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Applying forgiveness therapy to survivors of intimate partner violence (IPV)

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Abstract

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APPLYING FORGIVENESS THERAPY TO SURVIVORS OF INTIMATE
PARTNER VIOLENCE (IPV)

A Research Paper
Submitted
in Partial Fulfillment
of the Requirements for the Degree
Masters of Arts

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Abstract

Twenty-five percent of women in the United States will report some form of intimate partner violence (IPV) within their lifetimes (Mac, Ferron, & Crosby, 2009). At these rates, IPV has become an epidemic, touching the lives of most people. The effects of IPV on victim's physical and psychological health may be severe and chronic (Weaver & Clum, 1995). Finding potent therapy approaches with this population is essential. The author of this paper proposes forgiveness therapy as an approach worthy of further investigation. This paper focuses on explaining what forgiveness is and is not, describes common sequelae of IPV, reviews Enright's model of forgiveness therapy, and a brief literature review of research concerning forgiveness therapy and its application to participants who have endured deep hurts.

Applying Forgiveness Therapy to Survivors of Intimate Partner Violence (IPV)

Intimate partner violence is a global phenomenon affecting millions of women each year. In the United States alone, 25% of women will report some form of intimate partner violence within their lifetimes (Macy, Ferron, & Crosby, 2009). Based on population surveys conducted within the United States and Canada, approximately ten to 15% of women reported intimate partner violence (IPV) within a year (Campbell, 2002). At these rates, intimate partner violence has become an epidemic, touching the lives, either directly or tangentially, of most people. Based on research, the effects of intimate partner violence on victims' physical and psychological health may be severe and chronic (Weaver & Clum, 1995). The following proposal focuses primarily on defining intimate partner violence and forgiveness therapy, describing common sequelae of intimate partner violence, and reviewing Enright's model of forgiveness. In addition, it provides a brief literature review on forgiveness therapy approaches applied to populations which have endured trauma and relational disturbances and presents the methodology of the proposed study. The purpose of this study is to analyze the relationship between forgiveness education and intimate partner violence survivors' anger and hope levels, along with their overall understanding of forgiveness. It is hypothesized survivors who participate in a forgiveness education workshop, compared to controls, will develop a greater understanding of forgiveness, increase their propensity to forgive past abusers, decrease their anger levels, and will increase their levels of hope.

Defining Terms and Models

Intimate Partner Violence (IPV)

Before reviewing the effects of intimate partner violence on victims and survivors, it is first necessary to decrease potential confusion by defining several terms and variables. Traditionally, IPV has been called *spouse abuse*, *marital abuse*, *domestic violence*, and *marital violence* (Barnett, Miller-Perrin, & Perrin, 2005). These terms are outdated and profoundly limit the scope of what types of relationships are considered. For example, the terms limit intimate relationships to couples who are married and, presumably, heterosexual. Based on the relationships existing in today's society, it is appropriate to adopt a term more accepting of relationship diversity. That term is *intimate partner violence*, which is defined as: The repeated experience of forceful actions (including physical assault, threats of physical harm, rape, psychological abuse, stalking, coercion, intimidation, and deprivation of needs) (Campbell, 2002) between an actor, the one committing the violence, and his or her current or former intimate partner, who is the victim and recipient of the violence. This definition is broad and includes couples currently or previously dating; cohabitating, married, or divorced couples; couples who had children together but never were in a committed or defined relationship; and gay, lesbian, bisexual, and transgendered couples (Barnett et al.). An analysis of all forms of IPV is beyond the scope of this paper,

which focuses primarily on physical, sexual, and psychological abuse against female, heterosexual victims.

Forgiveness

Because much of the opposition raised against forgiveness therapy is based on misunderstanding what it means to forgive, it is important to first define forgiveness, what it is and what it is not, before discussing it as a therapy approach. Although there is no one definition favored by all researchers (Freedman, Enright, & Knutson, 2005), one widely accepted is Enright and Fitzgibbon's (2000):

People, upon rationally determining that they have been unfairly treated, forgive when they willfully abandon resentment and related responses (to which they have a right) and endeavor to respond to the wrongdoer based on the moral principle of beneficence, which may include compassion, unconditional worth, generosity, and moral love (to which the wrongdoer, by nature of the hurtful act or acts, has no right). p. 29

When broken down, this definition contains four core conditions (Holmgren, 1993). First, an individual is injured (physically, emotionally, socially, psychologically, etc.). According to Enright and the Human Development Study Group (1991), this injury must be deep and long-lasting. It is not a trivial annoyance. Second, a person or persons are responsible for the injury regardless of intentions (Enright & the Human Development Study Group). Third, the injured person (the forgiver) must *willfully* change one's negativity toward the offender by eliminating resentment, desire for revenge, and negative affect

(Holmgren). A victim, therefore, actively chooses to forgive (North, 1987) and does not first require an apology, although it does make forgiving easier (Enright and the Human Development Group). Forgiveness is completed when the forgiver replaces the negative elements with accepting the offender's humanity and value as a person (Holmgren).

