
- Wiggins, J. D., & Lederer, D. A. (1984). Differential antecedents of infidelity in marriage. *American Mental Health Counselors Association Journal*, 6, 152–161.

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