

Wedding the Gottman and Johnson Approaches into an Integrated Model of Couple Therapy

Paul David*
Antioch University Seattle

Despite the established efficacy and the recognition that the Gottman and Johnson approaches have achieved in the field of couple and family therapy (Bradley, Friend, & Gottman, 2011; Byrne, Carr, & Clark, 2004; Gottman, 1993; Gottman & Gottman, 2008; Gottman & Kimberly, 2005; Halchuk, Makinen, & Johnson, 2010; Johnson, 2008a; McLean, et al., 2008; Naaman, Pappas, Makinen, Zuccarini, & Johnson-Douglas, 2005), there is surprisingly little in the literature that discusses the integration of these two models. This lack of synthesis is particularly noteworthy given the trend toward the integration of treatment models in the field of couple therapy (Benson, McGinn, & Christensen, 2012; Blow & Sprenkle, 2001; Davis & Piercy, 2007a; Davis & Piercy, 2007b; Halford & Snyder, 2012; Sprenkle, Davis, & Lebow, 2009; Gurman, 2008).

This article discusses how the Gottman and Johnson approaches are compatible and how they can be successfully wed into a more comprehensive model of couple therapy. This discussion is divided into two parts. Part One delineates the major features of each therapeutic approach and examines their key differences, commonalities, and strengths. Part Two shows how these therapeutic approaches can be amalgamated into an integrated couple therapy (ICT) model and how their different methods can be incorporated into this ITC model.

Part One: Delineation

While both Gottman and Johnson agree that one of the most important cornerstones of their therapeutic approaches is improving the emotional regulation and connection of the couple, they differ in their theoretical roots, in their conceptualization of marital relationships, and in their treatment methods (Gurman, 2008; Young, 2005).

Gottman's Approach

Gottman's approach was developed from his research about the relational factors that contribute to failed marriages and about the therapeutic interventions that contribute to maintaining successful marriages (Babcock, Gottman, Ryan, & Gottman, 2013; Bischoff, 2002; Gottman, 1982; Gottman, 1998; Gottman, 2004; Gottman & Gottman, 2008; Gottman & Levenson, 1984; Gottman & Levenson, 1988; Gottman & Levenson, 1992; Gottman & Levenson, 2002a; Gottman & Levenson, 2002b; Gottman, Markman, & Notarius, 1977; Gottman, Ryan, Swanson, & Swanson, 2005; Jenicus & Duba, 2003; Levenson & Gottman, 1985; Madhyastha, Hamaker, & Gottman, 2011; Shapiro, & Gottman, 2005;). His early research was not so much focused on how to facilitate clinical treatment, but on identifying key

* Address correspondence to Paul David, Ph.D., Antioch University Seattle, 2326 Sixth Avenue, Seattle, WA 98121. E-mail: pdavid@antioch.edu

communication and problem solving characteristics of both healthy and unhealthy marital relationships. Because of this research emphasis, he avoided becoming identified with any particular school of couple therapy, and his observational studies produced ground breaking findings that were influential across the theoretical spectrum in the field of couple therapy (Atkinson, 2005; Young, 2005).

Some of Gottman's most influential research findings had to do with his depiction of the interactional components of marital distress. His findings demonstrated that when couples become distressed, their communication becomes increasingly characterized by criticism, defensiveness, contempt, and stonewalling that spiral their relationship downward into a state of negative sentiment override where they view even neutral and positive events as negative. Building on this dynamic, Gottman was able to show how distressed couples experience a cascade of escalating conflict, negative reactivity, distancing, and isolation in their relationships.

