Helping Clients Heal: Does Forgiveness Make a Difference?

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People often come to therapy to deal with symptoms related to some type of offense, hurt, or trauma. Even clients whose presenting issues do not include a serious offense often report hurtful experiences later in therapy. Helping clients to make sense of and to get beyond these experiences is often a necessary and helpful therapeutic goal. Certainly, processing these events in a supportive and validating environment is a large part of the healing process. It is not hard to imagine that many clients achieve some degree of healing from these simple interventions, but is it enough? Perhaps there is more that therapists could do to help their clients resolve their hurts. Would explicitly addressing forgiveness in sessions help clients more than simply facilitating the reduction of anger, sadness, and fear?

The term forgiveness, particularly as it is applied in therapy settings, elicits a range of reactions from anger and rejection to excitement and support. This variation in reaction is often a result of one’s definition of forgiveness and understanding of how forgiveness is applied with clients in pain. Clinicians researching the application of forgiveness interventions have come to some consensus regarding a definition (for a review, see Wade & Worthington, 2005). Most agree that forgiveness is primarily an interpersonal process, in which those who have been hurt release negative thoughts and feelings for the offending person and gain some measure of acceptance for the events (which might also be accompanied by positive feelings for that person). However, most assert that forgiveness does not necessarily have to include reconciliation. They also assert that forgiveness is not condoning a hurtful action, forgetting the wrong, or ignoring the natural consequences of the offense. Finally, forgiveness is not simply reducing the negative thoughts or emotions associated with unforgiveness.

We agree with these elements, and, for the project described below, we have defined forgiveness as replacing the bitter, angry feelings of vengefulness often resulting from a hurt with positive feelings of goodwill toward the offender. Potentially, this is a complex process in which those who have been hurt replace hostile, unforgiving feelings with more positive emotions toward the offending person without giving up appropriate physical and emotional boundaries that provide safety from hurtful people. True forgiveness, as we define it, requires the ability to see others in realistic terms (both the good and the bad) and to hold them accountable to natural consequences, yet still to feel compassion, empathy, or some degree of positive feelings for them. Implicit within this definition is the need for people to possess at least a moderate degree of self-respect, self-esteem, or, perhaps, ego strength to appropriately forgive those who hurt them.

Though working through this complex process may seem daunting, several clinicians and applied researchers have suggested that explicitly addressing forgiveness in therapy is a worthwhile goal that may offer specific benefits to clients (e.g., Enright, Eastin, & Golden, 1992; Ferch, 1998; Fitzgibbons, 1986). For example, Fitzgibbons (1986) claimed that forgiveness can free clients from the control that past events have exerted over them and that it can decrease their tendency to project angry feelings onto others in future relationships. In addition, some have claimed that forgiveness can assist in restoring broken relationships (Worthington & DiBlasio, 1990) and in “healing inner emotional wounds” (DiBlas-
Denton and Martin (1998) surveyed a sample of 101 clinical social workers and found that the majority believed that forgiveness was particularly helpful with relationship issues, grief and loss, and the guilt and self-recrimination associated with chemical dependency.

Similar support for forgiveness interventions was also evident in a survey of 381 members of the American Mental Health Counselors Association (Konstam et al., 2000). Almost every counselor in this study agreed that it was appropriate for therapists to raise the issue of forgiveness (94%), and just over half (51%) reported that it was the counselor’s responsibility to raise forgiveness as an issue in appropriate situations. Konstam et al. (2000) also found that 75% of these counselors reported using forgiveness interventions that were client focused (e.g., helping clients express and release their anger). Furthermore, 39% reported using techniques that were more offender focused, such as helping the client develop empathy for the person who hurt them. These results, stemming from a large number of practicing mental health counselors, provide evidence that forgiveness interventions are used in clinical settings. However, one limitation of this study was the low survey response rate (35.8%), which raises the possibility of a response bias favoring those interested in, or in favor of, forgiveness as a clinical issue. Therefore, these results could be overstating the general acceptance and use of forgiveness interventions in therapy.