Forgiveness should not be confused with forgetting, being selfish, pardoning, condoning or excusing, justifying, decreasing anger due to the passing of time, nor as a passive act (McGary, 1989; Enright & the Human Development Study Group, 1991; Freedman et al., 2005). Because forgiveness is a choice, one way among several to cope with hurt, it is an active process requiring the victim to journey through the various steps (which will be presented later) involved in the forgiveness process. Because it is active, forgiveness cannot, by definition, occur solely by the passing of time without any emotional or cognitive processing of the hurt. Saying "I forgive you" without going through the forgiveness process is not forgiveness because the victim still holds on to her or his negative emotions and resentment (Enright & the Human Development Study Group). Similar to the passing of time, forgiveness is not forgetting (McGary; Enright & the Human Development Study Group; Freedman et al.). Although time may blur the details of everyday life, the pain felt after an intense injury may still exist. Also, according to McGary, forgiveness and forgetting are "incompatible." To forgive, the victim must be aware of the injury's existence. Forgetting eliminates the

conscious awareness of the wrong and no longer allows forgiveness to be a possibility.

Forgiveness is not a selfish act (McGary, 1989; Enright & the Human Development Study Group, 1991). Although the offender does not deserve the victim's consideration, forgiveness requires the victim to try to understand the offender's circumstances and motivation for committing the hurtful act. In addition, it entails no longer viewing the offender as a monster, but as a fellow member of the human race (Freedman et al., 2005). Even if a victim is motivated to forgive purely to diminish the pain, anger, and resentment one feels, without considering the offender, one is not being selfish (McGary). Forgiving for one's own sake is a responsible way of protecting and nurturing one's mental and physical health. It can be equated to feeding oneself. To accuse a person of being selfish for eating food and drinking water is unfounded. One is merely caring for the self. In the same way, a victim is taking care of oneself. In addition, McGary argues forgiveness is not selfish not only because in the process of forgiving, no harm is inflicted upon or ill will is directed toward the offender, but also because "the reason has nothing whatsoever to do with a desire to maximize the satisfaction of his desires at the expense of others" (p. 345).

Forgiveness is not the same as pardoning the offender's behaviors (McGary, 1989; Enright & the Human Development Study Group, 1991; Freedman et al., 2005). To pardon is to not punish one as severely as one deserves even though he or she is completely responsible for the injurious behavior (McGary). Pardoning and forgiveness occur within two completely different

contexts. Forgiving occurs between the victim and the offender, while pardoning occurs within the legal system. A judge, not the victim, decides whether or not to reduce the deserved punishment (Enright & the Human Development Study Group).

Forgiveness does not justify the offender's behavior by providing rationalizations rendering the injurious action as acceptable (Enright & the Human Development Study Group, 1991). Rather, forgiveness holds the offender accountable for his actions (McGary, 1989). The victim acknowledges what the offender has done as wrong and, in turn, releases anger and resentment. Despite the victim's undeserved offering, the victim may still seek justice by, for example, pressing charges. Forgiving and seeking justice are compatible in that they may occur together and both always hold the offender accountable for his or her actions (Hill, Exline, & Cohen, 2005). In addition, because a victim who forgives acknowledges the pain inflicted, forgiveness is not equivalent to condoning or excusing (Enright & the Human Development Study Group; Freedman et al., 2005). When one condones or excuses behavior, he or she belittles the harm inflicted and deems it as inconsequential.

