Assessing Relationship Betrayals

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Relationship betrayals, such as sexual and emotional infidelity, are commonly encountered in the practice of psychotherapy, yet clinicians often report difficulties in assessing and treating them. In this article we offer suggestions for assessing relationship betrayals. We address the definition of relationship betrayals, methods of assessing relationship betrayals, when and whom to assess, confidentiality, and assessing related clinical concerns. We illustrate with case vignettes the assessment and treatment of betrayals in close relationships. © 2005 Wiley Periodicals, Inc. J Clin Psychol/In Session 61: 1383–1391, 2005.

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Psychotherapists working with couples can expect to encounter relationship betrayals such as sexual infidelity with some regularity. Although data on the prevalence of infidelity are difficult to obtain, several studies have found that it is common enough to merit regular assessment by therapists. In one of the largest community studies conducted to date, 21% of men and 11% of women reported extramarital involvement (Laumann, Gagnon, Michael, & Michaels, 1994). Studies examining the annual incidence of extramarital sex suggest that approximately 2%–4% of all married men and women are likely to have engaged in extramarital sex in the past year (Treas & Giesen, 2000; Wiederman, 1997). Studies that have used expanded definitions of infidelity have found even higher rates of extramarital involvement.
Despite its prevalence, clinicians may not always accurately identify infidelity or its role in a couple’s difficulties. Even skilled couple therapists may miss the opportunity to treat infidelity because they don’t inquire about it or recognize infidelity as a possible issue.

In this article, we discuss the assessment of relationship betrayals in couple therapy. Specifically, we address the definition of relationship betrayals, specific methods for assessing relationship betrayals, when and whom to assess, confidentiality, and assessment of related clinical concerns.

Definition of Relationship Betrayals

Both the research and the clinical literature on infidelity have emphasized sexual relations with someone other than the primary partner. Although this may be a primary component of extradyadic relationships, it is important to consider that such relationships may also be defined in terms of emotional involvement with another person (Glass & Wright, 1992). Such relationships are often denoted as extramarital, but this term does not easily translate to extradyadic involvement for other types of relationships (e.g., same-sex or cohabiting couples).

Because of the difficulties inherent in the terms commonly used in the literature, we have chosen to focus our article on relationship betrayals, by which we refer to violations of expectations for emotional and physical exclusivity with one’s partner. People involved in romantic relationships most often expect to have certain needs met exclusively by their romantic partner. Infidelity, affairs, and other forms of sexual and emotional betrayal violate such expectations of exclusivity.

One indication that a person is engaging in behavior that they believe violates their partner’s expectations for exclusivity is that they try to keep the relationship secret from their partner. Thus, disclosure of betrayals often involves feelings of being deceived, which are likely to result in disillusionment and further relationship problems.

Clinicians should bear in mind that people differ in their expectations for exclusivity. For example, one couple may believe that a close cross-sex friendship is a violation of exclusivity, whereas another couple may encourage such relationships. Similarly, sexual relations with persons other than the partner, a violation of exclusivity for many couples, may not violate expectations for exclusivity for a couple in a sexually open relationship. The important point is that assessment needs to be individualized because partners often have diverging definitions of what is acceptable within the parameters of their relationship.

Assessing Relationship Betrayals

Assessment of relationship betrayals should be ongoing, fluid, and responsive to the changes that occur as treatment progresses. Decisions about how and when to ask questions, and how to respond to the information gathered, need to be integrated within the particular therapeutic context. Inquiries concerning relationship betrayals, particularly sexual infidelity, need to be pursued with respect, sensitivity, and attention to nonverbal cues and the therapeutic relationship.

We recommend that therapists inquire about betrayals as routinely as they would about such other matters as history of violence or substance abuse. Questions such as, “Have there been any sexual or emotional betrayals or infidelities in the relationship?” can convey that the therapist is equipped to handle such information, and that such disclosure is welcome in the context of treatment, thereby easing disclosure. We recommend the use of the term infidelity over related terms such as affairs or cheating because there
are some sexual encounters (e.g., one-night stands, sex for pay) that may not be seen by couples as meeting their definition of these terms. This term also reflects our emphasis on assessing behaviors that violate the couple’s expectations of exclusivity. Given the potential for different interpretations of the word infidelity, general questions about infidelity should be followed up with specific questions about whether either person has had sex with anyone other than the partner in the recent past.