Regardless of the actual percentage of agreement, certainly not all clinicians agree that promoting forgiveness with clients is the most appropriate, ethical, or therapeutic route to take (see Lamb & Murphy, 2002). For example, Lamb (2002) argued that promoting forgiveness for violence and abuse that female clients have suffered at the hands of men is fundamentally problematic. She claimed that the promotion of forgiveness in these situations might encourage a lack of self-respect, shut down a healthy and necessary expression of anger, and reinforce gender role socialization that encourages women to suppress their anger, to quickly repair relationships, and to take care of others (even at their own expense). Lamb (2002) argued that forgiveness is particularly complex for women who historically have been in a subordinate role, wondering whether true forgiveness can occur “without reinforcing that subordination” (p. 165).

Although opinions differ about the usefulness of forgiveness in therapy, judgments could be informed by the needs and desires of clients. Unfortunately, few clinical outcome studies have investigated the need and desire for and effectiveness of explicit forgiveness interventions with actual clients. To date, the studies in this area focus almost exclusively on the efficacy of intervention models designed to promote forgiveness by examining the impact on student or analogue client samples. In a meta-analysis of 27 studies of forgiveness interventions, Wade, Worthington, and Meyer (2005) found that group forgiveness interventions effectively helped participants forgive specific offenders. Average effect sizes for forgiveness treatment groups (.57) were significantly larger than for no treatment or waitlist control groups (.10). However, compared with effect sizes from comparison treatments (.43), the data were less clear. Although in some individual studies the explicit forgiveness intervention group promoted more forgiveness than comparison treatments, overall there was no significant difference among the types of treatment. These results raise the possibility that participants in any form of treatment may report increased forgiveness, which might indicate that there is no specific need for forgiveness interventions per se.

Two studies of forgiveness interventions that closely resemble individual psychotherapy with actual clients were not included in the above meta-analysis (because the interventions were provided in individual formats). These studies provide a closer approximation of the effects of explicit forgiveness interventions in individual psychotherapy. In the first, Freedman and Enright (1996) provided an intervention specifically designed to promote forgiveness for 12 women who were victims of incest. Compared with 12 women in a waitlist control group, the women who received the individual forgiveness treatment reported more forgiveness for their perpetrators, greater hope for the future, less anxiety, and less depression following the treatment. In a similar study, Coyle and Enright (1997) adapted the intervention for men who were upset with their partners’ choices to get abortions. This study had similar results; the 5 men receiving individual forgiveness treatment reported more forgiveness and less anxiety, anger, and grief than the 5 men in the control group.

These studies provide empirical support for the use of forgiveness in therapy, showing that explicit forgiveness interventions can help both men and women suffering from serious offenses increase forgiveness and decrease psychological symptoms. However, there is a notable limitation. Both studies recruited participants from the community who responded to the request for research participants (analogue clients) rather than actual clients in therapy. Though in many ways the differences between such groups are negligible, there is at least one key difference. The characteristics of people who seek therapy for a broader array of problems and concerns—people who may or may not be open to forgiving their offenders—are likely to be quite different from people volunteering for an explicit forgiveness treatment. This leaves several important questions unanswered. How many clients actually need forgiveness interventions, and how many would actually want to forgive their offenders? Which clients would be more willing to overtly discuss forgiveness with their therapists? If forgiveness interventions were used, how effective would they be in such a setting? Answering these questions can help therapists to better understand whether and when explicit forgiveness interventions are appropriate for their clients.

The Forgiveness in Therapy Project

In light of these questions and concerns, we conducted an investigation with two main goals. The first goal was description of the experience of hurts and forgiveness in therapy. Specifically, we were interested in the percentage of clients who (a) could recall a time when they were hurt and struggled to forgive the perpetrator, (b) wanted to forgive the perpetrator, and (c) either had talked or wanted to talk specifically about forgiveness in therapy. The second goal of this investigation was prediction. Specifically, we examined whether the use of forgiveness in therapy predicted overall symptom improvement. First, we investigated the characteristics that predicted clients’ desires to discuss forgiveness with their therapists. We examined three separate trait characteristics and one state characteristic that have been identified as likely predictors of forgiveness (Wade & Worthington, 2003). The trait characteristics were religious commitment, self-esteem, and trait forgiveness (the willingness to forgive across time and situations).
Higher levels of each of these characteristics were anticipated to predict a greater willingness to talk about forgiveness. The state characteristic was the degree of unforgiveness. More unforgiveness for the reported offense was expected to be related to a greater desire to talk about forgiveness. Second, we used these answers to explore the most important question: Is the use of forgiveness interventions related to overall symptom improvement?

