

An Expressive-Cognitive Approach to the Resolution of Unfinished Business

**Georgios K. Lampropoulos
Donald R. Nicholas**

An expressive-cognitive approach to the resolution of unfinished business is proposed as an eclectic adaptation of the experiential model for resolving unfinished business (Greenberg, Rice & Elliott, 1993). The rationale for using this adaptation is presented, based on limitations of current practice. This easily implemented approach may be used as a complementary or alternative choice to the empty-chair intervention, particularly for clients who have difficulty engaging in or benefiting from experiential counseling. The case of a depressed client who was successfully treated with a brief expressive-cognitive approach to the resolution of unfinished business is presented.

Experiential psychotherapy is one approach to mental health counseling that has been receiving increased empirical investigation (Greenberg, Elliott, & Lietaer, 1994). Experiential counseling for depression (ECD) has received empirical and theoretical support (Beutler et al., 1991; Daldrup, Beutler, Engle, & Greenberg, 1988; Greenberg et al., 1994; Greenberg et al., 1993; Greenberg & Watson, 1998; Watson & Greenberg, 1996a; Watson & Stermac, 1999), while the Gestalt concept of unfinished business (UFB) has been linked to depressive symptoms. It has also been shown that the resolution of UFB contributes to the cure of depression (Daldrup et al., 1988; Greenberg et al., 1993; Greenberg & Watson, 1998; McMain, Goldman, & Greenberg, 1996).

As major contributors to this research, Greenberg and associates have developed theoretical models describing the process of resolving UFB (Greenberg et al., 1993; McMain et al., 1996); tested these models in out-

Georgios K. Lampropoulos is a doctoral candidate in counseling psychology and Donald R. Nicholas, Ph.D., is a professor of psychology. Both are with the Department of Counseling Psychology and Guidance Services at Ball State University, Muncie, IN.

Versions of this article have been presented at the 1999 Annual Conference of American Mental Health Counselors Association, Crystal City, VA, and the 2000 Great Lakes conference in Counseling Psychology, Muncie, IN. Correspondence should be addressed to Dr. Nicholas, Department of Counseling Psychology and Guidance Services, Teachers College 622, Ball State University, Muncie, IN 47306. Email 00drnicholas@bsu.edu

come studies using manualized, experiential interventions (Greenberg & Watson, 1998; Paivio & Greenberg, 1995; Watson & Stermac, 1999), and verified them via task analytic strategies, distinguishing between successful and unsuccessful resolution cases (Greenberg & Foerster, 1996). In these studies, it was noted that not all clients are willing to engage in ECD and that not all clients benefit from experiential techniques (Greenberg & Watson, 1998). Thus, it is important to consider alternative or modified interventions designed to match client characteristics (for reviews see Beutler, Clarkin, & Bongar, 2000; Dance & Neufeld, 1988).

The purpose of this paper is to describe a modification of experiential counseling for the resolution of depression-related unfinished business. This modification could be used with clients unwilling or unable to benefit from the traditional experiential approach. The traditional experiential model is explained first, followed by an outline of its limitations. Next, the alternative approach, based on a cognitive-type adaptation of the experiential model, is proposed. Finally, a case illustration is presented to further clarify this approach.

THE EXPERIENTIAL MODEL

According to the experiential model, UFB emerges and can be identified in the session by the presence of the following markers: (a) a lingering, unresolved feeling such as hurt or resentment, often accompanied by a complaining quality, (b) this feeling is related to a significant other who has been developmentally significant, (c) this feeling is currently experienced, but not fully expressed, and (d) the experience is currently problematic for the client (Greenberg & Foerster, 1996). The appropriate technique for the resolution of UFB in experiential counseling is the empty chair dialogue (ECD). The change mechanism (resolution model) in ECD for UFB is that the client, after expressing blame, hurt, and unresolved feelings towards a significant other, engages in a dialogue with the imagined significant other (in ECD) by recalling past events and experiences and clarifies, differentiates, and actively expresses previously unexpressed feelings and unmet needs. This results in relief, an empowered state of self, a potentially new view of the significant other (either accepting/forgiving or holding the other accountable), and letting go of the unresolved feeling and the unmet need. A detailed description of the Gestalt resolution model of UFB is available in Greenberg et al. (1993, ch. 12), Greenberg and Foerster (1996), and McMain et al. (1996). In this experiential model, the role of the mental health counselor consists of specific operations to facilitate clients' progress through these processes, including stimulating and directing, but not instructing the client.

