Resolving Unfinished Business: Relating Process to Outcome

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This study related the process of the resolution of unfinished business with a significant other to therapeutic outcome in a population of 26 clients who suffered from various forms of interpersonal problems and childhood maltreatment. Clients were treated in emotion-focused, experiential therapy with gestalt empty-chair dialogues. Those clients who expressed previously unmet interpersonal needs to the significant other, and manifested a shift in their view of the other, had significantly better treatment outcomes. The presence of the specific process of resolution in the clients’ empty-chair dialogues was also found to be a better predictor of outcome than the working alliance. Degree of emotional arousal was found to discriminate between resolvers and nonresolvers.

Avoidance of painful emotion was considered in Gestalt therapy to be a key mechanism in the development and maintenance of unfinished business (Perls et al., 1951). When primary emotional experience is inhibited or avoided, individuals are deprived of access to potentially adaptive information, with the result that they are apt to become psychologically and/or emotionally stuck. Greenberg and Safran (1987) hypothesized that a key affective change process relevant to empty-chair work with unfinished business involves the arousal and expression of previously suppressed primary emotions, and the identification and expression of the attendant unmet interpersonal needs (cf. Greenberg et al., 1993). They argued that accessing self–other schematic structures for fundamental change is facilitated by emotional arousal and the evocation of memories and beliefs crucial to the original development of the unfinished business. In this formulation, change comes about by acknowledging and allowing previously interrupted emotional experiences to enter one’s awareness. Once permitted into awareness and fully processed, the newly accessed emotions and needs can be used to restructure existing self–other schemas. In this process (Greenberg, 2002) the therapist helps clients examine their emotional reactions rather than continue to react impulsively (Greenberg & Safran, 1987; Shiffirin & Schneider, 1977).

In a test of the efficacy of empty-chair dialogue for the resolution of unfinished business, Paivio and Greenberg (1995) compared the outcomes of clients who engaged in empty-chair dialogue with those who were in a psychoeducational group. They found that using the empty-chair intervention in therapy was significantly more effective than the psychoeducational-group intervention in reducing symptom and interpersonal distress, reducing discomfort in target complaints and achieving resolution of unfinished business. Beutler and his colleagues (Beutler, Daldrup, Engle, Guest, & Corblishley, 1988; Beutler, Engle, Mohr, Daldrup, Bergan, Meredith et al., 1991) have also demonstrated that an expressive form of this dialogue can be effective in working with pain and depression, especially when working with people who experience overcontrolled anger.

Even when a treatment has been demonstrated to be effective, an important question still remains unanswered: What are the processes of change? Neglecting to account for this hidden, intervening variable is one of the major problems with current clinical...
trials (Greenberg & Foerster, 1996; Greenberg & Newman, 1996). Without studying the process of change it is not possible to determine what portion of the outcome is accounted for by the process represented by the therapeutic model and what portion is accounted for by other factors, such as the therapeutic relationship and a good working alliance (Horvath & Greenberg, 1989).

Intensive analyses of the client’s change process in the empty-chair dialogue led to the development of a model of the essential components of resolving unfinished business (Greenberg, 1991; Greenberg & Foerster, 1996). This model specifies a number of components of resolution (Greenberg et al., 1993). In the process of resolution, researchers have hypothesized that the person moves from expressing blame, complaint, and/or hurt to the arousal and expression of the unresolved emotion to the mobilization of a previously unmet interpersonal need. In more successful dialogues, the view of the other shifts and he or she is portrayed in a new way. Resolution finally occurs by means of the person adopting a more self-affirming stance and understanding and possibly forgiving the imagined other, or by holding the other accountable.

In a previous study of productive therapy sessions, resolved empty-chair dialogues were found to result in greater assertion of needs and a new view of the other. Some evidence for greater emotional arousal in the resolved dialogues was also found (Greenberg & Foerster, 1996; Hirsheimer, 1996; Pedersen, 1996). In addition, McMain (McMain, 1995; McMain, Goldman, & Greenberg, 1996) found that assertion of needs was a better predictor of therapy outcome than a new view of the other, in part because in abuse cases, for example, resolution can occur without changing the view of the other.

The purpose of the current study was to test whether:
1. Those clients whose in-therapy processes contained crucial resolution components (unmet interpersonal need, a shift in their view of the other, and resolution) improved significantly more on the outcome indices than those clients whose therapy processes did not include these crucial performance components.
2. The presence of the three crucial components of resolution accounted for more of the outcome variance than early treatment-working alliance.
3. Resolution dialogues had significantly more high arousal emotion than nonresolution dialogues.

Method

Clients

Advertisements in the local media and mental health facilities announced the availability of a brief program of psychotherapy to individuals experiencing unfinished business (Paivio & Greenberg, 1995). More than 250 respondents were screened by telephone on the following criteria: they were above 18 years of age; there was an absence of current psychosocial treatment, psychotropic medication, reported drug or alcohol problems, self-harm or other current crisis; and they were not currently involved in a violent relationship. On the basis of intake interviews, clients were excluded as unsuitable if there was evidence of severe psychological disturbance in the form of borderline personality disorder, psychosis, or a high risk of suicide. The 97 potential clients interviewed also had to be able to identify a circumscribed area of unfinished business in which they were motivated to work. They also had to be judged capable of maintaining adequate interpersonal contact, suitable for brief therapy, and not to have a complicating medical illness. Forty-two clients were accepted into the study, and 38 clients began the brief psychotherapy treatment. Six clients did not complete the study for a variety of reasons including change in location, health concerns, and lack of involvement in the treatment, leaving a pool of 32 clients from whom the sample for this study was drawn. Seventeen of these clients composed the treatment sample in the Paivio and Greenberg (1995) study. The remaining 15 were additional clients treated in the same project as part of this larger study relating process to outcome. Noncompleters were defined as those who withdrew before Session 5.