Participants, Procedures, and Measures

Clients (N = 59) from three university counseling centers in the East (n = 20), South (n = 17), and Midwest (n = 22) regions of the United States participated in this study. Participants were predominantly Caucasian (89%) and female (90%), ranging in age from 18 to 57 years (M = 23.5, SD = 7.3). The majority of participants (66%) reported Christian religious affiliation, with another 17% reporting no affiliation and 17% reporting other affiliations, including Buddhist, Jewish, Muslim, and Wiccan.

Although the sample was small compared with the total number of clients actively in therapy at these centers, the actual participation rate was much higher. Approximately 50% of the clients at each center who were offered the opportunity to participate agreed and completed questionnaires.

In collaboration with Nathaniel G. Wade, participating centers chose a 2-week window within which to collect data. Clients who had already completed initial screening or intake assessments and had started individual therapy were eligible for the study. Clients learned about the study from the receptionist at the time they checked in for their individual appointments. They received a consent form and a short questionnaire that they completed anonymously and returned in separate sealed envelopes to drop-off locations determined by the individual centers. Nathaniel G. Wade then either received the sealed envelopes in the mail or picked them up. The two-page questionnaire included demographic questions, measures of religious commitment, presenting problems, symptom improvement, self-esteem, trait forgiveness, state unforgiveness, and questions about the needs and preferences to receive forgiveness interventions. Descriptive statistics for these measures are reported in Table 1.

Forgiveness-related items. We measured clients’ needs and preferences for forgiveness interventions with a series of questions. After reading our definition of forgiveness, clients responded to the following question: “Can you think of a time when you forgave someone or something?” If they answered positively, they were asked to rate their degree of change on a 5-point Likert scale (ranging from 1 = definitely no to 5 = definitely yes): (a) “Is forgiving this person something that you would like to talk about in counseling?”, (b) “Have you talked specifically about forgiveness with your counselor?”, and (c) “Do you think that your counselor would be open to talking with you about forgiveness (you forgiving others)?”

Overall symptom improvement. Participants rated their symptom improvement with the Temple Scale of Relative Change (Sloane, Staples, Cristol, Yorkston, & Whipple, 1975). This scale uses a two-step procedure to measure the degree of change in presenting symptoms clients experience. First, clients listed up to three of their most troubling symptoms at the time they entered therapy (retrospectively). Second, they rated the degree of change that they experienced in those symptoms since starting therapy on a 12-point Likert scale (from 0 = very much worse to 6 = no change to 12 = very much better). Previous psychotherapy outcome research has used this scale, which has been significantly and positively correlated with therapists’ and observers’ ratings of client change (Sloane et al., 1975).

Religious commitment. Religious commitment was measured with a one-item scale (“How committed are you to your religion?”) (ranging from 0 = not at all to 5 = totally). This scale has shown strong correlations with an established scale of religious commitment (Worthington et al., 2003).

Self-esteem. Self-esteem was measured with the 10-item Rosenberg Self-Esteem Scale (Rosenberg, 1965). Wylie (1989) reported alphas ranging from .74 to .87 and test–retest reliabilities ranging from .63 to .91. For validity, Rosenberg Self-Esteem scores have been linked negatively to depressive affect, anxiety, psychosomatic symptoms, and interpersonal insecurity (Wylie, 1989). The internal consistency in the current sample was .88.

Trait forgiveness. Trait forgiveness (the propensity to forgive across time and situations) was measured with the Trait Forgiveness Scale (Berry, Worthington, O’Connor, Parrott, & Wade, 2005). The Trait Forgiveness Scale is a 10-item self-report scale that has shown strong reliability (Cronbach’s alpha of .78–.80; 8-week test–retest = .78), correlates with other measures of forgiveness as a trait, and is related to personality traits in hypothesized directions. The internal consistency in the current sample was .81.