RATIONALE FOR AN EXPRESSIVE-COGNITIVE APPROACH: LIMITATIONS OF CURRENT PRACTICE

Not all clients are willing to engage in ECD and other experiential techniques. Some clients may experience significant distress and discomfort during an ECD and refuse to continue. Other clients may lack the necessary verbal or cognitive skills for ECD, and thus be unsuitable to participate. In a randomized clinical trial of process-experiential counseling, some clients had difficulties engaging in the chair dialogues (Greenberg & Watson, 1998) or withdrew completely from ECD counseling (Paivio & Greenberg, 1995). Describing contra-indications for the experiential interventions, Greenberg et al. (1993) reported (a) lack of abilities to introspect, (b) unsuitable processing styles, (c) lack of readiness to focus on moment by moment inner experience, (d) description of feelings in global terms such as "upset" and "frustrated," and (e) preferences and needs for the counselor's advice, guidance, and interpretation. Mahrer (1983) reports that as many as almost half of clients "who may well be appropriate for all other therapies are not appropriate for experiential psychotherapy" (p. 94). These include clients (a) with low motivation for change, (often referred to counseling by others), (b) who are on psychotropic medication that may interfere with their in-session experiencing, and (c) who are too dependent on the counselor and have difficulty focusing on themselves (Mahrer, 1983).

Even when competently presented, ECD and other experiential techniques are not always effective. In Greenberg and Foerster's (1996) study of 29 cases of ECD work for UFB, conducted by well-trained experiential counselors (and monitored for the accurate delivery of the intervention), only 11 clients were categorized as resolvers, while 18 were categorized as nonresolvers. This suggests that the ECD is not effective for all clients. The 18 nonresolvers might have been helped by an alternative or complementary counseling approach.

Further, many have argued that there are both cognitive and emotional aspects of awareness/insight (which is a core process in the resolution of UFB), and subsequently, there are corresponding cognitive and experiential routes to reaching awareness/insight (Crits-Christoph, Barber, Miller, & Beebe, 1993; Elliott et al., 1994; Kennedy-Moore & Watson, 1999; Mahoney, 1991; Stalikas, Rogan, & Bercovic, 1996; Wachtel, 1989; Watson & Greenberg, 1996b). Thus, rather than referring clients to other counselors for other forms of counseling, integrative or eclectic counselors might prefer to adapt their interventions, by providing a cognitive version of resolving UFB, that still follows the general principles of Greenberg et al.'s resolution model. A cognitive route to the resolution of

UFB might be helpful with previously unsuccessful cases of experiential counseling or as an alternative form of intervention. The idea of modifying Greenberg et al.'s resolution model is consistent with the belief that different counseling processes and techniques may result in the same outcomes (equifinality principle; Norcross, 1988). Thus, it appears that an alternative approach to UFB is needed.

THE EXPRESSIVE-COGNITIVE APPROACH TO UFB

The proposed expressive-cognitive approach is a cognitive adaptation of the experiential model of resolution of UFB (Greenberg et al., 1993; Greenberg & Foerster, 1996). Its goal is to guide the client through the steps of the UFB resolution model via a cognitive (conceptual) route, without employing the ECD. Initially, basic common factors and facilitative conditions such as (a) a supportive relationship and a working alliance, (b) empathic reflections, (c) encouragement, (d) opportunity for catharsis, and (e) an increase in positive expectations for problem solution (Frank & Frank, 1991) are provided. In addition, the proposed approach aims to provide an active intervention, comparable to the ECD (Greenberg et al., 1993; Greenberg & Watson, 1998). This active and engaging cognitive intervention focuses on continuous client assessment and progress through the steps of Greenberg et al.'s (1993) model for UFB resolution.