Gottman eventually began testing and developing a set of methods designed to reverse this cycle marital distress. He and his associates gradually assembled these methods into a clinical approach based on what he calls "Sound Relationship House Theory." This approach is designed to help couples deepen their friendship, build their trust, strengthen their conflict management, and create shared meaning and purpose in their relationship (Gottman, 1999, 2002, 2011; Gottman, Driver, & Tabares, 2002; Gottman & Gottman, 2008; Gottman & Silver, 2012; Gottman, Swanson, & Swanson, 2002). Gottman has shown that these methods can be successfully applied to improving a variety of marital relationships, including those experiencing severe distress, those transitioning to parenthood, those experiencing minor domestic violence, and those suffering the effects of poverty (Gottman, Ryan, Swanson, & Swanson, 2005; Shapiro, & Gottman, 2005; Babcock, Gottman, Ryan, & Gottman, 2013; Gottman, 2004; Gottman, Ryan, Swanson, & Swanson, 2005).

Gottman's (1999) Sound Relationship House (SRH) therapy is comprised of a series of protocols and methods that are organized into what he terms an "orderly and logical" therapeutic process. Although Gottman and Gottman (2008) do not formally organize these methods and interventions into stages per se, they do present them as a series of treatment steps that can be broadly summarized into the following four stages: (1) assessment of the couple's emotional connection and conflict, (2) enhancement of the couple's friendship, (3) improvement of the couples' conflict management, and (4) reinforcement of the advancements that have taken place and, if necessary, counteraction of the various forms of resistance that emerge while implementing the previous stages. When applied to distressed couples, this therapeutic process is geared to be completed in an average of 15-20 sessions (Gottman & Gottman, 2008).

The role of the SRH therapist is to carry out these stages of treatment that contain what Gottman and Gottman (2008) call the "blueprints" for helping couples improve their relationship. These blueprints serve as an explicit guide for SRH therapists to help couples develop the requisite perspective and skills needed to address their conflicts and to increase their closeness. Toward these ends, SRH therapists rely on a set of protocols and structured exercises to help their clients develop this perspective and enhance their social skills in such areas as empathetic listening, compassionate validation, physiological self-soothing, acceptance of influence and compromise, and repair of emotional wounds (Gottman & Silver, 2012).

In working toward these ends and imparting these skills, the therapeutic style that best characterizes SRH therapists are what Gurman (2008) refers to as “educator/coach” and “healer” roles. By combining these roles, the therapist imparts expert knowledge to the couple while helping them experience the transformative power of their relationship. This dual role provides a catalyst, allowing the couple to develop a deeper emotional connection with one another as they progress through therapy. The educator/coach aspect of the therapist’s role typically involves facilitating this interaction and connection by means of both instruction and encouragement.

Johnson’s Approach

Johnson’s approach to couple therapy grew out of her clinical work in family therapy and her efforts to develop a clinical approach that incorporated the principles of client centered, family systems, and attachment theories (Jenicus, 2003; Johnson, 2008a). As clinician, Johnson was initially interested in applying therapeutic approaches drawn from experiential/gestalt (e.g., Perls, Hefferline, & Goodman, 1951; Rogers, 1951) and interactional/family systems (e.g., Fisch, Weakland, & Segal, 1983) theories. Later, she adopted Bowlby’s (1969, 1988) attachment theory as the synthesizing framework for her therapeutic approach. Because her therapeutic approach is primarily focused on attachment-related emotions, Johnson (2004) refers to it as “Emotionally Focused Therapy” (EFT).

Based on this EFT perspective, Johnson (2004) posits that when a couple’s bond is not able to be established or is disrupted, emotional dysregulation takes place in such a manner that the partners become entangled in self-perpetuating cycles of negative interaction that further reinforce their insecure attachment. The goal of EFT is to help couples curtail these cycles of negative interaction, become more responsive to their attachment needs, and establish a more secure bond in their relationship (Johnson, 2013). When applied in clinical settings, there is a considerable body of outcomes research, across a wide variety of couples and presenting problems, that demonstrates the efficacy of EFT (Clothier, Manion, Gordon-Walker, & Johnson, 2002; Couture-Lalande, Greenman, Naaman, & Johnson 2007; Denton, Burlison, Clark, Rodriguez, & Hobbs, 2000; Denton, Wittenborn, & Golden, 2012; Dessaulles, Johnson, & Denton, 2003; Greenman, Faller, & Johnson, 2011; Greenman, & Johnson, 2012; Honarparvaran, Tabrizy, & Navabinejad, 2010; MacIntosh, & Johnson, 2008a; Makinen, & Johnson, 2006; McLean, & Nissim, 2007; McLean, Walton, Rodin, Esplen, & Jones, 2011; Priest, 2013).