Clients’ primary problem typically centered on unresolved issues with a parent. All clients were seen for 12–14 1-hr weekly sessions of individual therapy using the empty-chair dialogue intervention from process-experiential psychotherapy (Greenberg et al., 1993).

Therapists and Treatment

Eight advanced doctoral student therapists, who each had a minimum of 3 years of clinical experience, including a minimum of 1 year of supervised training in the empty-chair method, conducted the therapy. All clinical activities were supervised and monitored for treatment adherence to the empty-chair intervention (cf. Paivio & Greenberg, 1995). The treatment followed the manual for process-experiential therapy (Greenberg et al., 1993). In using this intervention, therapists follow an empathic style, and having established an alliance introduced an empty-chair dialogue when they detected a “marker” of unfinished business that was judged as clinically appropriate. Such markers typically involve the client making statements of lingering unresolved feelings toward a significant other, or statements of painful childhood memories after Session 2. These statements are accompanied by interrupted or restricted verbal expressions of despair and anger over past treatment by the other or nonverbal behavior such as clenching one’s jaw, holding one’s breath, or stifling tears as the distressing interactions are described.

It is important to note that rather than being a psychoeducational intervention used to teach clients what to do to resolve their unfinished business, this is an experiential method designed to promote the re-experiencing and restructuring of earlier experience. The model of resolution is used by the therapist as an empirically grounded map of the process of resolution. As such, it serves as a guide to the therapist of where the client is in the process of resolution and how the therapist might facilitate the next emotional processing step (Greenberg et al., 1993).

The Resolution Model

A description of the essential components of resolution in the model is provided below. Examples are provided of each step from the therapeutic process of a middle-aged man who felt humiliated and emotionally rejected by his mother’s habitual hurtful, teasing, seductive behavior, and public shaming.

Component 1: Blame, complaint and/or hurt. As the client engages in this process, his or her first comments to the imagined other tend to be expressed in the form of blaming the other for their problems, complaining about the other’s behavior, or expressing a sense of hurt over the damage done. In the case of our example client, he said to his imagined mother,

You were self-centered and you didn’t care too much about me and the way I was brought up as far as my emotions go. You didn’t care about anybody but yourself.

Component 2: Enactment of negative, frustrating other. The next step is for the client to enact the behavior of the negative other as he or she imagines the other to be (e.g., rejecting, hostile, critical, or uncaring). The purpose of enacting the negatively construed other is to create a sense of lively contact between the client and imagined other that will evoke the self-experience of being with the other. It also acts as a baseline against which any shifts in representation of the other can be checked. In response to the complaint that his mother was self-centered and uncaring, our example client imagined his mother responding with indignant denial,
What are you talking about? What do you mean? I don’t understand what you’re saying. Why are you talking like this? I gave you the best years of my life. Someone had to look after you. I did the best I could.

**Component 3: Expression of intense primary emotion.** Emotions are expressed as the client’s complaint is differentiated into a clear expression of primary emotions such as anger and sadness. The client shifts from a reactive, defensive stance that is outwardly focused to a more internal, exploratory stance, focused on contacting and expressing core inner experience. Emotional memories that formed the context for the development of unfinished business often are evoked. Having recalled an especially hurtful interaction with his mother, our example client tearfully expressed the results of that kind of interpersonal experience:

I was hurt so much. I carry that. I lost some of that warmth inside me when I was growing up. It affects the way I have relationships. The way I relate to myself. The way I feel about myself. All these years I thought I was a joke. This is what I carry [crying]. I’m ashamed. I feel real ashamed.

**Component 4: Expression of previously unmet interpersonal needs.** At this point, the wished-for aspects of the relationship are focused on to help the client identify his or her unmet interpersonal needs and then to express those needs to the imagined other. A sense of entitlement to those needs emerges as the client asserts them and examines his or her present circumstances and personal resources in regard to the other. In regard to humilitating and seductive interactions with his mother, our example client asserted himself by saying to his imagined mother:

I didn’t want you to do that. And that’s what you should’ve been told. Don’t do that. Don’t do that. Go away. I don’t want you to do that. I don’t like it. Go away. Stop it.

**Component 5: Shift in view of the other.** In this part of the process, the client begins to view the other in a more complex, multifaceted way. The other may now be seen as separate and as having both good and bad qualities. The client may also begin to see the other from the other’s point of view: to see the other as having had his or her own difficulties. This is marked by one of two outcomes: either the client’s attitude toward the other softens, and both the self and other are seen more positively (or at least, less negatively) or, as often occurs in cases of abuse, the other is held accountable for his or her actions and deserving of the client’s negative feelings. In the latter instance, the self is seen as empowered and worth-while, in relation to the other and entitled to the negative feelings held toward the other. As the self is experienced as more powerful, the other is seen as less threatening. When the client in our example reached this point in the process, he imagined his mother becoming more receptive to his perspective and saying:

Yes, I know I did some of those things you said. And I could have been a better mother, but I guess I was young. I was still a child myself. I couldn’t give you the emotional stability you wanted . . . I didn’t know how to bring up a baby. I’m sorry that it had an effect on you. I realize now that it was not the right way.

