



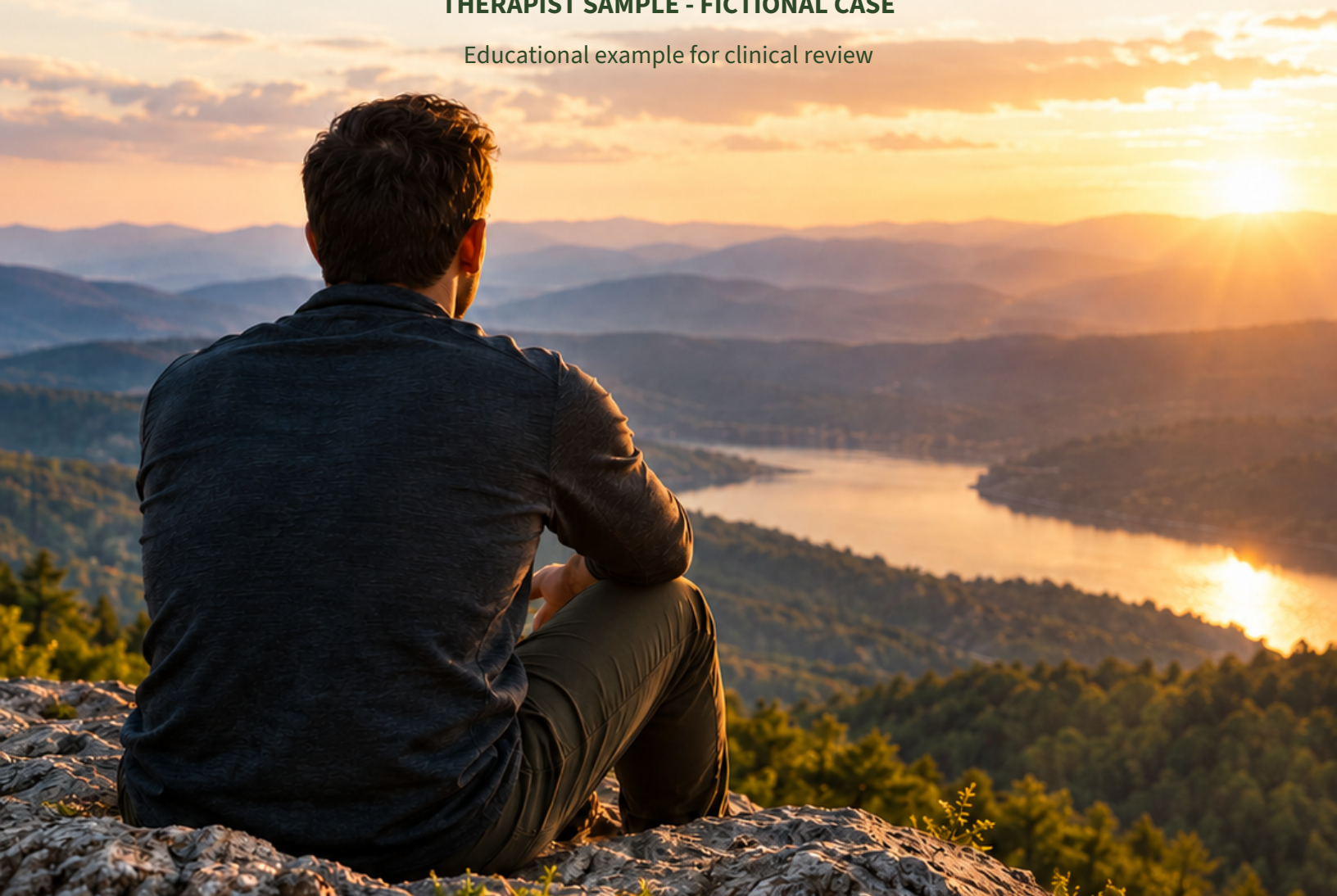
The Intimacy Repair Method

Healing | Accountability | Lasting Change

Acting-Out Partner Clinical Formulation

THERAPIST SAMPLE - FICTIONAL CASE

Educational example for clinical review



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Is behavioral recovery becoming dependable relational repair?