This expressive-cognitive approach resembles the psychoeducational control group used in Paivio and Greenberg's (1995) study of UFB resolution, with one very important difference. The present approach is interactive as opposed to instructional, and the client is fully engaged in an empathic and supportive relationship that includes client self-disclosure and counselor interpretations of events (though not in the psychodynamic, transference-related sense). Thus, the expressive-cognitive approach appears to be an adequate equivalent to the experiential approach, both in terms of common factors and specific interventions employed.

In order for the client to reach a resolution of UFB, it is important to target the therapeutic components of the resolution model. These components include (a) the expression and differentiation of feelings, (b) the expression of unmet needs, (c) new view of others and self-affirmation, and (d) letting go of unresolved feelings and unmet needs (Greenberg & Foerster, 1996). In the traditional experiential model, the counselor encourages and structures a one-to-one "conversation" between the client and a significant other (who is imagined as present in the empty-chair). When an UFB issue is identified, the experiential counselor

prompts the client to express needs and feelings to the imagined significant other as well as to imagine and to enact the other person's responses (for details see Greenberg et al., 1993, chapter 12; McMMain et al., 1996). This process increases client's experiencing, expression, and catharsis; facilitates insight through mental representations, experiential role-playing, and searching for the other person's perspective; and finally, results in reconstruction of client schemas about self and others. However, clients are basically assumed to reach these resolution steps "naturally and by themselves," with only encouragement and facilitation by the counselor (i.e., counselor prompts such as "tell him or her how you feel," "tell him or her that again," or "answer him or her.")

In the absence of a direct (empty chair) dialogue between the client and the significant other in the expressive-cognitive adaptation, the counselor has to assume a more active, directive, and contributing role. The counselor, knowledgeable about the sequential steps in the UFB resolution model, attempts to navigate the client through the process using a traditional third-person conversational style. To succeed in this goal, the counselor uses questions, suggestions, interpretations and guidance (in terms of **process** of exploring UFB and its **content**) in every step of the resolution model. That is, the counselor has a greater input in client's resolution journey (compared to the experiential approach), which often involves co-constructing client's resolutions. See the Table for a presentation of a comparative summary of counselor operations in the traditional ECD work and the cognitive adaptation.

Although both the ECD intervention and the cognitive adaptation work toward the same end and follow the same UFB resolution model, two major differences exist between the two. First, the traditional approach utilizes a dialogue between the client and their significant other to explore UFB, while the cognitive adaptation achieves this via the usual conversational style between client and counselor. Second, in the cognitive adaptation the counselor will often provide psychoeducational material and interpretations that may take the client one step further in his or her understanding to reach insights that may not be accessible otherwise. However, the inclusion of suggestions and interpretations to traditional humanistic/experiential counseling should be done in an unobtrusive manner, staying close to the information presented by the client and ensuring client's participation in the process.

A third difference is in the process of implementing change. In the cognitive adaptation model, the conceptualization is still past-focused and the steps of the resolution model remain the same. However, the implementation of change processes are modified. For example, when exploring the significant others' perspectives on client's UFB, some of the verbal interventions used in the cognitive adaptation include questions and suggestions