State unforgiveness. State unforgiveness (the degree of unforgiveness toward a particular offender) was measured with the Transgression Related Interpersonal Motivations Inventory (TRIM; McCullough et al., 1998), which operationalizes unforgiveness as the desire (or motivation) to seek revenge against and to avoid an offender. The TRIM has strong reliability (Cronbach’s alphas of .86–.93; 8-week test–retest = .31) and has been related to apology, rumination, and empathy in hypothesized directions. The internal consistency in the current sample was .91.

Table 1

<table>
<thead>
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<th>Measure</th>
<th>N</th>
<th>M</th>
<th>SD</th>
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<td>15–48</td>
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<tr>
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<td>27.3</td>
<td>5.3</td>
<td>14–38</td>
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<tr>
<td>Symptom improvement</td>
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<td>8.5</td>
<td>1.2</td>
<td>6–11</td>
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Outcomes

Therapy characteristics. We examined the characteristics of therapy to determine what clients were seeking help for and what changes they had experienced in their presenting problems. Participants reported that they had attended an average of 7.4 sessions with their current therapist (SD = 8.4; range from 1 to 4). They reported a range of presenting problems typical to university counseling center settings: anxiety (56%), depression (56%), and...
of time in therapy and symptom improvement. As expected, this came research, we calculated the correlation between the amount of actual talking about forgiveness explicitly in therapy. Of the 52 participants who indicated that they had experienced a significant hurt, 75% indicated a desire to forgive the offender (e.g., a friend "turned her back on me when I needed her most"), with disassociations (active or passive rejection) accounting for 19% of the offenses and assault or abuse accounting for 12%. The rest of the offenses (27%) were made up of teasing, criticisms, and hurts suffered by people close to the clients. These percentages are comparable with past forgiveness research on offenses experienced by nonclinical samples of college students (e.g., Wade & Worthington, 2003).

We compared the degree of unforgiveness in these four categories (betrayals, disassociations, assault–abuse, and other) with an analysis of covariance, controlling for the participants’ level of trait forgivingness. Not surprisingly, the groups were significantly different, F(3, 52) = 5.49, p < .01, with participants reporting the greatest degree of unforgiveness for assaults or abuse. The other categories were not significantly different from one another. As a result of this difference, we compared the percentages of participants who desired to forgive the offender and who wanted to talk about forgiveness in therapy across the different offense categories. Despite differences in the amount of unforgiveness for the offender, participants experiencing assault and abuse wanted to forgive their offenders and wanted to talk about forgiveness with the same degree of frequency as participants suffering other (perhaps milder) injuries.

Forgiveness in therapy. Finally, we explored the clients’ preferences to discuss these hurts with their therapists and the results of actually talking about forgiveness explicitly in therapy. Of the 52 participants who indicated that they had experienced a significant hurt, 75% indicated a desire to forgive the offender (e.g., because they “want to continue the relationship and move on”). Over one fifth of these clients (21%) stated that they did not want to forgive (e.g., because “he doesn’t deserve feelings of goodwill”), and 4% were ambivalent about it (reporting that they both wanted and did not want to forgive). Participants also rated their degree of agreement with several statements about forgiveness in therapy. All but 1 client believed their therapist would be open to talking about forgiveness (M = 4.5, SD = 0.7).

In contrast, there was much more variability in how much clients desired to talk about forgiveness with their therapists (M = 3.2, SD = 1.3). As a result, we conducted a stepwise multiple regression to determine which factors predicted the desire to talk about forgiveness in therapy (see Table 2). Dispositional factors (self-esteem, trait forgiveness, and religious commitment) as well as situational factors (number of sessions with the current therapist and state unforgiveness for the specific offense) were used as potential predictors. The results of the stepwise analysis indicated that both greater self-esteem and more sessions with the current therapist each uniquely contributed to the prediction of the desire to talk about forgiveness. Degree of state unforgiveness, trait forgiveness, and religious commitment were not significant predictors. Thus, contrary to expectations, none of these variables were related to the desire to talk about forgiveness. Of particular note is the lack of relationship between the clients’ religious commitment and desire to talk about forgiveness. Whether clients were committed to a religion or not was unrelated to their desires to discuss forgiveness.