Somewhat different from the Gottman approach, Johnson (2004) explicitly organizes her EFT approach into three distinct stages of treatment. However, since these stages are only concerned with treatment, there is no formal assessment stage included in the Johnson (2008) approach—despite the fact that there is a clear assessment component to it. By explicitly incorporating this component, the Johnson approach can be expanded into the following four stages: (1) assessment of the couple’s attachment and cycles of negative interaction, (2) de-escalation of the negative cycles of interaction in the relationship, (3) enhancement of the attachment in the relationship, and (4) consolidation and integration of the changes that have taken place. This therapeutic process is also time-limited and is designed to be completed in an average of 10-20 sessions (Johnson & Zuccarini, 2010).

The role of the therapist in the Johnson approach is to implement these stages of treatment in such a manner that the couple moves from a state of insecure attachment to one of more secure attachment. In carrying out these stages of treatment, Johnson (1999) delineates nine specific steps the EFT therapist completes with the couple. Essentially, these steps involve the therapist establishing a collaborative alliance with the couple, expanding their emotional connection, and restructuring their interactions in the direction of greater accessibility and responsiveness (Johnson, 2008a). When successful, the EFT therapist helps partners become more emotionally aware and integrate old emotional responses with newly activated aspects of experience to produce more adaptive responses. Different than the Gottman approach, EFT employs a “changing emotion with emotion” strategy that is based on the principal that maladaptive emotions can be transformed best by first arousing and then replacing them with more adaptive ones (Greenberg, 2002). As such, EFT therapists do not focus on developing social skills per se, and instead concentrate on enhancing couples’ capacities to form more secure attachments—secure attachments they see as the underlying basis for more effective communication and problem solving (Johnson, 2004).

The EFT therapist facilitates the accomplishment of this strategy by assuming a therapeutic style that can be best characterized by what Gurman calls the “perturbator” and “healer” roles. The combination of these roles involves the therapist facilitating the expression of each partner’s attachment fears and needs, while helping them experience the transformative power of their relationship. As with the Gottman approach, the transformative aspect of this role involves the therapist helping partners progressively experience a deeper emotional connection with one another. Somewhat different from the Gottman approach, the perturbator role is strongly emphasized and typically involves the therapist actively assisting partners to access and expand their feelings of attachment toward one another.

Commonalities & Strengths

Despite their different theoretical templates and clinical methods, the Gottman and Johnson approaches offer remarkably similar models of couple therapy. More specifically, both approaches share a number of distinctive commonalities. First, both offer relatively short-term and structured couple-centered approaches that are well supported by extensive empirical research. Second, both are present-oriented and emphasize the emotional engagement and connection of the partners through various experientially oriented interventions (Gurman, 2008). Third, both are highly systemic in that they focus on the dynamic interplay and recursive organization of emotions and interactions in intimate relationships (Johnson, 2008a; Gottman & Gottman, 2008). Fourth, both offer a rigorous application of humanistic-existential principles, emphasizing such values as self-actualization, here-and-now awareness, and emotional accessibility for the enhancement of intimacy in relationships (Gurman, 2008). Finally, because of their mutual emphasis of these principles, Gurman (2008) classifies both as humanistic-existential approaches to couple therapy.