Disclosure of betrayals does not always happen in conjoint sessions. If information about sexual or emotional infidelities is disclosed without both partners being present (e.g., in response to questionnaires, during individual sessions or other individual contact), it is important to ask whether the relationship is currently ongoing and whether the partner is aware of the relationship. We believe that ongoing secretive infidelities undermine a clinician’s ability to conduct couple therapy, and therefore need to be stopped and disclosed to the partner.

If it is found that one or both partners have engaged in sexual infidelity, it is important to follow this up with an assessment of whether a condom was used with the other person(s). If not, then the person who is engaging in sexual infidelity, as well as their partner, is at risk for contacting HIV and other sexually transmitted diseases. In a national sample of heterosexual couples who reported more than one sexual partner during the preceding year, 64% reported never using condoms with their secondary partner and 73% reported never using condoms with their primary partner; only 8%–12% of people with more than one sexual partner reported always using condoms with primary and secondary partners (Choi, Catania, & Dolcini, 1994). Even lower rates of consistent condom use have been reported: Leigh and colleagues (1993) found that only 1% of married or cohabiting individuals who had more than one sexual partner in the previous 12 months reported that they always used condoms. In a study with substance-abusing men (Fals-Stewart et al., 2003), 16% of men indicated that they had engaged in unprotected penetrative sexual intercourse with someone other than their wives during the previous 12 months, and 75% of wives of substance-abusing men reported having unprotected sexual intercourse with their spouses during the same period. The majority of wives (71%) were not aware that their husbands had engaged in a high-risk behavior. If a person has engaged in unsafe sex with a person other than their primary partner, they should be referred for testing for HIV and sexually transmitted diseases and encouraged to either abstain from, or use a condom during, sex with their primary partner until the results of such testing is available.

In summary, when assessing for relationship betrayals, clinicians may want to start with general questions about sexual or emotional infidelities, followed by questions about specific behaviors and, in the case of sexual infidelity, the use of condoms. If betrayals are disclosed without the partner present, then we recommend assessing whether the relationship is ongoing and whether the partner is aware of the betrayal. In addition to asking about each person’s own behaviors, it may be helpful to ask them about suspicions about their partner engaging in sexual or emotional betrayals. In Table 1, we have provided questions that can be used in assessing relationship betrayals.

Methods of Assessing Relationship Betrayals

Relationship betrayals, particularly those involving sexual relations with another person, are seen by most people as socially undesirable. Public opinion surveys have found that over the years, 70%–80% of Americans say that extramarital sex is always wrong, and most others express at least some disapproval (Smith, 1994). Because of the stigma
associated with sexual infidelity, people may be hesitant to admit to such behaviors in face-to-face interviews with a psychotherapist, particularly in the initial sessions before trust and a therapeutic relationship have been established. Therefore, clinicians may want to consider additional methods for assessing betrayals that may facilitate clients’ disclosing sexual infidelities. In addition to asking couples about betrayals in an interview, therapists may want to consider asking about them in a self-report questionnaire. There is some empirical support for such multimethod assessment of sexual infidelity. Treas and Giesen (2000) examined the prevalence and correlates of sexual infidelity in a national probability sample of people between the ages of 18 and 59. They found that the lifetime prevalence of infidelity differed by method of assessment, with 15.5% of respondents reporting a lifetime history of sexual infidelity on a self-administered questionnaire vs. only 11.2% when asked in an interview.

We are not aware of any data regarding different methods of assessing relationship betrayals yielding different results for people in treatment, but indirect evidence for the need for multimethod assessment in treatment comes from findings regarding the assessment of other relationship behaviors carrying similar social disapproval. For example, in assessing physical aggression in couples seeking marital therapy, the rates of aggression were lowest when based on questionnaire responses to open-ended questions about current marital problems, but successively increased when based on (a) interview responses to open-ended question about current marital problems, (b) interview responses to direct inquiry about aggression, and (c) self-report questionnaire responses to items directly inquiring about aggression (Ehrensaft & Vivian, 1996). Hence, clinicians may want to consider adding questions about relationship betrayals, similar to those provided in Table 1, to written assessment materials provided to couples.