Most importantly, forgiveness should never be confused with reconciliation (Freedman et al., 2005). Reconciliation means to restore a relationship by getting back together. Understanding the distinction between these two concepts is particularly important in the case of intimate partner violence. A survivor may forgive her partner, by releasing her anger and resentment and hoping that her partner will cease abusive behaviors, while maintaining a safe

physical distance. A woman who forgives is by no means obligated or encouraged to return to an unsafe environment/relationship. While forgiveness only requires action by the victim, “true reconciliation” requires victim and offender participation (Enright & the Human Development Study Group). While the role of the victim is to forgive, the offender must change his or her harmful behaviors. In the case of IPV, an offender must stop emotional, physical, and sexual abuse before true reconciliation is a safe and possible option. Until then, a victim may choose to forgive from afar.

Forgiveness Therapy

Forgiveness therapy is a counseling approach in which the therapeutic goal is for the victim to consciously work toward forgiving her offender. A common forgiveness model is Enright’s, which includes 20 stages spread across four phases. Although the model appears linear, it is fluid, flexible, and incorporates the cyclical nature of injury and forgiveness processing. Because of the process’ predictable yet fluid nature, it is difficult to predict how long it will take for a victim to complete her forgiveness goal (Enright & Fitzgibbons, 2000). Also, although this approach’s ultimate goal is for the victim to forgive, the client can at any time decide for herself that forgiveness is not a desirable or appropriate option. Forgiveness is a choice and should never be pushed on her.

Enright’s Forgiveness Model

The primary goal of the first phase (uncovering phase) is to aid the victim in exploring and gaining awareness as to how the hurtful act and her reaction to the offense has affected her life (Enright & Fitzgibbons, 2000). The uncovering

phase consists of eight subunits covering common, although not universal to every situation involving forgiveness, elements worthy of clinical attention. The first unit involves identifying the various defense mechanisms the victim utilizes to protect herself. Common defenses include denial, such as denying the depth of the hurt imposed; repression of hurtful memories; and displacement, characterized by expressing one's feelings toward an unintended or innocent recipient.

Although these defenses may have been helpful immediately following the injury, it is important for the victim to retire her defenses in order to see the hurtful act for what it is and how it has impacted her (Enright, 1996). The second and third units focus specifically on acknowledging and appropriately releasing the client's anger and shame. Not all victims experience shame; however, those who do may report feeling humiliated or embarrassed by their injurer or situation (Enright, 2000).

The fourth and fifth units of the uncovering phase include discussing the victim's energy level and how her negative emotions and fixation (cognitive rehearsal) on the injury is emotionally and physically taxing (Enright, 2000).

Ultimately, the goal of these units is for the victim to understand how much of her energy is focused on her past hurt. For instance, an IPV survivor may have left an abusive relationship ten years ago; however, she may devote most of her energy toward ruminating over her ex-partner, which may negatively affect her present living conditions, such as her work performance or ability to function in a healthy,

intimate relationship. The sixth unit may not apply to all victims, but entails a discussion comparing the victim's perceived injured condition to the offender's perceived well-being. Enright maintains this discussion is only appropriate if it is first initiated by the client. Acknowledging the injury has, perhaps permanently, affected the victim and altering the client's preconceived notion that the world is fair are the seventh and final units of the uncovering phase (Enright, 2000). These tasks may once again give way to negative and intense feelings, such as anger and hopelessness. The counselor may support the client by not only acknowledging and affirming their feelings, but also by pointing to forgiveness as a viable, potent, and optional therapeutic outcome.

The primary goal of the second, decision phase, is to educate the client on forgiveness, which involves a detailed explanation on what forgiveness is, is not, and what it entails. The second goal involves having the client decide whether or not to pursue forgiveness as a therapeutic outcome (Enright & Fitzgibbons, 2000). The decision phase includes three clinical objectives. First, the client evaluates her current coping mechanisms and strategies only to come to the conclusion that her efforts to harbor resentment and seek revenge are ineffective in alleviating emotional pain. At this time, the counselor may want to discuss the forgiveness paradox (Hope, 1987). The paradox is that to allow oneself access to the necessities required for healing, one must give up one's immediate desires. That is, a victim's immediate desire for revenge and harboring resentment are the very barriers to her long-term health and well-being. This conclusion, that the old ways of responding are no longer or have never been effective, provides the cognitive

space for the client to consider forgiveness as a practical, desirable, and eventual outcome (Enright, 1996). Again, this second unit delegates a great amount of time to educating the client about what it means to forgive. The counselor also should also make it a priority to clarify the distinction between forgiveness and reconciliation, condoning, justifying, forgetting, or pardoning the offensive behavior (Freedman et al., 2005). The final unit is accomplished once the victim makes a cognitive commitment to pursuing forgiveness by ceasing to condemn or wish ill-will toward the offender (Enright & Fitzgibbons).