While these approaches are remarkably similar, one is often strong in the areas where the other is less robust. A comparative analysis of each stage of their respective treatment models can contrast the relative strengths of these approaches. Consider, for example, the first three

stages of both approaches. In stage one, the client evaluation portion of the Gottman (1999) approach includes a broader and more standardized set of assessment measures than is typically included in stage one of the Johnson approach. In stage two, the deescalation portion of the Johnson (2004) approach focuses more extensively on expressing unmet attachment needs and emotions than typically takes place in the Gottman approach. Moreover, in stage three of both approaches, while the focus on changing maladaptive patterns of interaction is clearly a major strength, Gottman's added emphasis on conflict management provides another dimension to the therapy that does not take place to the same extent in the Johnson model.

Critical consideration of the theoretical perspectives that each model employs can also be a useful means of highlighting their relative strengths. Both models attempt to foster emotional connection, but Gottman relies on a more comprehensive interpretive lens to decipher the emotional experience of couples. Using Panksepp's (1999) affective neuroscience perspective, the Gottman approach views the couple's relational experience in the broader neurobiological context of mammalian emotion. Conversely, using the attachment perspective of such theorists as Cassidy and Shaver (1999), the Johnson approach is typically concerned with the more selected aspects of emotional experience related to adult attachment. This is not to imply the Johnson approach lacks a neurobiological perspective; it is clearly based on neurobiology, but is chiefly confined to the neurobiology of emotion related to human attachment (Johnson, 2008a).

Consider how a key emotion such as anger is viewed differently by these two clinical perspectives. Using the narrower focus of attachment theory, the Johnson approach typically views anger as secondary to what it considers as the more primary emotion of fear, positing that anger is often a natural reaction to the fear of not being able to secure or retain an attachment figure (Johnson, 2008b). In contrast, employing the broader focus of neuroscience, the Gottman approach views anger as an emotional reaction to a wide variety of threats that is governed by one of seven mood control centers in the brain. From this perspective, anger is a multidimensional reaction controlled by complex neural systems that cannot be invariably reduced to problems related to attachment (Gottman & Gottman, 2008). The advantage of the Gottman approach is it provides a more inclusive interpretive framework and it does not assume that problematic emotions are necessarily hierarchically related to attachment insecurity. In comparison, however, the Johnson approach provides a much more straightforward means for readily deciphering the complex emotional experiences of couples.

As the above comparative analysis indicates, each approach addresses important aspects of the therapeutic process; but each approach tends to lend itself more toward some aspects than others. This is particularly the case for the different roles the therapist assumes in each of these models. When the therapist assumes the pertubator role in the Johnson approach, the focus is more on helping partners experience their deepest feelings toward one another; whereas when the therapist assumes the educator/coach role in the Gottman approach, the emphasis is more on assisting partners to reflect on their deepest feelings toward one another. Experience and reflection are both critical aspects of improving emotional functioning (Atkinson, 2005; Greenberg, 2002); but again, each of these approaches is strong where the other is less robust.

Part Two: Integration

Incorporating the commonalities and strengths of the Gottman and Johnson approaches, an integrated couple therapy (ICT) model is proposed here. This model typically consists of 16-22 sessions that are carried out over the following five stages of treatment: (1) alliance/assessment, (2) stabilization, (3) enhancement, (4) conflict management, and (5) integration. Drawing on the Gottman and Johnson approaches, the delineation and sequencing of these five stages are based on the following treatment principles:

1. The beginning of therapy concentrates on establishing a solid alliance with the couple and conducting a thorough assessment of their relationship.
2. The initial stages of treatment focus on stabilizing the conflict in the couple's relationship so they can have greater access to one another's emotional needs.
3. Once emotional access is accomplished, the emphasis in treatment is on enhancing closeness in the relationship so the partners can become more secure and responsive to one another.
4. Building on the couple's enhanced closeness, treatment shifts to their unresolvable and resolvable differences so that the partners can more effectively manage their conflict with one another.
5. The ending of therapy concentrates on reinforcing the positive changes the partners have made in themselves and in their relationship.