Client A is a fictional demonstration case. Their answers come from the existing synthetic AOP case used in the client-report sample. This educational formulation applies the supplied therapist manual's interpretive framework; it is not a complete automated report, a diagnosis, or independently verified recovery.

No partner assessment is supplied. Client A's perceptions cannot establish what their partner feels, knows, or needs. The BP example on the therapist page is a separate fictional person, not Client A's partner.

Three clinical questions—not one recovery score.

1. Is behavioral recovery developing?

Client A reports their most recent behavior outside relationship agreements as **"7 months to a year"**. On the six-month behavior items, several experiences are reported as absent and some urges remain. The client rates behavior management **"Better"** and urge management **"A little better"**. These are separate self-reported indicators, not proof of sobriety or a measured longitudinal improvement.

2. Can the client remain accountable when impact becomes uncomfortable?

The client endorses taking responsibility and caring about their partner. The client also endorses withdrawal when ashamed, early apologies, defensiveness, and difficulty listening without justification. The possible treatment focus is how accountability holds up during emotional discomfort.

3. Are their capacities becoming dependable repair?

The client reports trust-building actions **"Often"**, but checking how their partner is doing **"Sometimes"** and difficulty returning after overwhelm. The clinician needs concrete examples of follow-through and—when appropriate and authorized—the partner's separate experience.

Establish the clinical boundary before couple interpretation.

This AOP case does not establish the betrayed partner's safety, disclosure completeness, or readiness for conjoint work. AOP-perceived relational safety and private screening for fear, coercion, violence, sexual safety, and retaliation are different tasks.

Clarify current behavioral recency, unresolved information, and conditions relevant to safe care. Do not use low behavior frequency, expressed concern, or repair effort as clearance for joint conversations or intimacy. This example does not claim that screening, clinician contact, or report release has occurred.

1. Behavior management is a strength to support—not the whole formulation.

Selected answers

I engaged in sexual behavior that I later regretted.

“Never”

I felt a strong internal pull to engage in sexual behavior, even when I did not want to.

“Rarely”

I take responsibility for keeping myself on track with my recovery.

“Strongly Agree”

My commitment to recovery does not depend on how my partner responds to my efforts.

“Agree”

What the pattern suggests

Client A reports no regretted behavior on that six-month item, some remaining pull toward behavior, and strong ownership of recovery. These are reported strengths that belong in the formulation alongside the relational difficulties.

Why this matters for treatment

Maintain attention to urges, context, and the practices supporting behavior management. Broaden treatment to honesty, accountability, and presence without treating relational work as evidence that behavioral recovery is already verified.

What I would want to explore next

What does Client A do when an urge appears? Which practices remain active when the client is discouraged or receives no reassurance from their partner? What evidence beyond a global improvement statement can the client describe?

2. Shame may interrupt accountability before listening is complete.

Selected answers

When I feel ashamed about my sexual behavior, I have a strong urge to withdraw or shut down.

“Strongly Agree”

When my partner expresses pain about my behavior, I apologize before I have fully listened to and understood their experience.

“Agree”

I become defensive when my partner brings up my sexual behavior.

“Agree”

What the pattern suggests

The pattern includes a strong urge to withdraw when ashamed, apologizing before fully understanding, and defensiveness. One hypothesis is that discomfort narrows their attention toward ending or escaping the conversation before the impact is understood.

Why this matters for treatment

Shame is not evidence of accountability. A useful focus may be noticing shame, regulating sufficiently to remain responsible, and hearing impact without seeking immediate reassurance. Shame can help explain a difficulty without excusing harmful behavior.

What I would want to explore next

In a recent conversation, what came first: shame, a defensive thought, an apology, or withdrawal? What did the client understand before apologizing, and what remained unheard?

3. Locate the empathy bottleneck: concern is stronger than regulation and impact listening.

Selected answers

My partner's emotional pain matters to me.