**When and Whom to Assess**

In order to address the effects of relationship betrayals, such betrayals first need to be revealed. Sometimes, prior to the first phone call to the therapist, a partner’s betrayal has been revealed to, or discovered by, the betrayed spouse. In such circumstances, therapists
should note who is calling, how they sound on the phone, how urgent is their request for
an appointment, how they describe the nature of the problem, and what questions they
ask of the therapist. Such observations may yield useful information about initial goals,
investment in treatment, and current distress.

Alternatively, relationship betrayals may first be revealed in session, and the initial
steps of assessment may include observations of who informs the therapist, how they
relay that information, and the affect and nonverbal behavior displayed by each partner.

Trudy and Brian had been in treatment for 2 months. Trudy had initiated treatment,
complaining that Brian had gotten so involved in work, where he’d just been promoted,
that he wasn’t spending much time with her or their children and seemed to be inordinately
distracted and distant. Trudy hoped that couple treatment could help Brian re-engage
in their relationship and their family. Although Brian agreed with his wife’s observations,
he consistently failed to follow through on homework assigned in couple sessions, and
began to talk about how he felt he and Trudy had “grown apart” and wasn’t sure they
should remain together if their relationship “needed this much work.” Oddly, Trudy also
observed that during this same time, their sex life improved significantly. She became
suspicious that Brian was involved in an affair. She began calling the numbers on his cell
phone bills and discovered that one number he called frequently belonged to a young
female employee in his office. Brian revealed his affair to Trudy when confronted with
this information.

It is also helpful to obtain information about what happened and how the affair was
discovered or revealed. This last point is illustrated in the following vignette:

Grace discovered her husband’s affair after his affair partner had broken off the
relationship. Feeling devastated, Dan had written his affair partner a letter on their home
computer and left a draft of the letter in the trash can, which Grace emptied the next day.
Grace kept telling Dan how much better she would have felt if he had just confessed his
affair to her. Indeed, rebuilding trust in the relationship took a long time because Grace
kept wondering if Dan would have ever revealed the affair to her directly.

We advocate that the majority of couple therapy take place in conjoint sessions, but
we also believe that individual assessment sessions are often a helpful component of
treatment. Individual sessions can provide a crucial opportunity to gather more informa-
tion about betrayals and assess each partner’s functioning more accurately. During an
individual session, psychotherapists can assess individual psychopathology, obtain indi-
vidual histories and histories of relationships, clarify individual goals, and assess safety
issues more effectively than might be possible in conjoint sessions (Wagers, 2003).

On the other hand, individual assessment sessions can have potential adverse effects
on treatment. The possibility of adding more secretiveness to the system, when such
secretiveness around the infidelity has already been so damaging, may be anxiety pro-
ducing for some partners. If the clinician conducts an individual session with each spouse
at the beginning of treatment, he or she would be well-advised to provide a credible
rationale to the couple for such sessions, and define the bounds of confidentiality in a
manner with which both partners are comfortable. We return to this point later when
discussing confidentiality.

Sometimes an individual seen in couple treatment is also in individual therapy, and
their therapist sometimes knows details about the betrayal that have not yet been revealed
to their partner or to the couple therapist. After a release of information is obtained to talk
to the other therapist, parameters should be set around the information to be shared that
will not put the couple therapist in the position of keeping secrets from the other partner.
Information may include an individual’s psychological functioning and relevant safety
issues such as history of suicide attempts.
Confidentiality in Assessing Relationship Betrayals

Clinicians often struggle with how to handle secret affairs. We believe that conducting couple therapy in the context of a secret, ongoing betrayal is contraindicated. Couple therapists should be alert to the possibility that one partner may share secrets about betrayals, and that these secrets can undermine the integrity of the couple treatment, as well as place the therapist in a potentially untenable position as treatment proceeds. In addition, if secrecy about a betrayal has already damaged the relationship, it becomes even more important that each partner be assured that secrecy will not be a threat in couple therapy.