Although these principles suggest a step-by-step approach for conducting couple therapy, they are not intended to be applied in a rigid or fixed manner. These principles provide an overall "road map" to the therapy; but like the Gottman and Johnson approaches, they should be flexibly adapted to the needs and circumstances of the couple. For example, if a couple is not particularly distressed, but would like to improve the quality of their intimacy, they do not necessarily have to begin their therapy in stage two. In other words, this couple-centered model starts at the stage most relevant to helping the couple move forward in their relationship.

This couple-centered model also means different couples receive different aspects of treatment. However, in order to provide some initial direction, almost all couples need to go through stage one where an assessment and goals for therapy are established. Since most couples seeking treatment are often severely distressed, the clinical assessment of their relationship most often indicates they need to begin therapy in stage two; but for less distressed couples, their clinical assessment might indicate it would make more sense for them to begin at stage three or even stage four.

Besides providing a clearer guide about how to proceed through therapy, the central purpose of these principles is to provide a useful guide about where to focus the treatment process. If a couple becomes stuck in one part of treatment, these principles can suggest the possibility that more work needs to be completed in a previous part of treatment. For instance, if a couple becomes bogged down in the problem-solving phase of therapy, the principles suggest the couple might be able to make more progress by refocusing on enhancing the security and closeness in their relationship. Moreover, sometimes a couple may have to go back and forth

between two stages before they progress to the third. The idea again is that these principles are not meant to be applied in a rigid sequential manner, but in a flexible recursive manner that takes into consideration the complexity of helping couples become more resourceful with one another.

Stages of Integrated Couple Therapy

Assuming a couple-centered approach in the differential implementation of the previously described five aspects of couple therapy, what follows are brief explanations of each of the stages of the ICT model. Also described are some of the therapeutic tasks, methods, and durations that are typically involved in implementing the different states of the ICT model.

Stage I: Assessment/Alliance

This initial stage takes place in the first four sessions that entails two conjoint and two individual sessions. During these sessions, the therapist completes three basic tasks: (1) forming a therapeutic alliance, (2) assessing the clinical problems, and (3) establishing a framework for therapy. Ideally, the completion of each of these tasks generally takes place in sequential order such that the alliance is well established by the first conjoint session, much of the assessment is completed during the second and third individual sessions, and the framework for therapy is agreed upon by the end of the next conjoint session.

Forming a therapeutic alliance is given considerable emphasis in the Johnson (2004) approach. Establishment of an alliance builds such joining qualities as acceptance, respect, empathy, and genuineness. It also allows the therapist to actively validate each partner's experience of the relationship without invalidating either partner's experience. By the end of the first session, the therapist should be able to present to the couple an accurate understanding of their presenting problems, and a nonjudgmental description of how their interactions appear to be organized around those presenting problems.

Assessing the clinical problems, which is strongly emphasized in the Gottman (1999) approach, involves conducting a systematic and comprehensive assessment of each partner and the relationship. As an important component of this assessment, the couple completes two assessment inventory packets. The first, to be completed independently prior to the couple's first conjoint session, includes a set of questionnaires designed to assess the overall degree of dissatisfaction and distress experienced in the relationship. The questionnaires used in this packet typically include the Lock-Wallace Marital Adjustment Test, the Weiss-Cerreto Marital Status Inventory, and the Gottman 17-Areas Scale (Gottman, 1991).

The second packet, to be completed prior to the individual sessions, is a series of questionnaires developed by Gottman (1999) to assess elements of Sound Relationship House (indications of friendship, skills in conflict management, and sense of shared meaning), as well as indicators of emotional abuse, conflict tactics, and individual psychiatric symptoms. Based on the data contained in both packets, the therapist takes a brief relationship history in the first conjoint session and, in individual follow-up sessions, encourages each partner to provide specific details about how they see their relationship and how they see themselves in their

relationship. In these individual sessions, the therapist also screens for indications of violence, infidelity, and substance abuse.