**Component 6: Resolution.** Clients who reach resolution do so by focusing on affirmation of the self as worthwhile, and finding it possible to let go and forgive them. In holding the other accountable, the client attributes responsibility for the wrong to the other and de-blames the self. Regardless of whether the client resolves their problem by holding the other accountable for wrongdoing or by understanding and/or forgiving the other, the end result is an experiential sense of resolution and completion with respect to the unfinished business with the other. This is often accompanied by a sense of empowerment and optimism about the future. The client in the example resolved his unfinished business with his mother by holding her accountable and affirming himself in the following way:

As a little boy I couldn’t tell you “Stop it. Don’t do it. Keep away.” But I can tell you now that I resent you for it, and I won’t forgive you. I am not going to protect you anymore. I’m not going to change the subject when it comes up. I’m not going to dance around you any more. I’m going to stand up for myself. I think it’s time.

**Measures**

The measures described in the next four paragraphs were used to assess outcome.

**Symptom Checklist—Revised (SCL–90–R; Derogatis, 1983; Derogatis, Rickels, & Roch, 1976).** This measure is a self-report instrument designed to assess the severity of a range of clinical symptomatology. Derogatis (1983) reported internal consistency ranging from .77 to .90 and test–retest reliability between .80 and .90 over 1 week.

**Inventory of Interpersonal Problems (IIP; L. M. Horowitz, Rosenberg, Baer, Ureto, & Villaseher, 1988).** This is a self-report measure that assesses interpersonal problems. It has been shown to have a test–retest reliability between .89 and .98 and internal consistency ranging from .89 to .94.

**Unfinished Business Resolution Scale (UFBRRS).** Singh (1994) developed this scale for the purpose of assessing the resolution of unfinished business. It consists of 11 items on which clients rate how they feel in terms of their unfinished business with an identified significant other. Singh reported high correlations between change on the UFBRRS and change on other outcome measures, as well as test–retest reliabilities over 1 month of .73 for a student sample and .81 for a clinical sample.

**Structural Analysis of Social Behavior (SASB) Short Form (Intrex) Questionnaire (Benjamin, 1988).** The short form questionnaires of the SASB model were used. Individual items on the questionnaires reflect the dimensions of affiliation and independence. The overall questionnaire has three sets of items that refer to perceptions of self, other, and introject. Clients were asked to rate themselves on a scale ranging from 0 (never/not at all) to 100 (always/perfectly) to determine how well each item described them and the significant other, who was the focus of their unfinished business. Pre- and posttreatment scores were used in this study. The three subscales used were: (a) Intrex-Self-Affiliation (Intrex-SA; how affiliative an individual feels toward the significant other); (b) Intrex-Self-Independence (SE; how separate–enmeshed an individual feels in regard to the significant other); and (c) Intrex-Introject Affiliation (IA; how affiliative, supportive, or loving an individual feels toward himself or herself). Scores on these measures were calculated with the weighted average procedure reported by Quintana and Meara (1990). Benjamin (1988) reported test–retest reliabilities ranging from .67 to .90 and has reported substantial evidence of construct validity.

**Target complaints.** This instrument is tailored to clients’ perceptions of up to three problem areas they want to address in therapy. Research carried out in developing the target complaints instrument (Battle, Imber, Hoehn-Saric, Stone, Nash, & Frank, 1968) suggests that it is a valid measure of clients’ complaints, correlating highly with other outcome measures, and has a test–retest reliability of .68 between pre- and postpsychiatric interviews. The target complaints instrument measures change in two ways. First, before treatment, clients were asked to identify up to three areas of change they wanted to see as a result of therapy. At the same time, clients were asked to indicate on a 13-point scale (from 1 [not at all] through 7 [pretty much] to 13 [couldn’t be worse]) how much each problem bothered them at that time. The average of how troublesome each complaint was became the data for the Target Complaints Discomfort Box Scale (TCDS). At termination, without seeing their earlier rating, clients were asked to again rate themselves on the TCDS. Second, they were also asked to make the second evaluation of change by indicating on a 9-point
scale (1 = worse, 5 = same, and 9 = much better) how much each problem had changed since the beginning of treatment. The average of the ratings for each target complaint on this second scale was used as the score for the Target Complaints Change Scale (TCCH).

The rating scales described in the next paragraphs were used to measure process.

SASB (Benjamin, 1974, 1988). This scale allows a rater to evaluate moment-by-moment transactions in the psychotherapy process itself. The SASB model represents interpersonal behavior in terms of focus (self, other, introject), degree of affiliation (love–hate), and degree of independence (separate—enmeshed). The ratings form eight clusters arranged in a circumplex. Transcripts are broken into thought units for ratings. The principal investigator carried out this unitizing before submitting the transcribed segments to the raters. Demonstrated interrater reliabilities of using Cohen’s kappa ranging from .65 to .85 have been found.

Experiencing Scale (EXP). Klein and colleagues (Klein, Mathieu, Kiesler, & Gendlin, 1969; Klein, Mathieu-Coughlan, & Kiesler, 1986) developed this scale to make a qualitative assessment of an individual’s personal, subjective experience, and it has demonstrated interrater reliability on Ebels class correlations ranging from .75 to .92. At lower levels of the scale, individuals give no indication of their own inner processes. Moving up the scale, at Level 4, individuals focus on their bodily felt experience, and their personal perspective becomes clearer until, at the highest levels, individuals are actively processing their subjective experience to solve problems. Scores of 4 and above are regarded as productive process. Raters were trained to reliability. All study reliabilities are reported below.