“Strongly Agree”

During difficult conversations, I regulate my emotions so I can stay engaged with my partner.

“Disagree”

I can listen to my partner's pain without trying to explain or justify myself.

“Disagree”

I adjust my responses to better support my partner emotionally.

“Slightly Disagree”

What the pattern suggests

Client A strongly endorses caring about their partner's pain, while disagreeing that the client can regulate during difficult conversations or listen without justification. The client also reports difficulty adjusting their response. This points to specific capacities to explore, rather than a global conclusion that the client does not care.

Why this matters for treatment

The manual separates attunement, understanding, regulation, perspective-taking, concern, and supportive response. In this case, concern may not remain usable when distress rises. A clinician could explore steadiness, impact-focused listening, and responsiveness to feedback rather than prescribing only “more empathy.”

What I would want to explore next

Can the client reflect the impact without adding an explanation? How does the client learn whether their response was useful? What helps them remain present when understanding the impact becomes painful?

4. Caring can still become fixing; a pause needs a dependable return.

Selected answers

I allow my partner to experience painful emotions without trying to change how they feel.

“Rarely”

I stay connected with my partner without trying to fix what they are feeling.

“Rarely”

When I become overwhelmed during a difficult conversation with my partner, I can calm myself and return to the conversation.

“Disagree”

What the pattern suggests

The client reports rarely allowing painful feelings without trying to change them or remaining connected without fixing. The client also disagrees that the client can calm himself and return after overwhelm. These answers suggest a gap between wanting to help and tolerating unresolved emotion.

Why this matters for treatment

Consider whether urgency to fix serves their discomfort as well as the relationship. If a pause is appropriate, it needs a clear purpose and reliable return; it should not become indefinite withdrawal, punishment, or a requirement that the partner stop feeling.

What I would want to explore next

What happens when the emotion cannot be resolved quickly? What would an appropriate pause-and-return agreement require, and how would the client take responsibility for returning?

5. Repairing shared reality requires clarification—not assumptions about disclosure.

Selected answers

I tried to keep things feeling normal so my partner would not know about my sexual behavior.

“Very true”

I left out details to alter how my partner understood what happened.

“Slightly Agree”

When my partner sensed something was wrong, I told them everything was fine even when it wasn’t.

“Slightly Agree”

What the pattern suggests

The concealment item refers to the period of hiding behavior. The omission and reassurance responses raise questions about how information has been managed. They do not establish that every behavior is continuing now or that disclosure is complete.

Why this matters for treatment

Preserve the timeframes. Explore what was hidden, what has been corrected, and what remains uncertain through an appropriate clinical process. The recovery task is not simply asking for trust; it includes helping make information more dependable.

What I would want to explore next

Which responses refer to earlier events, and which describe a current difficulty? Is there anything the client knows needs correction? What would accurate, non-defensive clarification require in the actual care context?

6. Reported effort and perceived safety are not interchangeable.

Selected answers

I take specific actions to help rebuild trust with my partner.

“Often”

I make an effort to understand how my partner is doing in their healing.

“Sometimes”

My partner seems at ease when they are around me.

“Slightly Disagree”

I believe my partner feels safe bringing difficult concerns to me.

“Slightly Disagree”

What the pattern suggests

Client A reports frequent trust-building actions, but less frequent attention to their partner's healing and less confidence that the partner feels at ease or can raise concerns safely. These are differences within their own report—not a comparison with a partner's assessment.

Why this matters for treatment

Ask what the actions are and how their effects are understood. Follow-through can be real while some experiences of openness or ease remain uncertain. A partner's account, if available through an appropriate process, must remain separate from Client A's perception.

What I would want to explore next

Which specific commitment was completed without a reminder? What happened when a difficult concern was raised? What feedback has the client actually received, rather than inferred?

7. Support needs may extend beyond the partner relationship.

Selected answers

I feel isolated from others.

“Often”

I sometimes feel hesitant to open up emotionally to my partner.

“Agree”

I worry about losing my partner or being left.

“Agree”

I can talk about my problems with my friends.