Establishing a framework for therapy typically takes place by the second conjoint meeting. The therapist provides the couple with a summary of the assessment data. This summary focuses on an overview of the major strengths and weaknesses reported, and includes recommendations for the potential goals for their therapy. Recommendations might also include options for adjunctive treatment, such as individual therapy with a different provider, referral for medical evaluation, or chemical dependency treatment. The therapist's collaborative approach is a critical element during this process. It is crucial that the therapist encourages the couple to be open with one another and discuss their reactions to the feedback and recommendations they have received. This session usually culminates with the therapist and partners negotiating a treatment plan.

Stage II: Stabilization

A key initial goal of the ICT model typically involves reducing the instability and distress that undermine a couple's relationship. For the therapist, stabilizing the relationship in this second stage consists of two fundamental tasks: (1) identifying the key emotional and interactional patterns that disrupt closeness in the relationship, and (2) enhancing the security and positive sentiments in the relationship. The application of Gottman's and Johnson's clinical practices and methods are very useful in carrying out these tasks.

To accomplish the first task, some of the most useful practices and methods—particularly those developed by Johnson (2005)—involve:

- Identifying the dysfunctional behaviors and negative interaction cycles that maintain the distress in the couple's relationship.
- Helping each partner access the unacknowledged feelings and insecurities that underlie their dysfunctional behavior and interactional position in the relationship.
- Assisting each partner in redefining the couple's problems in terms of attachment needs, frustrated emotions, and negative interaction cycles.
- Helping the couple explore different ways of relating that deescalate their cycles of negative interaction.
- Helping the couple develop an "empowering" perspective about emotional expression and interaction that promotes a secure attachment in the relationship.
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To accomplish the second task, some of the most useful methods and interventions—a particularly those developed by Gottman (1999)—include:

- Educating the couple about the primary role that active expression of caring plays in intimate relationships.
- Collaborating with the couple in the formulation of norms and limits to increase the security and caring in the relationship.
- Helping the couple identify the satisfying qualities they both would like in their relationship.

- Assisting the couple in increasing the expression of appreciation, caring, and admiration in the relationship.

Depending on the receptivity of the couple, this stage of the therapy most often takes from 3-5 sessions to complete, but may require more sessions if the couple is highly unstable. A crucial aspect of this stage is helping both partners become more emotionally vulnerable to one another. Partners, especially partners with long histories of chronic distress, can be hesitant to open up to one another, and there is a tendency at this juncture to get bogged down in the micro-details of their internecine conflict. Johnson's (2004) methods of reflection, validating, and reframing can be particularly useful in helping clients successfully move through this stage of the therapy.

Stage III: Enhancement

Once the relationship is more stable, the third stage of the ICT model focuses on enhancing the emotional connection between the partners. For the therapist, this stage consists of three major tasks: (1) expanding each partner's emotional experience with the other, (2) strengthening each partner's sense of responsibility for emotional engagement with the other, and (3) restructuring the couple's interaction so each partner has greater emotional accessibility and responsiveness to the other.

To expand the emotional experience of the partners with one another, Gottman and DeClaire (2001) and Johnson (2005) provide a wide range of clinical practices and methods. Some of the most useful include:

- Educating the couple about emotional communication and teaching them basic emotional communication skills.
- Assisting each partner in directly expressing primary emotions and in constructively responding to each other's bids for emotional connection.
- Exploring the emotional disconnection each partner experiences with the other.
- When discussing their disconnection, helping the partners express their primary emotions (e.g., needs for affection) and modulate their secondary emotions (e.g., anxieties about being rejected).

To strengthen each partner's identification of and responsibility for emotional engagement, Johnson's (2005) methods are particularly helpful. Some of the most salient are:

- Focusing on and expanding each partner's expression of primary emotions as reflective of an emerging and more genuine sense of self.
- Helping the partners attribute ownership to their primary emotions so they see their emotions belonging to themselves and not to each other.
- Promoting interactions that evoke and reinforce the essential worthiness of each partner.