Table. Counselor Operations

Experiential ECD	Cognitive Adaptation
Establish collaboration to work on UFB and prepare client to engage in experiential ECD.	Establish collaboration to work on UFB and prepare client to cognitively access and discuss these events
Evoke the sensed presence of the significant other in the empty chair, and evoke a specifically recalled event by guiding the client to start a dialogue with the significant other (with the client enacting both roles).	Prompt, inquire, and help client to cognitively recall and describe specific events or experiences with the significant other that were representative of the related unresolved issue and feeling.
Access and differentiate client feelings towards the significant other via a client-enacted dialogue between the two, where the client essentially relives the unresolved situation.	Access, differentiate, and explain client feelings towards the significant other by discussing a related event, with the counselor clarifying, suggesting, and interpreting the two points of view.
Facilitate full and direct experiential expression and validation of client authentic and adaptive feelings (e.g., grief, pain, anger) and client unfulfilled needs in regard to significant other during the ECD.	Facilitate identification, expression (in a moderate experiential level), explanation and validation of specific client feelings and personal needs from specific significant other in specific situations.
Empower the client and support emerging new positive representation of self and positive or negative representation of significant other that comes naturally from client dialogue with significant other	Empower the client and co-construct client new views of self (positive) and significant other (positive or negative) by explaining and interpreting both parties' behaviors, feelings, needs, and motivations.

such as the following: "What was/might have been this person's explanation for his or her behavior? How would you describe the significant other's life during this period? What problems did he or she experience at that moment? Do you think that this event/situation you mentioned may have affected this person's behavior in that way? What other conditions or situations were present when this happened? How could he or she have acted differently? In contrast, in the traditional ECD approach, to access the significant other's perspective, the counselor would have encouraged the client to change chairs, enact the position of the significant other, and respond to the needs and feelings previously expressed by the client.

In both versions it is important for the counselor to know and follow the experiential model for UFB resolution (Greenberg et al., 1993; Greenberg & Foerster, 1996; McMains et al., 1996). The knowledge of the

required resolution components and processes is necessary to keep the client on track and to guide the client's journey toward UFB resolution.

The following case example presents more clearly the new approach. It is described in terms of a common factors condition, plus the cognitive adaptation of the active part of experiential intervention (i.e., ECD). After a brief discussion of the facilitative conditions and common factors of importance to this case, a case-related description of the cognitive adaptation follows.

CASE ILLUSTRATION

Case History

At the time of her referral for mental health counseling, this client was a 48-year-old, married Caucasian female with the presenting problem of depression. Two years prior to this referral she was diagnosed with depression. At the time of her initial diagnosis of depression, in addition to other symptoms, she reported suicidal ideation. She began a period of treatment with antidepressant medication and reported that her suicidal ideation ceased. She has been consistently treated with antidepressant medication since. During the period of her mental health counseling, she consistently and regularly took her medication as prescribed.

At the start of the mental health counseling, she acknowledged that the antidepressant medication had helped, (e.g. no further suicidal ideation, improved sleep pattern, and decreased weight), but that she was continuing to experience other depressive symptoms. These included early morning awakenings, indecisiveness, lack of self-confidence, a sense of loneliness even when with others, and irritability and anger that often resulted in "blow ups" at her husband. A pretreatment score of 24 on the Beck Depression Inventory-II categorized her in the range of moderate depression (Beck, Steer, & Brown, 1996).

In exploring possible contributing factors to her depression, the client reported a supporting and loving environment, a patient and understanding husband, and satisfactory relationships with children and grandchildren. She reported quality moments of marital life, good interpersonal family relationships, and no complaints or unsatisfied needs from her husband and children. Further, she was happy with her occupation, which she perceived as helpful to countering her feelings of loneliness. Finally, no existential worries, major life disappointments or regrets, or cognitive and interpersonal deficits were noted and thus ruled out as possible contributing factors to depression.

In identifying contributing factors to her depression, this client reported unresolved feelings and needs from important significant others in her life. These included her stepfather and her mother. Her stepfather psychologi-

cally (and occasionally physically) abused and neglected her when she was 10–12 years of age, before sending her to live with her grandparents. Her mother, who failed to recognize and prevent the stepfather's abuse, essentially abandoned the client after marrying this stepfather and failing to interrupt the move to live and be raised by the client's grandparents. The client reported that she never had a chance to discuss and express her feelings to her mother and stepfather, nor was she ever able to find any satisfactory resolution to these unresolved feelings. Her mother never admitted that her daughter was abused, nor did she ever acknowledge her failure to protect the client. Her stepfather never admitted or explained his abusive behavior (although the abuse stopped after the client's marriage).