Finally, to directly examine the relationship between the use of forgiveness interventions and symptom improvement, we conducted a hierarchical multiple regression. Because the number of sessions that a client had with their current therapist was significantly related to symptom improvement, we entered this in the first step of the regression. The degree to which clients agreed that they had talked about forgiveness with their therapists was entered in Step 2. As Table 3 indicates, talking explicitly about forgiveness (as perceived by clients) was significantly related to symptom improvement, above and beyond the number of sessions a client had completed. This is a meaningful result as it would seem to indicate that not only does talking about forgiveness help clients to cope with their specific hurts but it appears to be related to increased symptom improvement as well.

Two primary limitations with the current project should be noted. First, the sample that these data are based on is a select group of homogeneous clients in therapy at university counseling centers (i.e., mostly White, female, and Christian). Also, as a result of being college students, these clients have unique characteristics, such as younger age, moderate intellectual functioning, advanced educational backgrounds, and potentially greater financial resources that are not necessarily reflected in all general practice settings. Thus, because of the restrictions of this sample, therapists should be cautious about generalizing from this information to other groups of clients. Second, the design of the current study is correlational and quasi-experimental. Therefore, it would be inap-

<table>
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<th>Variables entered</th>
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<th>$\Delta R^2$</th>
<th>$B$</th>
<th>$SE$</th>
<th>$\beta$</th>
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<td>.12*</td>
<td>.055</td>
<td>.022</td>
<td>.342**</td>
</tr>
<tr>
<td>Step 2</td>
<td>Self-esteem</td>
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<td>.08*</td>
<td>.073</td>
<td>.034</td>
<td>.286*</td>
</tr>
</tbody>
</table>

Note. Variables not entered included trait forgivingness, state unforgiveness, and religious commitment.

* $p < .05$. ** $p < .01$. 637 HELPING CLIENTS HEAL
propriate to conclude from these results that causation was established. Although this project provides some important implications for therapy, they must be considered in light of the correlational design.

Implications for Practice

For Clients Who Have Been Hurt, Talking About Forgiveness May Provide Greater Symptom Improvement

This is potentially the most important finding of the current project. It appears that explicitly discussing forgiveness may result in better outcomes for clients, even general outcomes such as improvement in presenting problems (such as depression, anxiety, or school-related problems that were of central concern to our sample). Why might specifically addressing forgiveness help with general symptom improvement? First, this relationship might work directly. Perhaps, for those clients who have experienced significant hurts, the hurt itself is contributing to or causing the presenting problem. It is not a stretch to imagine a client coming to therapy for depression or anxiety with little or no awareness that an earlier hurt or traumatic event may be triggering this problem. In these situations, then, specifically addressing forgiveness enables the clients to work through and resolve the core concern that then directly alleviates the presenting symptoms. On the other hand, this relationship might work indirectly. For those with significant hurts in their past, experiencing additional emotional or relational problems might tax their coping resources, making it difficult to manage the current problem. Perhaps by talking about the hurt and exploring forgiveness, the clients are able to essentially manage the extra stressor and have more energy and ability to cope with the presenting concern (and as a result alleviate those symptoms).

Although these are reasonable explanations, they do not explain why discussing forgiveness specifically might be more beneficial than simply addressing the hurt. In fact, past outcome studies have not clearly shown that interventions designed to promote forgiveness are any different in efficacy than interventions that have been used for decades by therapists to reduce anger or fear, to cope with sadness and disappointment, or to process confusing emotions (Wade, Worthington, & Haake, 2005). However, results from the current project indicate that discussing forgiveness might be more helpful for clients who have been hurt, alleviating general symptoms more effectively than does therapy that does not specifically address forgiveness.

So, what specifically about discussing forgiveness helps with general symptom reduction? One possible reason is that promoting forgiveness is something more than just reducing anger or unforgiveness (Wade & Worthington, 2003). Perhaps, the something more is the promotion of positive, prosocial (or even virtuous; see Peterson & Seligman, 2004) experiences and outcomes. The addition of promoting strengths rather than only addressing weaknesses in therapy may be a key for helping people not only with specific hurts but also with general symptom reduction.