To restructure the couple's interaction toward greater accessibility and responsiveness to one another, Gottman and DeClaire (2001) and Johnson (2005) again provide a wide array of interventions. Some of the most instrumental include:

- Helping partners develop a better understanding of their personal inclinations and aspirations (“love maps”) as a means of accessing their inner psychological worlds.
- Assisting partners in building up their “emotional bank accounts” by more actively engaging in caring behavior toward one another.
- Helping each partner support the other through listening and validation.

Like the previous one, this stage of therapy generally takes 3-5 sessions to accomplish. This stage is often the most difficult part of the therapy for the couple. Progress through this stage is highly dependent upon how easily the couple progresses through the previous stabilization stage, and the degree of gridlock that exists in the couple’s relationship. The degree to which progress in the therapy has been slowed by unresolved factors can generally predict the extent to which this stage exceeds beyond the 3-5-session parameter. Johnson’s (2008) methods for treating attachment injuries and Gottman’s and Gottman’s (2008) methods for bridging meta-emotion mismatches can be helpful tools for facilitating progress through this stage of the therapy.

Stage IV: Conflict Management

The next stage of the integrated model addresses the substantive differences the couple cannot resolve even in the midst of their newfound emotional connection. This fourth stage is an important part of successful treatment because emotional connection is often a necessary condition for couples to better manage their conflict. However, as Gottman and Gottman (2008) point out, emotional connection is usually not a sufficient condition. Couples also need to come to terms with their differences and be able to engage in effective problem solving about them. Toward the achievement of these ends, the therapist at this stage facilitates the completion of two basic tasks: (1) helping the couple work on their resolvable problems, and (2) assisting the couple in addressing their unresolvable ones.

Gottman’s (1999) research differentiates between resolvable problems (those that are situational and time-limited) and unresolvable problems (problems that are personal and perpetual). His research has shown that approximately two-thirds of couples’ problems are unresolvable and usually not subject to change. In addition, he argues that if couples are to make progress on their resolvable problems and effectively manage resolvable conflict, it is vital they learn and apply basic problem-solving skills (Gottman & Silver, 1999).

Based on Gottman’s distinctions of the different types of relational conflict, couples are asked to put aside their unresolvable problems until later in the therapy and work to address their resolvable conflicts. At more advanced stages, the focus shifts to developing the needed perspective and tools for managing unresolvable problems more effectively. In helping the couple work on their resolvable problems, the therapist enlists some of the following practices and methods:

- Helping the couple distinguish their perpetual unresolvable problems from their resolvable situational ones.
- Identifying the particular resolvable problems that the couple wants to address.

- Teaching the couple the following conflict management skills: (1) using softened start-ups, (2) complaining constructively, (3) making repairs, (4) accepting influence, (5) finding compromise, and (6) soothing tension.
- Helping the couple apply these skills to resolvable problems.
- Assisting the couple in repairing their relationship in the aftermath of an argument.
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Once some headway is made in the couple's conflict management approach to resolvable issues, therapy shifts to concentrate on issues determined to be unresolvable. The following clinical practices and methods are used to address the couple's unresolvable problems:

- Identifying specific unresolvable problems that partners wish to address.
- Assisting partners to become more aware of the accommodating adaptations they may have already made but have not yet fully acknowledged, as they struggle with their unresolvable problems.
- Uncovering the hopes and dreams that underlie each partner's position as they attempt to deal with their unresolvable problems.
- Working with the couple to find ways to change the "influence process" so, as individuals, they can move toward honoring one another's hopes and dreams.
- Establishing an ongoing dialogue about their unresolvable problems.

Most, but not all, couples need assistance at this stage of the therapy. When warranted, this stage of the therapy generally entails 3-5 sessions. However, couples who are successful establishing some stability and emotional connection in previous sessions may regress at this point due to the intense frustration and agitation they experience while problem-solving. In these cases, this stage of the therapy may take considerably longer to complete successfully.