The overall goal of the work phase is to focus attention on the offender and restore the victim's perception of the offender as a valued human being and no longer a monster (Enright & Fitzgibbons, 2000). The first unit of four directly focuses on changing the victim's view of the offender by discussing the offender's background, context for the hurtful behavior, and his value as a fellow human being. By understanding the offender's history, the victim may begin to feel empathy and compassion toward her offender, which are the second and third work phase units (Enright, 1996). In no way does empathizing or having compassion for the offender justify the offender's behaviors or relieve him of responsibility, it merely allows the victim to see her offender in a new light and aids in promoting forgiveness. However, Enright and Fitzgibbons warn while encouraging the development of empathy, counselors must assist clients with assessing a repeat offender's trustworthiness while not encouraging vulnerability through inappropriate reconciliation.

The final work phase unit is characterized by the client's new willingness

to absorb the pain (Enright) and express beneficence. According to Enright and Fitzgibbons, for the client to bear the pain, she must accept the following: “The hurtful event happened; it is part of one’s historical record; it cannot be reversed; the person is capable of bearing the pain caused by this historical event while seeking a fair solution in the present” (p. 84). A victim who bears the pain may come to the realization that she is stronger than she originally thought, which in turn increases her self-esteem. After bearing the pain, the client may be ready to safely and appropriately express positive behaviors, thoughts, and feelings toward the offender.

The final phase, deepening phase, is characterized by the victim’s increase in positive feelings, the emergence of a new found purpose in life, and creating meaning surrounding the offensive incident (Enright & Fitzgibbons, 2000). The first of five objectives of the deepening phase is to help the victim find meaning in her experience. The victim may, for example, come to believe the painful experience increased her ability to cope with future troubles, strength, and self-respect (Enright, 1996). In addition, the victim may adjust her previous just world perspective to one that acknowledges life’s challenges and afflictions. The second objective of this phase is for the victim to consider moments when she needed to be forgiven for the wrongs she committed. By acknowledging personal wrongdoing, the client may find it easier to extend forgiveness toward the offender (Enright & Fitzgibbons). A counselor should consider connecting the victim with positive natural supports (such as friends, family, support group members, victims of similar offenses, etc.) in order to decrease her feelings of

solitariness. These connections may facilitate the development of a personal and new purpose in life. For instance, an IPV survivor may want to write a book about her experiences in order to let other IPV victims know they are not alone in their experiences. Decreasing one's sense of being alone in the world, finding new meaning, and increasing emotional, psychological, and oftentimes physical, well-being are the final stages of the forgiveness process. Before terminating counseling, the client and counselor will want to reflect on the counseling experience and forgiveness process while acknowledging the progress the client has accomplished.

Common IPV Effects

Now that terms, variables, and Enright's forgiveness model have been defined and thoroughly explained, it is imperative to provide a brief literature review of past research. Relevant areas of interest include the psychological side-effects of IPV in addition to forgiveness therapy's efficacy in treating individuals who have endured deep hurts. Survivors of IPV, oftentimes, are not freed from their abusive experiences after leaving their unhealthy relationships. Many continue to suffer from the psychological and physical aftermath, which the abuser inflicted. The following briefly describes a few of the most common psychological sequelae of IPV: PTSD, depression, and anxiety. Furthermore, anger and hopelessness will also be discussed since they are oftentimes co-morbid with these major diagnoses.

Posttraumatic Stress Disorder (PTSD)

PTSD, along with depression and anxiety, is one of the most prevalent mental health consequences experienced among IPV victims (Pico-Alfonso, Garcia-Linares, Celda-Navarro, Blasco-Ros, Echeburua, & Martinez, 2006). Diagnosis criteria require exposure either through direct involvement or witnessing of a seriously threatening and frightful event (APA, 2000). Victims of IPV are technically not exposed to a single trauma, but do experience abusive trauma continually throughout the duration of the relationship. For this reason, a less duration specific diagnosis has been suggested in order to incorporate and describe the experiences of IPV victims. This diagnosis, although not included in the DSM-IV-TR, is called *complex PTSD* (Briere & Jordan, 2004). Additional PTSD criteria are characterized by a persistent pattern of re-experiencing and avoiding past trauma and increased arousal (Goodman, Koss, & Russo, 1993). Re-experiencing may occur through flashbacks, nightmares, and somatic memories, while avoidance may include repressing the trauma from one's memory and avoiding discussing topics or engaging in activities reminiscent of the trauma (APA).