The client also reported feelings of abandonment by her biological father, who left the client and her mother after the client's birth, but in the following sessions she focused her attention exclusively to UFB with her mother and stepfather. These interrelated, unresolved issues frequently bothered the client during her childhood, both while she was awake and in her dreams. Further, she identified these issues as possible factors contributing to her depression, and, in the assessment of the counselor, all the markers of UFB were present. Thus, this suggested that work with UFB would be a good intervention.

Intervention

Common factors and facilitative conditions. The establishment of a good counseling relationship was a first priority in order to set the context for further counseling. Empathy, the therapeutic bond, and other relationship variables were consistently rated high by the client, across different sessions, through self-reported ratings on the Session Impact Scale (SIS; Elliott & Wexler, 1994) and relevant comments in the final session. Similarly, SIS ratings of perceived support were high, which is very important in the treatment of depression (Arkowitz, 1992).

With a strong relationship established, the client was provided with a counseling rationale. This included a mutual definition of the problem, a description of how counseling would proceed to deal with the defined problem, and how the problem will be altered. This resulted in increasing her hope and expectations about improvement. Remoralization and provision of a rationale for change were important considering that the client entered counseling with a negative image about the counseling process (e.g., images of restricting mental institutions), and doubts about its value. These initial misconceptions were quickly disconfirmed.

Subsequently, an agreement on specific goals and tasks was reached in the first two sessions. The primary, agreed-upon task was to explore and

finish the client's UFB with significant others. Finally, an important part of the first two sessions was devoted to empowering the client and reaffirming the positive aspects of her life in an empathic, encouraging, and client-centered atmosphere.

Active ingredient: The cognitive adaptation of the UFB model. The first active ingredient of this counseling process consisted of opportunities for catharsis and relief from tension. Although this factor is typically considered common to many successful counseling models (Frank & Frank, 1991), it is particularly important in the resolution of UFB. Emotional expression and catharsis are core goals of the resolution model of UFB and were pursued in every session (and were accomplished, as measured by relevant SIS items and client in session reports).

The second active ingredient is the search for awareness and understanding of self and others (i.e., problems, behaviors, feelings, thoughts, past experiences). This is an important component of UFB work and also a major common factor in many models of counseling. Operating in an effective counseling relationship, insight and understanding of the problem is half of the counseling process (replacing the problematic behaviors with new, adaptive ones is the other half; see also Hill & O'Brien, 1999; Lampropoulos, 2000). In the resolution of UFB, increased awareness is a very important active ingredient, even sufficient for cure by itself. This is particularly true when the significant other is not alive, present, or posing an ongoing problem. This was the life situation of the present client; the main focus of counseling was to understand and interpret the old experiences and less to modify current behaviors (since client was no longer emotionally abused by her mother and stepfather).

The client and counselor mutually agreed, in the first two sessions, to explore and close the UFB with the significant others. The exploration length of each topic of UFB was determined by the client's resolution of each conflict as well as her reported need to pursue each exploration. However, the client's UFB issues were obviously related, and they were viewed as a whole counseling entity, rather than as distinct units of counseling process.

Following this preliminary work in the first two sessions, the third session was devoted to dealing with UFB with the client's stepfather. The client's experiences and the resulting thoughts and feelings, both past and current, were discussed and analyzed at a mild to moderate level of emotional arousal. The counselor tried to help the client realize and state aloud, her unmet needs from her stepfather (coverage of basic living expenses, need for affection, acceptance as a child, equal treatment with her step-siblings in a nonabusive environment) as well as to clarify, understand, and state her related emotions (anger, hate). The focus was on accepting these client needs as legitimate and valid. Following an understanding of each person's actions,

motives, and feelings, and failing to identify any legitimate and acceptable explanations for her stepfather's abusive relationship, the focus shifted to (a) holding the stepfather accountable for his actions and (b) emphasizing the client's survival. The client resolved the UFB by realizing that other people in her life met her needs (her grandparents), and by praising herself for her survival despite the abuse. The counselor enhanced a sense of pride for the client's strengths and emphasized her accomplishments in building a satisfying life and a happy family despite her bad experiences. Although the client was able to acknowledge some of her stepfather's problems and difficulties in his step-parenting role, the main feelings toward him remained negative and emphasized holding him accountable for his actions.