Some couples get particularly stuck here. Many remain in denial about the unresolvable nature of their problems, harboring the mistaken belief that their problems are resolvable and their partners can and should change for them. One useful aid in breaking through this denial is for the therapist to ask each partner to recite to one another what is euphemistically called the Relationship Declaration. This declaration reads as follows:

*Please help me obtain the necessary perspective
To accept the problems in our relationship that we cannot resolve;
To understand the problems in our relationship that we can resolve;
And to gain the wisdom to know the difference.*

Properly used, this declaration can serve as a valuable resource for helping the couple shift perspective and their entrenched positions with regard to their unresolvable problems. Once this shift in perspective takes place, the couple is in a much better place to address their unresolvable problems. Some emotionally focused methods and interventions, primarily those developed by Atkinson (2005), can be effectively applied at this juncture in therapy and include:

- Uncovering the patterns of blaming and feelings of marginalization that contribute to the gridlock in the relationship.
- Exploring how the partners might pathologize each other because of their different coping styles.
- Assisting partners in exploring how their marginalization of each other comprises an integral aspect of their unresolved problems.

Some additional cognitively-oriented tools, developed by Gottman, for this stage of the ICT model include the Solvable Problem Checklist (Gottman, 1999) and Two-Circle method for compromise (Gottman & Gottman, 2008).

Stage IV: Integration

The focus for this last stage of therapy is on reinforcing and strengthening the changes the partners have made in themselves and in their relationship. Three essential tasks occupy the therapist at this stage: (1) amalgamating the partners' newly processed emotional experiences and self-schemas, (2) merging the partners' new interactional and coping capacities, and (3) integrating #1 and #2 to help the couple develop a new model for understanding their relationship.

A number of clinical methods, specifically those developed by Johnson (2005), can be successfully employed to help partners amalgamate the newly processed emotional experiences and self-schemas they have derived through participation in couple therapy. Some of these are:

- Having each partner present an affirming account of the change process they have undertaken.
- Helping each partner discuss his or her own expectations for continued self-development.

Additional interventions, again mostly developed by Johnson (2005), can be considered for merging the partners' new interactional and coping capacities. Some of these include:

- Presenting an affirming account of how the couple has improved their relationship.
- Assisting the couple in identifying how new patterns of interaction and problem solving have enhanced the intimacy and conflict resolution in their relationship.

Finally, a number of related interventions, suggested by Gottman and Gottman (2008) and Johnson (2005), can be used to help the couple develop a new model for their relationship. Some of these involve:

- Validating the couple's development in terms of the new ways that partners are coping with their insecurities.
- Encouraging the partners to continue sharing their emotional needs and fears with one another.

- Elaborating on the responses to bids that each partner finds soothing and reassuring.
- Inviting the partners to describe explicitly how their relationship has changed and how it now meets their respective needs.

The frequency of sessions and overall duration of this last stage of the integrated model varies greatly. Ideally, stage five occurs over a period of several months, wherein the couple meets with the therapist every three weeks—a marked departure from the weekly sessions that take place in the previous stages. When this more ideal scenario is not financially or logistically possible, or when routine therapy is no longer desired by the couple, it is incumbent on the therapist to insure that some kind of integration process occurs before therapy is completed. A common backup option in these circumstances is to implement what Gottman and Gottman (2008) refer to as the “dental model” of follow-up; that is, the couple is encouraged to return on an as-needed basis for checkup and repair.

Summary

The integrated approach presented here shows how the Gottman and Johnson approaches can be merged into one new comprehensive system of treating couples. By combining the best of both approaches, the ICT model offers a promising treatment approach worthy of further refinement and evaluation. Although this model has received promising anecdotal results over the past decade as a didactic template for training couple therapists, its value and utility would be advanced by outcome studies that assess its overall efficacy in the treatment of couples.

Because this new model is built upon the strengths of the Gottman and Johnson approaches, the efficacy of many of its methods and interventions has already been established through extensive empirical research. This is not, however, the case for the overall design of this new model, which should be subjected to the rigorous outcome studies that have characterized the development of the Gottman and Johnson approaches. Hopefully, the highly delineated nature of the ICT model will make it particularly amenable to outcomes research.

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