To the degree that these results hold true for a broader sample of clients, they have serious implications for therapists. Therapists might be able to provide more effective therapy for clients who have been injured in significant ways by explicitly discussing forgiveness. In these situations, not only would it be appropriate to help clients move toward forgiveness but therapeutically indicated as well. However, the diversity of people who might encounter hurtful or traumatic events makes any formulas or blanket statements inadequate and potentially damaging. Although forgiveness may be something that can help those clients who have a hurt deal with their presenting problems, therapists remain dependent on their clinical judgment for the specifics of who, what, and when regarding forgiveness.

Clients Are Very Likely to Have Experienced Hurts That They Have Not Forgiven

It is no surprise that a high percentage of clients in individual psychotherapy report having experienced a significant hurt. For many clients these hurts (and the emotional and mental problems they cause) are the very reason for seeking help. Most psychotherapists are well equipped to deal with the injuries and abuses that clients bring to therapy and to help clients process the pain, understand and cope with the anger and fear, and move toward healing. Furthermore, experienced clinicians are not surprised that clients who have suffered assault or abuse are more likely to experience higher degrees of unforgiveness (operationalized as desires for revenge against and avoidance of the offender). In these situations, unforgiveness may help protect clients by motivating them to stay away from the people who have injured them. Explicitly promoting forgiveness in these situations may not be clinically indicated (Lamb, 2002). However, our results indicate that participants suffering from these more severe offenses are just as likely to desire forgiveness and want to talk about it in therapy as participants suffering from other offenses. Of note here is that our results are based on a small sample of specific clients. These findings would require further validation from larger samples of participants coping with assaults and abuse before clinical decisions should be based on them. Therefore, helping clients to cope with unforgiveness, whether by explicitly promoting forgiveness, encouraging the pursuit of justice, experiencing personal empowerment achieved through a process of grief and acceptance, or a combination of these, needs to be carefully considered by each clinician.

More surprising than the high percentage of clients reporting injuries is the high percentage of our client sample who desired to forgive their offenders. Although it was not unanimous, a large portion of the sample (75%) indicated that they would like to forgive their offenders, even when forgiveness was defined as “replacing the bitter, angry feelings of vengefulness that often
result from a hurt with positive feelings of goodwill toward the person who hurt you.” This high endorsement of forgiveness might reflect some of the offender and offense characteristics. With an overwhelming majority (93%) of offenders being in intimate relationships with the client (partners, family, and friends) and only a minority of offenses being very severe forms of assault or abuse (12%), forgiveness might be an understandable goal. Most likely, clients either are or want to remain in relationships with their offenders. Perhaps they see forgiveness as the primary (or only) way to cope with the hurt while maintaining the relationship.

The high percentage of endorsement for forgiveness might also result from the largely Christian sample. The Christian religion is well known for the importance that it places on forgiveness, even unqualified forgiveness of enemies (Payne, Bergin, & Loftus, 1992). This ethos may be reflected in the clients’ reported desires to forgive their offenders; perhaps their reported desires to forgive stem more from feelings of moral obligation than from a simple personal desire. These sentiments might also be present in clients committed to other religions that teach the importance of forgiveness. However, in our analyses, religious commitment was not significantly associated with the desire to talk about forgiveness in therapy. If being committed to one’s religion was influencing the desire to forgive, these variables should have been related. This suggests a need for further investigation into the effect of religious commitment on the desire to forgive.

Without exploring these issues with individual clients (religious or not), it is difficult for the therapist to determine whether religious belief or commitment is influencing a client’s desire to forgive. Therefore, clinicians should be aware of their clients’ religious affiliations and commitment levels and the impact that these have on their desires to forgive (Richards & Bergin, 1997; Worthington et al., 2003). Assessing for these variables and inviting clients to discuss the role that religion might play in their recovery can avoid unnecessary complications or further victimization. These sentiments might also be present in clients committed to other religions that teach the importance of forgiveness.