The fourth session was spent on dealing with UFB with the client's mother. Her mother's nonsupportive behavior with respect to the client's abuse by her stepfather and her uncritical support and dependence on her husband were recurrent and persistent issues. Abuse incidents from the client's childhood were recalled to describe and clarify how she felt her mother behaved and how she believed her mother should have behaved. Emphasis was given to explaining and understanding the mother's behavior during these incidents as well as her current denial of these facts. Assisted by the counselor's interpretations, the client came to see her mother in a less critical way and acknowledged her mother's weaknesses and problems (i.e., a lonely, single-parent trying to raise her children alone for 10 years, who subsequently became dependant on her abusive husband, the client's stepfather). The client expressed insight in the session using phrases such as "hmm...I guess I have never thought about that...(and)...I never thought about it that way..." (the SIS post-session rating on the "understanding others" item showed a notable increase). As a result, the client softened her criticism towards her mother and changed her behavior as well. This positive shift in the client's feelings and behavior towards her mother was reflected in the client's between-session experiences, as reported in the next session (e.g., they had a pleasant conversation on the phone, the client's feelings were more positive compared to past occasions, and the client admitted feeling more accepting toward her). Thus, a different kind of resolution occurred for the client regarding her mother (new view of mother, better understanding) compared to the resolution regarding her stepfather (holding him accountable for his behavior, while affirming self).

Outcome

Evidence from different sources demonstrated that this client changed, in both her level of depression and her resolution of UFB. Her BDI-II score dropped from 24, before the start of the UFB work, to a score of 8

at the end of counseling, a pre-post difference of 16 points. This magnitude of change indicates a reliable, clinically significant change that moved the client from the range of moderate depression to within the normal range for the general population (Beck et al., 1996; Ogles, Lambert, & Masters, 1996). It is worth noting that the BDI score of 24 was measured after the first two sessions and right before the start of the cognitive adaptation of UFB. This suggests that the 16-point change should be attributed mostly to the active intervention. Common factors seem to have also contributed to change, as indicated by the client's reports at the beginning of the first two sessions that she was already feeling much better since her intake interview and her first session, respectively. That is, it can be speculated that this client's real depression level was at first probably higher than a BDI score of 24, and it went down to 24 as a result of the common factors employed in the first two sessions.

In addition to the 16-point difference in BDI, the client reported during the wrap-up session that she had accomplished her goals to close her UFB, which no longer bothered her. She also reported that her emotional and behavioral interaction with her mother was improved. The client also added that her improvement had been acknowledged by a variety of people, including her immediate family, her physician, friends, and distant relatives as well as people with whom she has occasional contact. At this point, it was mutually agreed to terminate counseling, while the counselor left open the opportunity for additional sessions in the future.

Summary and Discussion

To summarize the overall approach, there was an intentional effort by the counselor to guide the client through the steps of the UFB resolution model as developed by Greenberg et al. (1993). Since ECD was not used, the counselor had to actively direct the client to achieve the resolution steps. Although the focus was on the past and the effort from the counselor was to help the client realize and acknowledge her feelings and needs, this was achieved in a conversational way, via intellectual recall, rather than through the intense experiential reliving of an ECD. It is important to note that a key factor for the success of this cognitive adaptation of UFB is the complete and clear expression of needs and feelings in order for the client to achieve catharsis and become more accepting of a significant other's perspective. If this does not take place, the client will probably resist any interpretations, regardless of their accuracy.