“Strongly disagree”

What the pattern suggests

Client A describes isolation, hesitation to open emotionally, fear of losing their partner, and limited ability to discuss problems with friends. These may leave fewer places to process shame or distress while sustaining accountability.

Why this matters for treatment

Explore whether appropriate support can provide honesty, perspective, and regulation without making the betrayed partner responsible for recovery. Fear of loss does not establish a fixed attachment style and does not justify withholding or pressure.

What I would want to explore next

Who can support their recovery while challenging secrecy and blame? When the client feels afraid of losing the relationship, what does the client become tempted to hide, control, or avoid?

Integrated formulation

A working hypothesis to test with Client A

Client A reports behavioral improvement, recovery ownership, and genuine concern. At the same time, shame-related withdrawal and difficulty regulating may narrow their capacity to stay with the impact of their behavior. Early apologies, justification, or fixing may then interrupt the listening and responsiveness needed for repair. Unresolved questions about truth and limited outside support may add difficulty. This possible pattern needs testing against specific recent interactions; it has not been observed or established by the assessment.

The initial clinical task may be to preserve the practices supporting behavior management while strengthening the bridge from caring and insight to truthful, steady, repeated action. The partner's healing, trust, and choices remain independent of Client A's account of their efforts.

A proposed treatment sequence grounded in the answers

These are possible focuses to choose and refine with the client after appropriate clinical clarification. They are not an automatically assigned plan, a fixed priority score, or a deadline for the partner's healing.

1. Clarify context, truth, and safety

Evidence: Reported behavior recency, selected omission responses, and no partner assessment.

Possible focus: Clarify the relevant timeframes and unresolved information. Determine what individual safety review is needed before considering shared work.

What to review: Document what is known, what remains unknown, and the next appropriate clinical step; do not treat self-report as independent verification.

2. Sustain internally owned recovery

Evidence: Strong ownership responses alongside remaining urges.

Possible focus: Identify specific practices and appropriate accountability supports that continue regardless of partner reassurance.

What to review: Review recent choices and responses to urges, including how concerns are communicated and support is used.

3. Practice staying with impact

Evidence: Shame-related withdrawal, early apologies, and difficulty listening without justification.

Possible focus: Explore one recent interaction. Consider a regulation-and-listening practice that supports responsibility rather than self-exoneration.

What to review: Can the client identify the defensive impulse, describe impact accurately, and remain curious before explaining or apologizing?

4. Make return and follow-through dependable

Evidence: Difficulty calming and returning; reported trust-building actions more frequent than checking on healing.

Possible focus: If appropriate, agree on one manageable commitment and a clear pause-and-return practice. Participation by the partner remains voluntary and subject to safety and readiness.

What to review: Review whether the commitment and return occurred as agreed, what was difficult, and what needs adjustment—without requiring forgiveness or reassurance.

5. Build recovery-supportive connection

Evidence: Isolation and limited friend discussion alongside fear of loss.

Possible focus: Identify an appropriate support person or group that reinforces honesty, responsibility, and emotional regulation.

What to review: Explore whether the support was used and helped sustain accountable choices; support availability alone is not proof of felt connection.

What would meaningful recovery look like in practice?

Proposed signs to review include telling the truth when discomfort rises, listening before explaining, returning after an agreed pause, following through without reminders, and using appropriate support beyond the partner. These are possible review targets—not achievements already demonstrated in this fictional case.

Reassessment, when appropriate, can compare the client's own answers using the same version and timeframes. Keep retrospective improvement separate from repeated measurement, and keep the partner's report separate from the AOP's perceptions.

Interpretive framework: IRM Acting-Out Partner Therapist Administration, Theory, Scoring & Interpretation Manual, 2026 Complete Integrated Edition, supplied by Dr. Skinner. Exact questions and fictional answers come from the existing AOP-FINAL-092326 demonstration case; production wording takes precedence where the manual and implementation differ. No answers, numerical results, severity cutoffs, diagnoses, or achieved outcomes have been added. The formulation and treatment possibilities are explicitly illustrative and require clinician review.