The prevalence of PTSD within IPV populations varies. In Chemtob and Carlson's (2004) study, 50% of mothers, who were survivors and had not been engaged in a violent relationship for at least six months, met the criteria for PTSD diagnosis. Nixon, Resick, and Nishith's (2004) research studying comorbid PTSD and depression found that 27% of victims seeking shelter met the criteria for PTSD only; however, 49% had depression with PTSD, suggesting that PTSD is,

more often than not, dually diagnosed with depression (Campbell, 2002; Macy et al., 2009). These findings are supported by research by Pico-Alfonso et al. (2006) where a mere two to three percent met PTSD criteria only. The majority, 35-45% met depressive symptoms only or co-morbid PTSD and depression (25-30%). In addition to depression, PTSD has also been linked increased levels of anger and reality dissociation (Chemtomb & Carlson).

Based on these links and the prevalence of other to be discussed effects, viewing victims solely through a PTSD lens, in regard to understanding abuse aftermath, is limiting (Goodman, Koss, & Russo, 1993). The bearing of IPV on the lives of women is far beyond the scope of a simple diagnosis (Briere & Jordan, 2004). Despite the prevalence of PTSD among victims, practitioners are well-advised to consider the following further effects (among others) in order to gain a more complex picture of the lives of their survivor clients.

Depression

According the DSM-IV-TR (APA, 2000), symptoms of depression include: recurrent and ongoing feelings of sadness, emptiness, and worthlessness, decreased or increased sleep and eating patterns, a lack of interest in activities that were once pleasurable, feeling tired, restless, or slowed down, and suicidal ideation. As previously stated, depression is one of the most prevalent effects of IPV and is oftentimes found comorbid with PTSD (Campbell, 2002; Nixon et al., 2004; Pico-Alfonso et al., 2006). Nearly 80% of IPV survivors experience some degree of significant depression, regardless of a PTSD diagnosis (Wolkenstein & Serman, 1998). Pico-Alfonso et al.'s research provides slightly lower rates of

depression: Approximately 70% of women experienced varying degrees of depression ranging from mild (36% for physically and psychologically abused women and 36.4% for only psychologically abused women) to severe (17.3% for physically and psychologically abused and approximately five percent for only psychologically abused).

Rates of depression alone (not diagnosed with PTSD) are highly variable. While only five percent of victims met the criteria for Major Depressive Disorder alone in Nixon et al.'s (2004) study, an average of approximately 40% of IPV survivors had many symptoms of depression within Pico-Alfonso et al.'s (2006) research. This discrepancy may be easy to explain. While the first study only included victims who met the full criteria for an MDD diagnosis, the latter included those with any number of depressive symptoms. Therefore, the first study's researchers had more exclusive parameters for inclusion and limited their numbers by excluding those with only a few depressive symptoms.

Researchers have also studied the relationship between depression and numerous other variables. As previously mentioned, Pico-Alfonso et al. (2006) studied the different types of abuse experienced by IPV victims and their levels of depression. Specifically, they compared depression levels between victims who experienced both psychological and physical abuse to those who only experienced psychological abuse. Results indicated that both types of survivors' experiences are significantly related to levels of depression. No significant differences between the two types existed among survivors who only met the criteria for depression. On the other hand, depressive symptoms were significantly more

severe among co-morbid depression and PTSD victims who had been both physically and psychologically abused.

Numerous other researchers have also studied how depression levels change during the transition from a help-seeking victim to a survivor status (Lewis et al., 2006; Campbell, 2002; Sullivan & Davidson, 1995). Although some women may struggle with depression prior to entering an abusive relationship, the experience and repeated exposure to abuse may exacerbate the severity of those with prior depression and may be initiated within those who have no depression history (Campbell). Understandably, women entering shelters oftentimes report significantly high levels of depression (Lewis et al.). Research by Campbell et al. (1995) conducted a longitudinal study on depression levels of women who had left the shelters and maintained a survivor status by not returning to an abusive relationship. Concurrent with Campbell (2002), depression levels tend to decrease significantly with the passing of time and distancing from violent relationships.