To avoid being caught in secret disclosures, therapists must make their perspectives on this matter known from the beginning of therapy. We do this by informing clients in the initial session that anything that is brought up by either person becomes part of couple therapy; that is, they are told that there are no secrets between the therapist and an individual client. One method of establishing clear expectations with couples around how information will be handled is the use of a separate consent-to-treatment form for couples, with the parameters of confidentiality defined therein. One such form states that:

I may share with your partner any information conveyed to me by either of you. Please be aware that information you choose to share with me that is particularly pertinent to both of you may come out in therapy. This pertains to all verbal, written, and phone conversations and messages. If I meet with one or both of you in individual sessions, we will likely share the contents of that meeting with the partner at the next couple’s session. (Dea, 2005, personal communication)

Of course, not all disclosures regarding relationship betrayals occur in the comfort and clarity of the treatment room. For example, one of us (TPW) was cornered in the bathroom of the office building by the female partner in a couple that had just started treatment, who then proceeded to share an important detail about her affair that she had yet to disclose to her husband.

Another case (Wagers, 2003) illustrates the significant damage involved when a therapist is placed in the position of keeping a secret about an infidelity.

A therapist, relatively new to the field, was treating a couple and making little progress in treatment. Two months into treatment she got a phone call from the husband of the couple, who asked her if he could reveal something in confidence. She unfortunately agreed, out of her own frustration with the treatment process, and the hope that his revelation would help her be more effective with the couple. He disclosed the presence of an affair, but stated he did not want the affair to be revealed to the wife. The therapist pleaded with the husband to reveal the affair, offered to reveal it herself, and devised a plan where they could reveal it together, but to no avail. In this case, sadly, the therapy was terminated when the husband told his wife he didn’t want to work with the therapist, leaving the therapist feeling quite ineffective and awkward.

Imagine how much easier the handling of this information might have been had the couple signed a “no secrets” disclosure. Therapists should not allow inappropriate secretiveness to be a by-product of assessment fervor. We believe that secrets damage couples, whether they are kept by one of the partners or the therapist. If one partner discloses an ongoing betrayal in an individual session, the therapist should encourage that person to end the outside relationship and inform the partner about its existence. The therapist can work with him or her on ways of telling the partner. For example, one person may want the therapist to tell the partner in a conjoint session, another may want to tell the partner themselves in a conjoint session, and yet another may want to tell the partner themselves at a time other than in a therapy session.
Assessing Related Clinical Concerns

If it is found that a relationship betrayal has occurred, several other areas of functioning should be assessed. First, it is important to assess for the overall quality of the relationship. Although some research suggests that affairs occur even in cases in which there is high marital satisfaction (Glass & Wright, 1985), there is substantial empirical and clinical support that relationship quality is associated with the probability of engaging in extramarital sexual behavior (e.g., Atkins, Baucom, & Jacobson, 2001). Moreover, in a study examining the associations among extramarital sex, marital happiness, and divorce-proneness over a 17-year period (Previti & Amato, 2004), marital discord both predicted and was predicted by extramarital sex, suggesting that infidelity is both a cause and a consequence of relationship discord.

Second, clinicians should assess the emotional and behavioral functioning of each individual. In particular, therapists should assess for depression and posttraumatic stress disorder (PTSD). Women who had experienced either their husbands’ infidelity or threats of marital dissolution were six times more likely to be diagnosed with a major depressive episode than women who had not experienced either of these events; they were also more likely to report elevated symptoms of nonspecific depression and anxiety (Cano & O’Leary, 2000). Assessing depression is particularly important because of its association with other indices of health and well-being, including an elevated risk of suicide. If depression is present, the therapist should evaluate a person’s risk for suicide including assessing for suicide intent, preference and availability of method, and deterrents to killing themselves.

Nan entered treatment shortly before her husband, Craig, left her to move into a new home with his affair partner. They had been in couple therapy for 2 years, and the affair had been revealed shortly after the beginning of treatment, at which time Craig assured Nan that he had broken it off and promised her he would not resume his relationship with the affair partner. However, Craig had broken that vow; Nan recently discovered that his affair had continued for 3 years. They decided to divorce. Upon entering treatment, Nan reported a number of symptoms of depression including depressed mood, sleep disturbance, concentration difficulties, fatigue, feelings of worthlessness, and anhedonia. To make matters worse, Craig’s affair partner had been a friend of hers, and Nan reported that the disruption in that friendship had also resulted in disruptions of several friendships in her community. She felt isolated and cut off from her usual sources of social support.

