



The Intimacy Repair Method

Healing | Accountability | Lasting Change

Betrayed Partner Clinical Formulation

THERAPIST SAMPLE - FICTIONAL CASE

Educational example for clinical review



intimacyrepairmethod.com

From answers to an integrated clinical formulation.

Rachel is a fictional demonstration case. Her answers come from an existing synthetic BP assessment. This educational excerpt illustrates how the BP therapist manual can guide interpretation and treatment planning; it is not a complete automated report, a diagnosis, or a completed risk assessment.

The example follows an item-first approach: selected answers, patterns across clinical areas, unresolved questions, and a proposed sequence of care.

The clinical picture at a glance

Rachel reports substantial current repair from her partner and meaningful gains in her own enjoyment and confidence. At the same time, she describes frequent intrusive reminders, uncertainty in her own judgment, and periods of loneliness. The clinical question is not simply whether the relationship is improving. It is **which parts of healing remain difficult, what is still uncertain, and what support fits those needs.**

Only Rachel's answers are available. Her partner's behavior, intent, and current circumstances have not been independently verified.

First priority: clarify the safety response privately

Since discovering your partner's sexual behaviors, to what extent have you had suicidal thoughts.

"Sometimes"

This question refers to the period since discovery. The answer does not establish whether suicidal thoughts are current, historical, or both. It cannot be treated as a reassuring finding simply because other answers describe progress.

Clinical action before routine release or joint review

Directly clarify timing, current thoughts, intent, plan, access to means where relevant, past behavior, protective factors, and available support. Determine urgency and the appropriate response through the clinician's actual risk-assessment process.

Rachel selected **“Never”** on the included self-harm item and each included physical/sexual-safety item. Those responses do not establish that current safety has been fully assessed or erase the suicidal-thought response. No clinical contact, safety clearance, or notification is claimed in this demonstration.

1. Partner repair and trauma activation can coexist.

Selected answers

My partner makes consistent, observable efforts to change their behavior and rebuild trust.

“Strongly Agree”

My partner's efforts to change have helped me feel safer in our relationship.

“Strongly Agree”

How often do you have painful memories that remind you of your partner's sexual behaviors.

“Always”

How often do you struggle to think about other things besides your partner's sexual behaviors?

“More often than not”

What the pattern suggests

Rachel strongly recognizes consistent efforts and says those efforts have helped her feel safer. She also reports painful memories “Always” and difficulty shifting attention “More often than not.” These describe different dimensions of her experience; one does not cancel the other.

Why this matters for treatment

Persistent symptoms should not automatically be read as a refusal to recognize repair. Equally, recognized repair does not establish that all threat or uncertainty has ended. Clarify current conditions, then explore the reminders and functional effects that continue to need care.

What I would want to explore next

When a reminder interrupts a positive moment, is it linked to a current unresolved concern, a memory of earlier injury, or both? What happens in attention, emotion, and the body before the moment becomes difficult?

2. Verification may be serving disrupted self-trust.

Selected answers

When your partner disclosed sexual behaviors, how often did they tell only part of the story?

“Often”

How often has your partner told you that your perception of events was incorrect?

“Often”

I feel uneasy unless I can verify information for myself.

“Strongly Agree”

I second-guess my judgment or decisions.

“Strongly Agree”

What the pattern suggests

The history includes partial accounts and contradiction of perception. Rachel also strongly endorses needing to verify information and second-guessing judgment. One hypothesis is that verification helps her try to regain orientation after unreliable information.

Why this matters for treatment

The initial task is to understand the function of checking. A question that seeks still-missing information is different from a question that returns after the relevant facts are available. Neither should be dismissed without context.

What I would want to explore next

What is known, what remains unknown, and what would count as a sufficiently dependable answer? Can Rachel separate an observation, an interpretation, an emotion, and a decision without having to achieve complete certainty?

3. Available support is not the same as felt connection.

Selected answers

How often do you feel isolated from others?

“Some of the time”

I can talk about my problems with my friends.

“Very strongly agree”

I can talk about my problems with my family.

“Mildly disagree”

What the pattern suggests

Rachel reports very strong ability to talk with friends, but also some isolation and more limited ability to discuss problems with family. Having support available does not tell us whether it is usable for the painful parts of her story.

Why this matters for treatment

Explore support by source and by function. The aim is meaningful, agency-supportive connection rather than a larger network by default. The assessment’s “special person” must not automatically be assumed to be the partner.