This cognitive adaptation of the traditional experiential intervention for UFB might serve to fill a gap in the ability of the experiential approach to reach more clients. As previously mentioned, only 11 out of

29 cases resolved their UFB through the traditional ECD (Greenberg & Foerster, 1996). Perhaps a combined model of an experiential-cognitive approach would be optimal, to complement each modality. As an example, in a process analysis study applied to a case in the Sheffield II psychotherapy project, Hardy et al. (1998) demonstrated a directive psychodynamic-interpersonal approach to insight that combined experiential, interpretive and evaluative elements as somewhere between a process-experiential and a brief psychodynamic approach. Similarly, in cases in which an experiential intervention does not seem to work and the client cannot reach the desired resolution, experiential interventions can be complemented by psychoeducation and interpretations. Several routes to awareness and insight do exist (i.e., experiential, cognitive, and psychodynamic; Hardy et al., 1998; Elliott et al., 1994; Kennedy-Moore & Watson, 1999), and their integrative or eclectic use is coming of age.

CONCLUDING COMMENTS

The case presented here, following the steps of Greenberg et al.'s UFB resolution model, supported that UFB resolution may be also achieved on an intellectual level, through a cognitive self-exploration, assisted by the counselor's interpretations and guidance through the resolution model. This approach targeted all the important components of the experiential resolution model (i.e., the expression and differentiation of feelings, the expression of unmet needs, new view of others and self affirmation, and letting go of unmet needs), minus the *intense* expression of feelings that is typically associated with the two-chair dialogue. This suggests that the presence of intense feeling, as particularly elicited by ECD, may not be a necessary ingredient for change, at least for some resolvers. An opportunity to explore and clarify UFB in a supporting environment under the guidance and encouragement of an empathic counselor who helps the client understand and reframe past experiences might be enough to provide relief and closure (which are also the goals of traditional UFB work).

To conclude, the major contribution of this case study lies in a modified conceptualization of Greenberg et al.'s experiential model for UFB resolution that can complement or be used as an alternative to the experiential intervention. Whenever ECD is unaccepted, unsuitable, or ineffective, counselors should consider the use of an expressive-cognitive approach. The cognitive adaptation presented here seems to receive preliminary support, and it raises the need for (a) controlled experimental research of this approach, and (b) eclectic clinical practice to match counseling approaches to counselor's and client's preferences, needs,

strengths, and other individual and counseling variables (Kelly, 1988; Lampropoulos, 2000).

REFERENCES

- Arkowitz, H. (1992). A common factors therapy for depression. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 402–432). New York: Basic Books.
- Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory* (2nd ed.). San Antonio, TX: Psychological Corp.
- Beutler, L. E., Clarkin, J. F., & Bongar, B. (2000). *Guidelines for the systematic treatment of the depressed patient*. New York: Oxford University.
- Beutler, L. E., Engle, D., Mohr, D., Daldrup, R. J., Bergan, J., Meredith, K., & Merry, W. (1991). Predictors of differential and self-directed psychotherapeutic procedures. *Journal of Consulting and Clinical Psychology, 59*, 333–340.
- Crits-Christoph, P., Barber, J. P., Miller, N. E., & Beebe, K. (1993). Evaluating insight. In N. E. Miller, L. Luborsky, J. P. Barber, & J. P. Docherty (Eds.), *Psychodynamic treatment research: A handbook for clinical practice* (pp. 407–422). New York: Basic Books.
- Daldrup, R. J., Beutler, L. E., Engle, D., & Greenberg, L. S. (1988). *Focused expressive psychotherapy: Freeing the overcontrolled patient*. New York: Guilford.
- Dance, K. A., & Neufeld, R. W. J. (1988). Aptitude-treatment interaction research in the clinical setting: A review of attempts to dispel the 'patient uniformity' myth. *Psychological Bulletin, 104*, 192–213.
- Elliott, R., & Wexler, M. M. (1994). Measuring the impact of sessions in process-experiential therapy of depression: The Session Impacts Scale. *Journal of Counseling Psychology, 41*, 166–174.
- Elliott, R., Shapiro, D. A., Firth-Cozens, J., Stiles, W. B., Hardy, G. E., Llewelyn, S. P., & Margison, F. R. (1994). Comprehensive process analysis of insight events in cognitive-behavioral and psychodynamic-interpersonal psychotherapies. *Journal of Counseling Psychology, 41*, 449–463.
- Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing* (3rd ed.). Baltimore, MD: Johns Hopkins University Press.
- Greenberg, L. S., Elliott, R., & Lietaer, G. (1994). Research on experiential psychotherapies. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed.; pp. 509–539). New York: Wiley.
- Greenberg, L. S., & Foerster, F. S. (1996). Task analysis exemplified: The process of resolving unfinished business. *Journal of Consulting and Clinical Psychology, 64*, 439–446.
- Greenberg, L. S., & Watson, J. (1998). Experiential therapy of depression: Differential effects of client-centered relationship conditions and process experiential interventions. *Psychotherapy Research, 8*, 210–224.
- Greenberg, L., Rice, L., & Elliott, R. (1993). *Facilitating emotional change*. New York: Guilford.
- Hardy, G. E., Rees, A., Barkham, M., Field, S. D., Elliott, R., & Shapiro, D. A. (1998). Whingeing versus working: Comprehensive process analysis of a "vague awareness" event in Psychodynamic-Interpersonal therapy. *Psychotherapy Research, 8*, 334–353.
- Hill, C. E., & O'Brien, K. M. (1999). *Helping skills: Facilitating exploration, insight, and action*. Washington, DC: American Psychological Association.
- Kelly, K. R. (1988). Defending eclecticism: The utility of informed choice. *Journal of Mental Health Counseling, 10*, 210–213.