Client Vocal Quality Scale (CVQ) classification system. The client-vocal-quality-classification system was developed to provide a way of assessing the quality of a client’s involvement in the moment-by-moment therapy process (Rice, Koke, Greenberg, & Wagstaff, 1979). The four categories of vocal quality are identified by their unique combination of six aspects of speech (perceived energy, accent, accentuation pattern, regularity of pace, terminal contours, and disruption of speech pattern). The four categories are designated limited, externalizing, focused, and emotional. This measure has demonstrated interrater reliability of Cohen’s kappa ranging from .70 to .88 and predictive validity. Focused and emotional voices are regarded as productive therapeutic processes.

Client Emotional Arousal Scale Revised (EAS-R). The client EAS (Machado, 1992) enabled the evaluation of events in terms of the intensity of the emotional arousal involved. This instrument has demonstrated interrater reliability of Cohen’s kappa of .71 (Rosner, 1996). Because the EAS ratings involve assessing both verbal and nonverbal cues, raters were trained with both written transcripts and videotaped segments of nonstudy dialogue to make reliable ratings, discussing discrepancies in ratings until consensus was reached. To increase reliability in this study, the 7 points of the original EAS were collapsed into 5 points for intraclass correlation, with Points 2 and 3 collapsed into one point (2) and Points 5 and 6 into one point (4). The loss in discriminating power was not significant for the purposes of this study as the only ratings of concern were four or above or below four. A score of four or above on this 5-point scale indicated moderate arousal and was viewed as productive emotional processing.

Needs Scale (NEED). Drawing on Murray’s (1938) work, this scale was developed by Foerster (1990) specifically for the purpose of identifying need components in the resolution of unfinished business models. Using segments of nonstudy empty-chair dialogue, raters were trained to reliably identify the presence or absence of statements of interpersonal need. They were also trained to classify identified needs reliably, using a classification list developed by Foerster and refined by Pedersen (1996), who reported a Cohen’s kappa interrater reliability of .87.

The Working Alliance Inventory (WAI). The working alliance is a term used to describe the collaborative aspect of the relationship between therapist and client (Bordin, 1979; Horvath & Greenberg, 1989) and has reported alphas ranging between .87 and .93, and has been shown to be moderately but consistently related to therapy outcome (Horvath & Greenberg, 1994). The WAI (Horvath & Greenberg, 1989) is a 36-item self-report inventory developed for the purpose of evaluating client perceptions of the therapeutic relationship.

Training Raters

Eight doctoral students in psychology and an individual with a PhD in clinical psychology were trained to make process ratings with the five process measures. Each scale had two raters. Only two individuals carried out ratings for more than one process measure. A set of examples of unfinished-business dialogues of various levels of experiencing and types of vocal qualities were compiled to supplement the training material for the EXP and CVQ scales. Raters for each scale were trained to a reliability of above .70 on all scales before carrying out ratings on the study material.

The two SASB raters each rated two thirds of the dialogue segments, with 954 overlapping thought units. Interrater reliability was calculated with Cohen’s weighted kappa (Cohen, 1968), giving a coefficient of .70. In a similar manner, there was a one-third overlap between raters using the EXP. The intraclass correlation coefficient for peak EXP ratings was .73 (p < .001). Each EAS rater scored two thirds of the material for this study. The intraclass correlation coefficient on peak intensity was .85 (p < .001). For the NEED, both raters, as a reliability check, rated one third of the units. Cohen’s weighted kappa was calculated at .90.

Procedures

Component sampling procedure. A clinical judge, familiar with the resolution model but unfamiliar with the outcome of therapy, listened to those parts of the therapy tapes (audio, video, or both) that involved empty-chair dialogue. Using clinical judgment, the rater identified segments of dialogue that contained the best representation of each component of the unfinished-business model. The components under investigation were blame, complaint, and/or hurt; negative other; intense expression of emotion; expression of need; shift in view of the other; and resolution. A second rater was given 20 of these components and classified them with 100% accuracy.

Two-minute segments of dialogue per component were transcribed and submitted to clinical raters for each client. When the initially selected segments failed to meet criteria on one or more of the rating scales used, additional potential component segments were identified, transcribed, and rated. This was done until it was judged that a given component was not to be found in any of the client’s empty-chair dialogues. We used this procedure for component selection to attempt to rule out the occurrence of false negatives (i.e., cases in which components did exist but were not found). However, if a component did occur but was not identified, the dialogue would be judged as not having the component, and this would work against the tested hypotheses. This makes the test rigorous and conservative. For example, even though a need might have been expressed somewhere in a dialogue, if it was missed the case would be classified as unresolved, even though it might have been resolved and would have a better outcome. This misclassification would work against the hypotheses.

Given that the treatments met criteria for adherence (Paivio & Greenberg, 1995; i.e., the clients engaged in an unfinished-business dialogue according to the manual of process-experiential psychotherapy for at least 5 min), it was expected that every client’s dialogues would be judged to have a blame, complaint, and/or hurt and negative-other component. These components therefore were not expected to differentiate between successful and unsuccessful resolution processes. Components that were expected to discriminate resolved from unresolved clients were those of need, shift, and resolution. We reasoned that the presence of a resolution component including either a need component or a shift-in-view-of-other component would ensure that the person had truly reached a point of resolution. This would rule out false resolutions in which the person...
resolved in a preemptory fashion and would ensure that the person had experienced either self-assertion of need or a change in their view of the other, or both, as well as understanding, forgiving, or holding the other accountable.

Once it was determined which components of the model were present within the empty-chair dialogues of each client, it was possible to classify whether a given client’s unfinished business could be characterized as resolved or unresolved. A “resolved” client was one whose empty-chair dialogues contained the final resolution component and at least one of the other two preceding components of the model (need and shift) deemed crucial in the resolution process. This was done to eliminate pseudoresolutions where a client may have resolved without going through any process step. By contrast, a client was designated “unresolved” when two or more of the three crucial components (resolution, shift, or need) of the model were missing from the empty-chair dialogues.