**Ambivalence About Forgiving or Even Talking About a Hurt in Therapy May Be High**

Although in our sample a large majority reported hurts that they wanted to forgive, much greater variation was found in the desire to address these hurts in therapy. Thus, a significant portion of clients reported both the desire to forgive and the reluctance to talk about it in therapy. This suggests that clients may be ambivalent about dealing with their hurt. Being attuned to this ambivalence is important for genuine therapeutic work to occur. Therapists may need to initially address this ambivalence and help their clients explore the many possible reasons for it. Additionally, therapists may need to be aware of their own ambivalence about the topic of forgiveness. As discussed in the previous section, religion and implied moral imperatives may make many therapists reluctant to address forgiveness directly with their clients. In many situations, this may be the most therapeutic approach. However, other situations in which clients want assistance forgiving an offender might dictate a different response more open to forgiveness.

General ambivalence about dealing with an injury and thinking about forgiveness certainly makes sense. Forgiveness, as we understand it, can be a complex process. As many have argued, forgiveness is not condoning a hurt, pardoning an interpersonal offense, or letting an offender off the hook. It is also not the same as reconciliation or restoring a relationship with the offender (Worthington & Drinkard, 2000). It is not even the same as reducing unforgiveness, whether defined as the desire for revenge and avoidance or as an emotional complex made up of bitterness and hatred (Worthington & Wade, 1999). Forgiveness is the replacement of unforgiveness with positive, other-oriented emotions such as compassion, empathic concern, and benevolence. This is a tall order for many clients who have been injured. It takes at least a moderate degree of ego strength, maturity, and awareness to feel compassion toward offenders while retaining boundaries strong enough to hold them accountable for their actions. In many situations it may take even more emotional strength to consider reconciliation, make a wise choice, and follow through with it.

Under these conditions, it is no wonder that many clients (and their therapists) are ambivalent about the process of forgiveness (Lamb & Murphy, 2002).

Because of the ambivalence that is likely to surround forgiveness, it is crucial to assess clients’ goals regarding their injuries. Clients have many options for dealing with offenses; forgiveness is only one strategy (Wade & Worthington, 2003). Assessing the client’s desires and needs regarding forgiveness can help to clarify therapeutic goals, reduce ambivalence about dealing with the offenses, and lead to some surprising information relevant to other aspects of the therapeutic process. One of us experienced a good example of the last aspect with a client who was struggling with abuse and neglect in past relationships. During the 10th session, after an inquiry about the client’s desire to forgive, the client revealed the importance of her anger and bitterness toward those who had hurt her by claiming that she would have nothing to live for if she gave up her anger. This brief assessment about her injuries and desires to forgive led to a fruitful discussion about the meaning in her life, the role that holding onto the past played for her, and alternative ways that she might find meaning, healing, and growth.

Another useful strategy for dealing with client ambivalence is to educate clients about forgiveness and help them clarify their own ideas and conceptions. Used colloquially, forgiveness has many nuanced meanings, creating a rather ambiguous concept. The therapist can offer a clear definition and description of forgiveness, educate the client about the ways to separate internal forgiveness from interpersonal reconciliation, and explain how these goals might be achieved in therapy. Several resources already exist for helping clients to think about and pursue forgiveness (Enright, 2001; Luskin, 2001; Worthington, 2001). Each are appropriate for clients to read independently, but therapists interested in explicitly promoting forgiveness will find any one of these to be a useful reference. (For a review of intervention methods, see Wade & Worthington, 2005).

**Explicit Forgiveness Interventions May Be Desired by Many (But Not All) Clients**

For a variety of reasons, therapists are often hesitant to explicitly discuss forgiveness and so may choose instead to help their clients cope with their injuries in other ways. However, our data suggest that many, although not all, clients may want to explicitly discuss
forgiveness. How can a therapist know which clients are more likely to desire forgiveness and most benefit from it (and conversely, those who would not desire it or are less likely to benefit)? If this could be determined, therapists would be able to discuss and promote forgiveness in a way that would be more sensitive to individual clients. The data from our project suggest several guidelines.