Clinicians should also assess for symptoms of PTSD following disclosure of an affair. Many clinicians view infidelity as a trauma in the life of the couple, and the experience of betrayed spouses as similar to other individuals struggling with posttraumatic symptoms. Discoverers of infidelity often experience sleep disturbance, irritability or anger outbursts, difficulty concentrating, hypervigilance, exaggerated startle response, and recurrent intrusive thoughts about the affair. Such PTSD symptoms are illustrated in the following case:

Stuart called to request couple therapy for himself and his wife. He had recently discovered her longstanding affair with a work colleague. Stuart sounded quite upset during this initial phone call, and the therapist inquired about how the affair was revealed, and also what his experiences had been since the revelation. He reported that he couldn’t sleep, his stomach was in knots, he couldn’t eat, and he was irritable—not only with his wife, but also with his children and work colleagues. Stuart was feeling unproductive at work and couldn’t concentrate on work tasks, in part because he spent so much of his time going over and over the details of the affair that his wife had shared with him, as well as things that he imagined might have occurred. He was quite fearful that the relationship would end. The diagnosis of PTSD was explained to him, and the therapist suggested that his symptoms seemed to be
features of a posttraumatic response. The experiences he described were normalized as understandable reactions to the traumatic news.

Avoidance of stimuli associated with the affair is also common. If the betrayed spouse’s emotions during this initial phase of treatment are avoided and unexpressed, there is a risk of long-term resentment and hostility (Gordon & Baucom, 1999; Gordon, Baucom, & Snyder, 2004). Assessment in such cases needs to involve a more active process of exploring both the presence and effects of PTSD symptoms, even when a partner is reluctant to do so. More severe traumatic reactions may be anticipated for partners according to the degree to which their assumptions or expectations about their relationship are contradicted by the discovery of infidelity. The spouse of a habitual philanderer who discovers yet another affair may be angry, depressed, insecure, or resentful, or perhaps all of these—but will probably not be traumatized to the same extent as the wife who never suspected that her husband would be unfaithful. A lack of emotional responsiveness to the discovery of an infidelity may therefore be an indication of the betrayed spouse’s prediscovery assumptions about his or her spouse, or about the fragility of their relationship. However, because emotional numbing may also be operating in such cases, asking the betrayed spouse about their prior assumptions concerning the marriage and their partner may help the clinician to differentiate among levels of traumatic response.

Glass and Wright (1997) even suggest handing out a checklist of PTSD criteria to individuals struggling with these symptoms as a reminder that they are not alone, and that such symptoms are to be expected. The “normality” of traumatic symptoms in this context does not preclude ongoing assessment of their severity or their interference in one or both partners’ functioning.

As in other traumatic events that people face, a number of factors influence the development and course of symptoms, and these factors also need to be assessed. Clinicians should assess what kind of social support is available to the couple, individuals’ skills in accessing support, the extent to which it is accessed, and whether support is accessed inappropriately—for example, partners talking to younger children about the crisis. The case of Nan and Craig, described earlier, also points to the importance of assessing what sources of support have been disrupted by virtue of an infidelity. Other factors that render individuals more vulnerable to the effects of trauma, including prior exposure to trauma, preexisting psychiatric disorder, and family history of psychopathology (Fairbank, Ebert, & Caddell, 2001), should be evaluated in individual or conjoint sessions.

Clinical Issues and Summary

Relationship betrayals, such as sexual and emotional infidelity, are commonly encountered in the practice of psychotherapy. Couples’ own definitions of what constitutes a relationship betrayal should inform the psychotherapist’s assessment. Clinicians also need to competently assess for the presence of related mental health issues, including pre-existing relationship distress, depression, suicide ideation and intent, and PTSD symptoms. Knowing what, how, and whom to assess for betrayals, as well as familiarity with confidentiality concerns, should improve both the assessment and treatment of betrayals in close relationships.

Select References/Recommended Readings