Measurement criteria. Each component in the process was characterized by a set of criteria on the rating scales derived from a prior analysis of the resolution of unfinished business (Greenberg & Foerster, 1996). These criteria are illustrated in Table 1.

As can be seen in Table 1, all components required the presence of at least two talk turns in close proximity to one another or a minimum of eight lines of continuous dialogue. The intense expression of emotional arousal was the exception to this rule, requiring two sequential talk turns, or a minimum of eight lines of continuously sustained emotional arousal to count as representative of this component.

The blame, complain, and/or hurt component required that the selected segment of client dialogue be directed toward the imagined other in the empty chair and rated as being expressed in an external or limited voice on the CVQ. This meant that the client was either judged to be speaking in an outer-directed, lecturing (external) voice or in a tense, wary, low-energy (limited) voice. The dialogue segment also had to be rated at its peak as being spoken with no more than a low level of emotional arousal on the EAS (EAS = 4), and with no more than an inner-directed focus on the EXP (EXP = 4). At least 50% of the thought units in the segment had to be rated as belittling and blaming the other, disclosing and expressing the self, and/or sulking and appeasing the other.

A dialogue segment rated as negative other had to be enacted from the empty chair and spoken in an external or limited voice (CVQ). In addition, at its peak, the enactment had to be carried out as no more than a reaction to external events (EXP = 3). It also needed to be rated on the SASB as watching and managing, blaming and belittling, attacking and rejecting, ignoring and neglecting, deferring and submitting, sulking and appeasing, protesting and withdrawing, and/or walking off and avoiding the client.

The intense-expression-of-emotional-arousal rating required that the selected segment of client dialogue be directed toward the imagined other in the empty chair and expressed at its peak in an emotional voice that deviated from its normal platform or in an inner-directed, exploratory and focused voice (CVQ). It also had to be expressed with at least an inward focus (EXP = 4) and at least a moderate level of arousal evident in the verbal or nonverbal indices of the EAS (EAS = 4). In addition, at least 50% of the thought units in the dialogue segment had to be rated as expressions of attacking and rejecting the other, asserting oneself and separating from the other, disclosing and expressing oneself, or protesting and withdrawing from the other (SASB).

Previously unmet interpersonal needs had to be expressed from the self-chair with a sense of entitlement and rated at their peak as being expressed with at least an inward focus (EXP = 4) in an emotional or focused voice (CVQ). At least 50% of the thought units had to be either instances of self-disclosure and expression or instances of self-assertion and separation from the imagined other (SASB). In addition, the statements had to express an identifiable interpersonal need on the NEED.

Ratings of shifts in the view of the other varied as a function of whether the shift was to a more affiliative or less threatening other. Shifts to a more affiliative other were typically reenacted from the empty chair and required that the segment be judged as having been expressed in an emotional or focused voice (CVQ) with at least an inward focus (EXP = 4). At least 50% of the thought units had to be judged as representative expressions of the enacted other as affirming and understanding, nurturing and comforting, or helping and protecting the client. Alternatively, the imagined other could be enacted as disclosing and expressing himself or herself to the client. Shifts to a less threatening other were also typically enacted from the empty chair and required that the segment be judged as expressed in a limited or focused voice (CVQ) with at least an inward focus (EXP = 4).

At least 50% of the thought units had to be judged as either representing statements of self-disclosure and expression or self-assertions and separations from the other. The same proportion of thought units in understanding and forgiving resolutions had to be judged as statements of self-disclosure and expression or self-assertions and separations from the other. The proportion of thought units in understanding and forgiving resolutions had to be judged as statements of self-disclosure and expression or self-assertions and separations from the other.

To demonstrate how the criteria work, we can refer to the segment of empty-chair dialogue provided as an example of the expression of a previously unmet interpersonal need. Referring to the episodic memory of the client’s mother’s humiliating seductive behavior and hurtful teasing, the therapist said, “Let’s go back to that scene. There you are, you’re a little boy. Let’s see if we can help the little boy say some things.” In response, the client said:

> How can the little boy say anything, or even think of saying anything? What he should’ve said was “Don’t do that! Don’t!” “I didn’t want you to do that.” And that’s what you should’ve been told. “Don’t do that. Go away. I don’t want you to do that. I don’t like it. Go away. Stop it.”

The italicized portions of the client’s response can be considered an expression of previously unmet interpersonal needs for the following reasons: (a) The content conveys the need to be free of violation (NEED = positive rating); (b) the words represent the client’s feelings, conveying his internal perspective and what it was like to be him (EXP = 4); and (c) the client’s vocal qualities were congruent with someone turning their attentional energy inward to the task of tracking inner experience (CVQ = focused).

Results

The average pretreatment score on the Global Severity Index of the SCL-90–R (Derogatis, 1983) was 0.88 (SD = 0.58), and according to outpatient norms this group showed mild depression, anxiety, and interpersonal sensitivity. They also showed mild to moderate symptoms of distress, difficulties, or both in social, occupational, or school functioning prior to commencing therapy. The mean age of clients in this study was 42 (SD = 8.95) and ranged from 27 to 68. Three clients had a high school education, 17 had some postsecondary education, and 6 had postgraduate education. Seven were single, 11 were married, and eight were separated or divorced.