According to Campbell et al. (1995), results indicated a significant improvement in depression after ten weeks away from the shelter as a survivor. Initially, only 17% experienced no symptoms of depression. At the ten week follow-up half of the survivors no longer maintained symptoms. Their improvement slightly increased by one percent and was then maintained as measured by a follow-up assessment occurring six months later (almost nine months since leaving the shelter). The passing of time and distance from violence appears to be significantly related to improved mental health. Although encouraging, it is clear time does not seem to heal all wounds. At the six month

follow-up, 49% of survivors maintained depressive symptoms ranging from mild (23%), to moderate (14%), and severe (12%).

Anxiety

Like depression, nearly 80% of IPV victims experience anxiety and sometimes meet criteria for panic disorder and generalized anxiety disorder (Wolkenstein & Serman, 1998). Anxiety symptoms often endured by victims include: panic attacks, excessive worry, persistent anxiety, fearfulness, and hyperarousal (APA, 2000). Anxiety increases as a victim's expectation of violence increases (Goodman et al., 1993). They may feel as if they are walking on pins and needles. Survivors may also experience anxiety especially when something in a safe environment reminds the victim of her past abuse. Anxiety could be sparked by an unlimited amount of reminders including smells, sounds, objects, sayings, and physical features. Due to their anxiety, IPV victims and survivors may also struggle with eating and sleep disorders, hypervigilance, and with being easily frightened (Goodman et al.).

According to Briere and Jordan (2004), anxiety severity is related to numerous factors, such as the intensity of the abuse, how often the abuse occurred, the length of the violent relationship, and the time since the abuse discontinued. In addition, mothers who saw how their children's witnessing and/or co-victimization of IPV negatively impacted the children's mental health self-reported high levels of anxiety and worry concerning their children's mental health (Wittenberg et al., 2007). Contrary to Briere and Johnson, Fisher and Regan's (2006) research indicated no significant relationship between abuse

frequency and anxiety levels. They also found that anxiety is related to all types of abuse. In addition, the prevalence rates of anxiety are similar across each type. For example, in general, victims who were only psychologically abused have similar rates and levels of anxiety as those who only experienced physical abuse.

Anger and Hopelessness

Victims and survivors of IPV experience numerous feelings throughout the period of abuse and the recovery period. These feelings may include: indignity, reliance, fault, a sense of responsibility, fear of losing their minds, insignificance, irritation (Wolkenstein & Sterman, 1998), decreased self-worth (Wolkenstein & Sterman,; Briere & Jordan, 2004; Lewis et al., 2006), helplessness (Wittenberg et al., 2007; Wolkenstein & Sterman), loneliness, fatigue (Wittenberg et al.), and fear (Wittenberg et al.; Wolkenstein & Sterman). Above all, these numerous feelings oftentimes lead to deep anger (Taft et al., 2007; Wittenberg et al.; Wolkenstein & Sterman), despair, and hopelessness (Briere & Jordan; Wolkenstein & Sterman). Anger is most often directed toward their offenders and is sometimes, inappropriately, directed toward the victims. The victim may feel despair and hopelessness in a variety of ways, including her ability to develop healthy relationships, stand on her own, parent, etc. Due to the common experience of these intense emotions, it is unsurprising that suicidal ideation and behaviors, along with homicide against offenders, are significantly associated with IPV (Campbell, 2002; Campbell & Soeken, 1999; Macy et al., 2009; Pico-Alfonso et al., 2006).

Posttraumatic stress disorder, anxiety, depression, anger, and hopelessness

are only a few of the most severe outcomes of intimate partner violence. Unfortunately, a comprehensive analysis of the negative effects of IPV on survivors' physical and mental health would be quite lengthy. The current research utilizes hope and anger levels, along with forgiveness propensity and knowledge of forgiveness, as the primary variables determining whether, in this case, an intensive psycho-educational workshop focusing on forgiveness is efficacious in its application to IPV survivors. Anxiety, PTSD, and depression are not directly measured due to the researcher's inability to determine if these diagnoses pre-existed prior to the occurrence of IPV. Before presenting the research's methodology, the following provides a brief literature review on forgiveness therapy and its application to individuals with a variety of concerns.