- Kennedy-Moore, E., & Watson, J. C. (1999). *Expressing emotion: Myths, realities, and therapeutic strategies*. New York: Guilford.
- Lampropoulos, G. K. (2000). Evolving psychotherapy integration: Eclectic selection and prescriptive applications of common factors in therapy. *Psychotherapy, 37*, 285-297.
- Mahoney, M. J. (1991). *Human change processes: The scientific foundations of psychotherapy*. New York: Basic Books.
- Mahrer, A. R. (1983). *Experiential psychotherapy: Basic practices*. New York: Brunner/Mazel.
- McMain, S., Goldman, R., & Greenberg, L. S. (1996). Resolving unfinished business: A program of study. In W. Dryden (Ed.), *Research in counseling and psychotherapy: Practical applications* (pp. 211-232). London: Sage.
- Norcross, J. C. (1988). The exclusivity myth and the equifinality principle in psychotherapy. *Journal of Integrative and Eclectic Psychotherapy, 7*, 415-421.
- Ogles, B. M., Lambert, M. J., & Masters, K. S. (1996). *Assessing outcome in clinical practice*. Boston: Allyn & Bacon.
- Paivio, S., & Greenberg, L. S. (1995). Resolving unfinished business: Experiential therapy using empty chair dialogue. *Journal of Consulting and Clinical Psychology, 63*, 419-425.
- Stalikas, A., Rogan, K., & Bercovic, M. S. (1996). Insight in counseling research. Measurement and methodological issues. *Journal of Psychotherapy Integration, 6*, 265-279.
- Wachtel, P. (1989). The ambiguities of insight. *Journal of Integrative and Eclectic Psychotherapy, 8*, 240-245.
- Watson, J. C., & Greenberg, L. S. (1996a). Pathways to change in the psychotherapy of depression: Relating process to session change and outcome. *Psychotherapy, 33*, 262-274.
- Watson, J. C., & Greenberg, L. S. (1996b). Emotion and cognition in experiential therapy: A dialectical-constructivist position. In H. Rosen & K. T. Kuehlwein (Eds.), *Constructing realities: Meaning-making perspectives for psychotherapists* (pp. 253-274). San Francisco: Jossey-Bass.
- Watson, J. C., & Stermac, L. (1999, June). *Comparing changes in clients' levels of depression, self-esteem, and interpersonal problems in cognitive-behavioral and process-experiential therapy*. Paper presented at the 30th Meeting of Society for Psychotherapy Research, Braga, Portugal.