On the basis of the process rating criteria, 13 clients were judged to have resolved their unfinished business. The remaining 19
<table>
<thead>
<tr>
<th>Rating the scale</th>
<th>Blame, complaint, and/or hurt</th>
<th>Negative other</th>
<th>Intense emotion</th>
<th>Interpersonal need</th>
<th>Shift in other</th>
<th>Resolution</th>
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<td>4 or more</td>
<td>Positive rating</td>
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<td>Talk turns or minimum of</td>
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Note. EXP = Experiencing Scale, on which 3 = reaction to external events; 4 = an inward focus; and 5 = a proposition about the self; SASB = Structural Analysis of Social Behavior; CVQ = Client Vocal Quality Scale, on which “external” = an outer-directed, lecturing voice; “limited” = a tense, wary, low-energy voice; “focused” = an inner-directed, exploratory voice; and “emotional” = a voice that breaks from its normal platform in expressing emotion; EAS = the 7-point Emotional Arousal Scale, on which 4 = low level of emotional arousal, and 5 = a moderate level of arousal; NEED = Needs Scale.

clients completed therapy but were judged on these criteria as not having fully resolved their unfinished business. Thirteen clients were randomly selected from the set of unresolved clients to make a comparison group. The resolved and unresolved groups were compared on the demographic variables of age, sex, level of education, and marital status. Chi-square analyses demonstrated no significant differences at the .05 level between groups on sex, level of education, and marital status, whereas a t test showed no significance at the .05 level on age.

Table 2 gives the means and standard deviations for pre- and posttherapy on the outcome measures for each group. No significant differences were found between groups before therapy. In addition, no significant differences were found between completers and noncompleters on any clinical dimensions, although noncompleters were predominantly single men with less education.

Table 3 indicates the number of components of the model that were judged present for each group. All but two of the resolved clients expressed a need. Two different resolved clients did not experience a shift in their view of the other, but did express a need. One of these could not be rated as either having a shift or not, because the client never portrayed the role of the other at the end of the dialogue. None of the unresolved clients experienced a shift in their view of the other, although three expressed a need. All of the resolved clients’ dialogues by definition contained a resolution component (and at least one of the other two crucial components), whereas none of the client dialogues in the randomly selected comparison group contained this component.

Using a Fisher’s Exact test, the two groups were found to differ significantly on the number of clients in each group who expressed intense emotion in their empty-chair dialogues (p < .01). In addition, to test whether emotion expression related not only to resolution but also to shift in view of the other, the probability that a client who expressed an intense emotion would experience a shift in their view of the other was calculated with a Fisher’s exact test. In the resolved group, of the nine clients who expressed intense emotions, two did not express a shift in their view of the other (although as pointed out, one of these could not be rated on a shift), whereas the three who didn’t express emotion did achieve this shift. One dialogue was removed from this analysis because a shift could not have been rated as the client never assumed the role of the other in the empty chair, a criterion for rating a shift. In the unresolved group, 3 of the 13 clients expressed emotion but had no shift, whereas the remainder had no shifts. A Fisher’s Exact test revealed that the probability of a shift occurring if an emotion occurred was p = .07. This was not significant at the .05 level.

Overall differences between groups at outcome were tested using a multivariate analysis of variance (MANOVA). Using the Wilk’s lambda multivariate test, we found the groups to be significantly different at posttreatment, F(8, 17) = 3.9, p < .01. Having established that there were significant differences between

Table 2
Summary of Pre- and Posttherapy Means and Standard Deviations and Comparative Effect Scores

<table>
<thead>
<tr>
<th>Measure</th>
<th>Resolved group</th>
<th>Unresolved group</th>
<th>d score</th>
<th>r²</th>
</tr>
</thead>
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<tr>
<td>SCL-90-R</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pretreatment</td>
<td>0.73</td>
<td>1.04</td>
<td>0.36</td>
<td>.48</td>
</tr>
<tr>
<td>Posttreatment</td>
<td>0.22**</td>
<td>0.74</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IIP</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pretreatment</td>
<td>1.47</td>
<td>1.89</td>
<td>0.58</td>
<td>.60</td>
</tr>
<tr>
<td>Posttreatment</td>
<td>0.7*</td>
<td>1.29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UFB-RS</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Pretreatment</td>
<td>40.54</td>
<td>44.77</td>
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<td>.64</td>
</tr>
<tr>
<td>Posttreatment</td>
<td>19.23***</td>
<td>37.46</td>
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<td></td>
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<tr>
<td>TCDS</td>
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<td></td>
<td></td>
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<tr>
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<td>9.76</td>
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<tr>
<td>Posttreatment</td>
<td>4.2</td>
<td>6.30</td>
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<td>TCCH</td>
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<tr>
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<td>1.44</td>
<td>.36</td>
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<tr>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intrex-IA</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pretreatment</td>
<td>113.85</td>
<td>-10.0</td>
<td>0.79</td>
<td>.47</td>
</tr>
<tr>
<td>Posttreatment</td>
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<td>-13.85</td>
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<tr>
<td>Intrex-SA</td>
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<td></td>
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<td>Posttreatment</td>
<td>233.08</td>
<td>168.46</td>
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</table>

Note. SCL-90-R = Symptom Checklist–90—Revised; IIP = Inventory of Interpersonal Problems; UFB-RS = Unfinished Business Resolution Scale; TCDS = Target Complaints Discomfort Box Scale; TCCH = Target Complaints Change Scale; Intrex-IA = Intrex-Introject Affiliation; Intrex-SA = Intrex-Self-Affiliation; Intrex-SI = Intrex-Self-Independence.