First, therapists should be skeptical of several factors that were not related to the desire to talk about forgiveness, although these may seem counterintuitive. The clients’ religious commitment, trait forgivingness, and degree of unforgiveness for the specific offense were not significantly related to the desire to talk about forgiveness. Although these factors may be crucial in understanding and helping clients deal with hurts, they do not seem to provide reliable information about the clients’ desires to discuss and work toward forgiveness.

Second, therapists should pay attention to the length of therapy and the level of trust in the therapeutic alliance. Clients in our sample who had been in therapy longer were more willing to talk explicitly about forgiveness. This could be a result of several factors. For example, more sessions might indicate a greater level of comfort with and trust in the therapist and a stronger therapeutic relationship. With greater trust and a stronger therapeutic alliance, clients might be more confident that their therapists will support them in their injuries, rather than shame them for their lack of forgiveness or judgmentally instruct them to forgive. Helping clients identify and talk about their level of trust can provide an assessment of their potential willingness to discuss forgiveness, and it can also be a powerful intervention itself for increasing trust.

Thus, allowing the therapeutic relationship to develop before explicitly exploring forgiveness may be prudent. The willingness to explore forgiveness also might be related to presenting concerns and pressing problems. Perhaps clients who have been in therapy longer have already addressed the more pressing concerns and so might more willing to explore the past injury. Whatever the underlying mechanism, the length of therapy appears to be an important factor in clients’ willingness to discuss forgiveness. This may have serious implications for therapists practicing in particularly short-term environments, in which rapid triage and primary symptom reduction are the main goals. In these settings, it might be more beneficial to refer to longer term treatments or provide self-help literature on forgiving.

Third, therapists interested in providing forgiveness interventions to interested clients should assess for the client’s level of self-esteem or ego strength. In our sample, clients who had more confidence in themselves and more appreciation for their own strengths and abilities were more willing to entertain the idea of forgiveness. This indicates that self-esteem, self-confidence, or perhaps even ego strength in clients may be an important prerequisite for discussing forgiveness. (This relationship with self-esteem may not be the same when discussing forgiveness of oneself; see Holmgren, 2002). This relationship also indicates that discussing forgiveness might be more effective after concerns related to self-esteem are addressed. Therapists should carefully consider their clients’ self-esteem and may decide to intervene in that area of the clients’ functioning prior to (or concomitant with) using interventions to promote forgiveness.


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**Call for Nominations**

The Publications and Communications (P&C) Board has opened nominations for the editorships of *Behavioral Neuroscience, JEP: Applied, JEP: General, Neuropsychology, Psychological Methods,* and *Psychology and Aging* for the years 2008–2013. John F. Disterhoft, PhD; Phillip L. Ackerman, PhD; D. Stephen Lindsay, PhD; James T. Becker, PhD; Stephen G. West, PhD; and Rose T. Zacks, PhD, respectively, are the incumbent editors.

Candidates should be members of APA and should be available to start receiving manuscripts in early 2007 to prepare for issues published in 2008. Please note that the P&C Board encourages participation by members of underrepresented groups in the publication process and would particularly welcome such nominees. Self-nominations also are encouraged.

Search chairs have been appointed as follows:

- **Behavioral Neuroscience:** Linda P. Spear, PhD, and J. Gilbert Benedict, PhD
- **JEP: Applied:** William C. Howell, PhD
- **JEP: General:** Peter A. Ornstein, PhD
- **Neuropsychology:** Susan H. McDaniel, PhD, and Robert G. Frank, PhD
- **Psychological Methods:** Mark Appelbaum, PhD
- **Psychology and Aging:** David C. Funder, PhD, and Leah L. Light, PhD

Candidates should be nominated by accessing APA’s EditorQuest site on the Web. Using your Web browser, go to http://editorquest.apa.org. On the Home menu on the left, find Guests. Next, click on the link “Submit a Nomination,” enter your nominee’s information, and click “Submit.” Prepared statements of one page or less in support of a nominee can also be submitted by e-mail to Karen Sellman, P&C Board Search Liaison, at ksellman@apa.org.

Deadline for accepting nominations is **January 20, 2006**, when reviews will begin.