Treating Psychological Symptoms

Although forgiveness therapy is a relatively young counseling approach, it has been utilized with numerous populations including: postabortion men (Coyle & Enright, 1997), elderly women (Hebl & Enright, 1993), incest survivors (Freedman & Enright, 1996), married (Gordon, Hughes, Tomcik, Dixon, & Litzinger, 2009; McNulty, 2008) and divorced couples (Rye, Pargament, Pan, Yingling, Shogren, & Ito, 2005), women (Lawler-Row & Reed, 2008), and families (DiBlasio, 1998; Worthington, 1998; Murray, 2002). To the author's knowledge, only one empirical study has been conducted researching forgiveness therapy's efficacy at reducing psychological symptoms among IPV victims who endured emotional abuse (Reed & Enright, 2006). The following provides a brief review of empirical studies analyzing the relationship between forgiveness

therapy and psychological health.

Hebl and Enright's (1993) study included 24 elderly women over the age of 65 who were open to exploring forgiveness. The research participants were randomly assigned to either an experimental or control condition. The experimental members participated in group sessions lasting for eight weeks. Each week, the participants learned and discussed the different stages of the process model of forgiveness and were encouraged to apply each phase to their personal hurts. The control members also participated in eight weekly sessions; however, they discussed random and unrelated social issues. Forgiveness was never discussed among the control members. Results indicated members from the control and experimental groups showed improvements in their depression and anxiety levels; however, members from the experimental group reported significantly less resentment, anger, and negative views toward their offenders compared to members of the control group.

Coyle and Enright's (1997) research consisted of ten male participants who reported feeling deeply hurt by their partners' decision to abort their pregnancies. Each participant's levels of forgiveness, anger, anxiety, and grief were assessed prior to his random assignment to either the experimental forgiveness condition or wait-list control group. The forgiveness intervention included 12 weekly, individual counseling sessions focusing on the phases of the forgiveness process model. Participants were reassessed post intervention. Compared to controls, results indicated significant, psychological improvements among members of the experimental group. The experimental participants

significantly reduced their anger, grief, and anxiety levels while increasing their scores on interpersonal forgiveness. The control members revealed similar results after participating in the forgiveness intervention.

Freedman and Enright's (1996) study utilized an intentional forgiveness intervention with 12 Caucasian incest survivors. Like Coyle and Enright's (1997) study, the women were randomly assigned to an experimental condition characterized by the forgiveness intervention or a wait-list control group. Each experimental participant met weekly with a counselor for, on average, 14.3 months to discuss how the forgiveness process model directly relates to the participant's relationship with her offender. Experimental participants' levels of anxiety and depression decreased significantly more than those in the control/wait-list condition. In addition, the forgiveness participants also showed marked improvement in hope, self-esteem, and forgiveness toward their offenders. After receiving treatment, the wait-list control members demonstrated equivalent results as the original experimental members.

Much empirical research concerning forgiveness and marriage and family has been conducted. Gordon et al.'s (2009) longitudinal study included 91 married couples and their children. Seventy-four men and 87 women self-reported experiencing a deep betrayal by their partners. Researchers looked specifically at forgiveness' ability to mediate marital satisfaction, the couple's ability to co-parent, and the participants' children's perceptions surrounding the parents' marital happiness. Although there was no forgiveness intervention utilized, participants were mailed numerous surveys and measures including: the

Forgiveness Inventory, Conflict Tactics Scale, Dyadic Adjustment Scale, Parenting Alliance Measure, and Children's Perceptions of Interparental Conflict Scale. Results indicated a significant, positive association between forgiveness levels, marital satisfaction, and ability to effectively co-parent. This suggests couples who do not resolve their past hurts through the forgiveness process may continue to suffer as demonstrated by decreased marital happiness and ability to co-parent their children.

Another longitudinal study, by McNulty (2008), also looked at the long-term effects of forgiveness on marital satisfaction. The sample included 72 newlywed couples who completed a series of measures throughout their first two years of marriage. Initial assessments measured marital satisfaction, forgiveness, and negative behavior. The couples also participated in ten-minute discussions during which researchers coded responses into positive and negative observed behaviors. The participants were reassessed every six months. Overall, results indicated, cross-sectionally, couples with higher forgiveness levels reported less severe problems within the marriage, fewer negative behaviors, and increased marital happiness. However, longitudinal differences in forgiveness and marital satisfaction levels were mediated by negative behaviors. For instance, those who forgave often after their partners consistently re-offended reported significantly less marital satisfaction than spouses who forgave their partners who rarely re-offended or behaved negatively. These results suggest forgiveness may not be appropriate for all married couples, particularly with partners who are long-term re-offenders. Rather, forgiveness may be more appropriate for couples with mild,

non-repeating negative behaviors. Based on these findings, one may hypothesize that forgiveness therapy may not be very effective with current victims of IPV since the abuse is repetitive. It appears likely the more a current victim forgives her offender, the more likely the IPV offense will re-occur.