*p < .05. **p < .01. ***p < .001.
the groups overall, it was then possible to test the differences between groups on specific outcome measures with analysis of covariance (ANCOVA) statistical procedures that used pretreatment scores as the covariate. We found significant differences between groups for the SCL-90–R, \(F(1, 23) = 13.30, p < .01\), the IIP, \(F(1, 23) = 4.59, p < .05\), the UFB-RS, \(F(1, 23) = 22.04, p < .01\), and the Intrex-IA subscale of the SASB measure, \(F(1, 23) = 10.65, p < .01\). Because there were no pretherapy scores to serve as a covariate on the TCCH, we used an ANOVA for this variable. We found the groups to differ significantly on this measure, \(F(1, 24) = 13.36, p < .01\).

We found no significant differences between groups for the TCDS, \(F(1, 23) = 2.61, p > .05\), Intrex-SI, \(F(1, 23) = 1.89, p > .05\), or Intrex-SA, \(F(1, 23) = 1.47, p > .05\). Two clients had been sexually or physically abused as children, and both were working on abuse-related issues in therapy. Because there was a striking difference between the Intrex-SA scores of these clients and all the other clients in the sample, we calculated the Intrex-SA ANCOVA for the nonabuse clients. The resulting \(F\) value, with the loss of 2 degrees of freedom in removing the two abuse cases, was not significant, \(F(1, 21) = 3.59, p = .07\).

### Effect Size

Table 2 reports the between-groups comparative effect size (Cohen’s \(d\) score), and the coefficient of determination (\(r^2\)). The difference in degree of significant change between groups ranged from 0.36 to 1.44 standard deviations, with an average difference between groups of 0.77 standard deviations. Differences of this magnitude suggest a medium to large effect size.

### Clinically Significant Change

The threshold for clinically meaningful unfinished-business resolution was a posttreatment score of more than two standard deviations below the pretreatment mean (below 43). According to this criterion, 85% of clients in the resolved group reported clinically significant unfinished-business resolution at posttreatment, whereas only 23% of the unresolved clients reported this type of resolution. Looking at symptom reduction on the SCL-90–R, we found that at pretreatment 38% of resolvers and 31% of nonresolvers were below outpatient thresholds (0.60) for distress. After therapy, 100% of resolvers and only 38% of nonresolvers were below threshold on this measure.

### Comparison With the Alliance

We found no significant difference with a \(t\) test, \(t(24) = 0.94, p = .36\), between the resolved and unresolved groups on the overall working alliance. To test whether the WAI predicted outcome differently for each group (i.e., resolvers and nonresolvers), we investigated the interaction term between the WAI and group membership in a regression analysis for each outcome measure. Group membership, \(t(22) = -2.74, p = .01\), WAI, \(t(22) = -2.34, p = .03\), and the Group × WAI interaction, \(t(22) = 2.06, p = .05\), terms were all found to be significant in the regression analyses for the IIP. Given the significant interaction, the main effects for this measure could not be interpreted easily, and adding the WAI therefore did not improve the predictive value of the regression analysis for the IIP. No further analyses were carried out for this measure.

The interaction term did not reach significance for the SCL-90–R, \(t(22) = .83, p = .42\), the Intrex-IA, \(t(22) = -2.03, p = .06\), the UFB-RS, \(t(22) = .60, p = .56\), or the TCCH, \(t(22) = -0.48, p = .63\), and was therefore dropped from the subsequent regression analyses on these measures. Given that, on average, the unresolved group consistently tended toward somewhat worse pretreatment scores than the resolved group, the pretreatment scores were included as an additional predictor in the regression equation.

An examination of the unique variance contributed by each of the variables in the regression model shows that although the WAI contributed 0%–5%, and pretreatment scores contributed 3%–5% of the variance, group membership contributed between 23% and 33% on these four measures. This supports the hypothesis that the crucial components of resolution are a better predictor of outcome than the WAI.

### Discussion

This study focused on testing whether the hypothesized process of change in the treatment of unresolved feelings toward a significant other predicted outcome. Those clients who expressed previously unmet interpersonal needs and manifested a shift in their view of the other, as well as affirming the self and either understanding the other or holding the other accountable, were found to have changed more than those who did not engage in these processes. Analyses demonstrated that compared with clients who did not resolve their unfinished business with a significant other in a manner consistent with the model, those who did enjoyed significantly greater improvement in symptom distress, interpersonal problems, affiliation toward self, degree of unfinished business, and change in target complaints. The measures on in-session indices such as depth of experience, vocal quality, interpersonal behavior, and emotional arousal used to classify clients as resolvers and nonresolvers were independent of the hypothesized model of change. This allowed the specifics of performance to be assessed in a more detailed manner than would be possible with clinical judgment alone.

A significantly greater number of clients in the resolved group were also found to express intense emotions, and those clients who expressed intense emotion were more likely to experience a shift in their view of the other. Almost all clients in the resolution group experienced the mobilization of an interpersonal need and a shift in their view of the other, whereas no clients in the unresolved group experienced a shift in their view of the other.

Group membership (i.e., the presence or absence of the crucial components of the resolution process in the clients’ empty-chair dialogues) was also found to be a better predictor of outcome than
the working alliance. Given the established relationship between working alliance and outcome, this suggests that the components depicted in the model represent specific change processes in resolving unfinished business over and above relational or collaborative processes. The effect sizes of the differences between resolvers and nonresolvers on the outcome measures were moderate, ranging between .36 and 1.44. The differences between groups on symptom reduction and on unfinished business resolution were clinically significant. One hundred percent of resolvers were symptom free at termination compared with 38% of nonresolvers, whereas 85% of the resolvers compared with only 23% of nonresolvers reported a clinically significant change in degree of resolution of unfinished business. This suggests that the components of resolution capture a clinically important process that relates to outcome.