What I would want to explore next

Who can hear the uncertainty, shame, or grief without minimizing it or deciding for her? What makes it easier or harder to use that support when a reminder appears?

4. Connection and protective distance can coexist.

Selected answers

I feel comfortable turning to my partner when I need support.

“Strongly Agree”

I tend to hold back from sharing my deeper feelings.

“Slightly Agree”

I worry about losing my partner or being left.

“Agree”

What the pattern suggests

Rachel strongly endorses turning toward her partner for support, slightly endorses holding back deeper feelings, and endorses fear of loss. This combination describes access to connection alongside some guardedness and worry.

Why this matters for treatment

These answers do not establish a fixed attachment style. Clarify whether holding back is serving a current safety need, regulation, boundary-setting, or an earlier relationship pattern before treating it as something to reduce.

What I would want to explore next

What makes a particular disclosure feel chosen and safe enough? When Rachel holds back, what is she protecting, and what response would help her retain choice?

Integrated formulation: what may be keeping healing difficult?

A working hypothesis to test with Rachel

Earlier deception and disruption of shared reality may help explain why Rachel still doubts her own interpretation of events. Intrusive reminders may reactivate uncertainty during moments she otherwise wants to enjoy. Verification and guardedness may then serve attempts to regain orientation or protect herself. Recognized repair, access to support, and greater confidence provide resources, while persistent symptoms and unanswered questions still need direct attention.

This is a hypothesis about how the reported experiences may fit together. It does not establish a causal sequence, prove ongoing deception, or determine whether the relationship should continue. A recent example—and Rachel’s correction of this account—would help refine it.

Strengths that should remain visible

“I am more confident about my needs and the choices I can make.”

Rachel also strongly endorses partner support and reports being able to enjoy former activities “More often than not.” These are resources for treatment, not reasons to minimize distress or bypass safety follow-up.

A proposed treatment sequence grounded in the answers

These are clinical discussion points, not an automatically assigned plan or a timeline for reconciliation. Safety findings and the client’s priorities can change the order.

1. Safety and immediate needs

Evidence: Suicidal thoughts since discovery were endorsed; current status is unknown.

Possible focus: Complete private clinical clarification and determine the appropriate response before routine joint review or release.

What to review: Current status, needed supports, and the clinician's disposition are clarified through the actual care process.

2. Trauma activation and daily functioning

Evidence: Frequent intrusive memories and difficulty shifting attention; triggers are the first ranked request for help.

Possible focus: Once immediate needs are addressed, map one recurring reminder, assess its functional impact, and collaboratively select a grounding or regulation practice.

What to review: Review a recent episode: what appeared first, what helped, and whether the client had more choice in responding.

3. Shared reality and self-trust

Evidence: Reported partial accounts, perceptual contradiction, and strong verification needs.

Possible focus: Clarify unresolved information needs; practice separating observations, interpretations, emotions, and unknowns.

What to review: The client can describe a question that needs factual clarification and a reminder that needs emotional care, while retaining the right to revise that distinction.

4. Support and connection

Evidence: Some isolation despite strong friend support; guardedness alongside access to partner support.

Possible focus: Identify one support relationship that can hold the difficult material. Consider partner conversations only when safety, permission, and readiness support them.

What to review: Discuss whether support felt usable and responsive, and whether a chosen conversation preserved agency and boundaries.

Keep the client's priorities in the plan.

In the fictional ranking responses, Rachel placed managing triggers and difficult emotions first, followed by trusting herself and feeling emotionally safe. Her stated hope gives those priorities a practical meaning:

“I hope to enjoy a moment of connection and be able to name a reminder without feeling that it takes over the rest of the day.”

This can become a collaboratively chosen direction: more freedom to name a reminder, identify what is needed, and decide how to respond. It is not a promise that reminders will disappear.

Questions that remain open

- Are suicidal thoughts present now, and what response and support are needed?
- Does current uncertainty reflect missing information, trauma-related reminders, current instability, or a combination?
- Which partner behaviors contribute to experienced safety, and which concerns remain unresolved?
- What function does a particular protective response serve?
- What would Rachel choose as a manageable next step once immediate needs are addressed?

Interpretive framework: IRM BP Therapist Administration, Theory, Scoring & Interpretation Manual, 2026 Final Therapist Edition, supplied by Dr. Skinner. Exact item wording and fictional answers come from BP-FINAL-092626-2; the manual's older item numbers are not applied to this version. No scores, cutoffs, diagnoses, or progress estimates have been invented. The formulation and possible treatment focuses are explicitly illustrative and require clinician review.