The findings provide support for the working through of unresolved issues with significant others as an important process of change for clients (Perls et al., 1951). Results support components of the specific model of resolution of unfinished business proposed by Greenberg et al. (1993), and more generally for the role of emotional arousal and the mobilization of needs and changes in self–other relationship schemas (L. M. Horowitz et al., 1988) in resolving unfinished business.

An issue that bears comment is that only 41% (13 of the larger sample of 32 clients) were judged to have fully resolved their unfinished business. In addition, if the 26 clients chosen for study are viewed as a single group for studying treatment effects, clinically significant changes in symptom reduction would have been found to occur in only 69% of the clients and change in unfinished business resolution in only 54%. However, the fact that 41% were judged as resolved does not indicate that only 41% benefited from the treatment, but rather that 41% were fully resolved on process rating criteria. It should also be noted that this is a study of the process of change and not of treatment effects. The overall results of the combined group above are not representative of the overall effects of this treatment, as they represent results of combining possible extreme groups of 13 resolvers and 13 nonresolvers selected from a total of 32 clients whose process data was available. The treatment program from which these clients were drawn previously has been shown to be significantly superior to a psychoeducative treatment. In this previous study, a group of 17 clients randomly assigned to treatment showed overall success rates of 89% on symptom reduction and 81% on unfinished business resolution (Paivio & Greenberg, 1995).

This study however does demonstrate that reports of overall treatment effects do not take into account the important role of the process of change and obscure the fact that there are at least two distinct groups in treatment: those who fully absorb the treatment, by engaging in the change processes the treatment is attempting to promote, and those who do not. This is a factor that has a major influence on outcome. The findings of this study demonstrate that the treatment can be viewed as not having fully engaged all the clients in the active ingredients of the treatment. Only some of the clients engaged fully in the proposed, specific mechanism of change, others engaged only partially, and others only minimally. This study therefore demonstrates that those who engaged fully in the proposed, specific change processes benefited more than those who did not, and benefit more than those who experience the more general benefits of a good alliance.

In relation to the role of the components in the change process, it can be seen that the number of clients in each group who expressed intense emotions were found to differ significantly (nine in the resolved group; three in the unresolved group). Facilitating admission into awareness and expression of previously inhibited primary emotion therefore appears important in resolving unfinished business. In light of this, this therapy can be understood, in part, as a process of activating salient problematic emotions and the restructuring of the schemas that generate them. Emotional expression alone however does not guarantee positive change and, as such, is not an end in itself. Clients need to go beyond the expression of previously inhibited primary emotion to mobilizing previously unmet needs and restructuring maladaptive self–other representations that have developed in the wake of traumatic or chronically frustrating interactions with a significant other. Among the clients in the resolved group, 11 out of 13 experienced a shift in their view of the other either to less threatening or to more affiliative. In addition, one of the dialogues without the shift did not provide the opportunity for this component to be rated by virtue of the therapist failing to have the client assume the role of the other. In contrast, none of the empty-chair dialogues of the clients in the unresolved group contained a shift component indicating the significance of the restructuring of self–other schema. A trend toward emotional arousal predicting a shift in the view of the other was also found. This however requires further investigation on a larger sample to see if emotional arousal significantly predicts a shift in the view of the other.

From intensive observation of those cases in which resolution occurred without demonstration of either emotion, need, or shift, we found that the components appeared to be there in almost all the cases but they failed to meet the measurement criteria set. For example, in some of the resolution cases emotion or need was present but not for two sequential talk turns, or emotions were only rated at Level 4 on the EAS Arousal scale, or the need component failed to be rated as having a focused voice on the CVQ. In the two cases that failed to show a shift, one case previously mentioned did not contain a role play of the other at this point in the dialogue, and so it was impossible to capture the shift. In the other case however, there did not appear to be an observable shift suggesting that on occasion resolution could occur through assertion of need and self-affirmation alone. From a clinical point of view, this type of resolution seems particularly likely in some cases of abuse or cruel abandonment where there may be no shift in their view of the other.

Carrying out a fine-grained analysis of the psychotherapy process, as has been done in the current study, is a labor-intensive and time-consuming task that necessitates setting realistic limits on the number of cases included. Unfortunately, the resulting small sample size and associated loss of statistical power limits conclusions, especially with null findings. Nonetheless, the current study did gather evidence of a positive relationship between the process of resolving unfinished business according to the hypothesized steps and psychotherapeutic outcome. Because of the correlational nature of the study, however, it is not clear whether resolution brought about the improvement in the outcome measures or whether some other as yet unidentified factor(s) brought about positive changes in both the process and outcome of the psychotherapy.
Given the range of issues brought to the therapeutic enterprise, it would not be reasonable to assume that people with diverse unresolved issues would all come to terms with those issues in exactly the same way. For example, both abuse survivors and those dealing with nonabuse issues struggle with what to do in the face of a deep interpersonal injury, but the outcome measures suggest that these two groups may differ markedly in terms of how they come to view and feel about the significant other. In this study, clients who have suffered from neglect of a more “normal” magnitude appeared to resolve by becoming more affiliative toward the other, whereas those who suffered a greater degree of trauma and abuse became more disaffiliative (2 of 2). Further research is needed to clarify change processes for clients with different forms of unfinished business and for populations with specified disorders.

References


Received November 7, 2000
Revision received March 27, 2001
Accepted April 26, 2001