Research indicates those who do not forgive may be more likely to obsess over past offenses and suffer from depression (McCullough, Bellah, Kilpatrick, & Johnson, 2001). Lawler-Row and Reed's (2008) study, consisting of 60 female undergraduates, found similar results. Participants were categorized into one of two groups (highly forgiving and low forgiving) after trait and state forgiveness were assessed. Results indicated, those with higher forgiveness traits suffered less from anxiety and depression compared to those with low forgiving personalities. Lawler-Row and Reed also looked specifically at the benefits of state forgiveness on mental health. They found those who forgave an identified person for a specific offense were significantly associated with decreased obsessions, anxiety, depression, and an increased ability to express anger in a healthy manner and feel empathy toward the offender after exploring his or her perspective. Based on these findings, it appears promoting forgiveness may be a plausible and potent approach for helping those who struggle with deep hurts inflicted by an offender.

Thus far, the research presented on forgiveness therapy and its application to individuals and couples who have endured pain and hardships has shown positive results. Forgiveness therapy may decrease depression, anxiety, and anger levels (Coyle & Enright, 1997; Freedman & Enright, 1996; Hebl & Enright, 1993) while increasing the victims' hopefulness and propensity to forgive (Freedman &

Enright). The research also indicates forgiveness intervention participants may demonstrate significant improvement in their ability to co-parent with an offender (Gordon et al., 2009) and may appropriately express anger while reducing ruminating tendencies (Lawler-Row & Reed, 2008). It is the current researcher's hope that IPV survivors may also benefit from the forgiveness psycho-educational workshop by decreasing their anger and increasing their hope and forgiveness levels. The following provides a review of the limited research available regarding forgiveness and IPV victims and survivors.

Although very little empirical research has been conducted specifically on IPV survivors/victims and forgiveness, Gordon, Burton, and Porter's (2004) study evaluated the relationship between forgiveness tendencies and the likelihood a victim would return to an abusive partner. The sample included 121 women temporarily living in nine domestic violence shelters. Participants completed several questionnaires measuring: variables complicating the leaving process, the abusive relationships' conflict resolution tactics, possible violence cues, tendencies to forgive, and whether or not the victims planned on returning to their abusive partners. Three months following the completion of questionnaires, researchers gathered follow-up information regarding the victims' current living arrangements (returned to an abusive partner, did not return to the partner, or living arrangement unknown). Results indicated forgiveness, more than any other variable, had the greatest power in predicting the likelihood of returning to an abusive relationship. More forgiving victims were significantly more likely to express an intention to return to harmful relationships. As abuse severity

increased, fewer victims had high forgiveness levels or planned on returning to their partners.

These findings suggest promoting forgiveness may not be the most beneficial intervention with women seeking refuge at domestic violence shelters (Gordon et al., 2004). Forgiveness may also be quite harmful for this population. Although many researchers and forgiveness experts draw a clear distinction between forgiveness and reconciliation (Freedman et al., 2005; Enright & the Human Development Study Group, 1991), this distinction may not be as easily distinguished by IPV victims who experience various pressures to maintain the status quo by forgiving and returning to abusive partners. Based on this information, practitioners treating IPV victims must be cautious and carefully consider whether forgiveness promotion is a beneficial and safe intervention (Gordon et al.).

Although forgiveness may not be beneficial for IPV victims at risk for returning to their abusive partners, Reed and Enright's (2006) research might support using forgiveness therapy with spousal psychological abuse survivors (women who are permanently separated from abusive partners for at least two years). The sample included 20 women who had been psychologically, but not physically, abused by previous partners. Participants were divided into ten pairs. One member from each pair was randomly assigned to the individual forgiveness therapy condition and the other participated in treatment aimed at validating anger and increasing assertiveness skills. Prior to treatment, participants were assessed on abuse history, forgiveness tendencies, self-esteem, anxiety, depression, PTSD

symptoms, and meaning-making. Assessments were also administered following treatment, which lasted eight months on average, and at follow-up. Results suggested positive outcomes for participants in the forgiveness therapy condition. Compared to the alternative treatment, forgiveness therapy participants significantly decreased depression, anxiety levels, and PTSD symptoms while significantly increasing their self-esteem, forgiveness, and ability to find meaning in their past suffering. Most encouraging, the results were maintained at follow-up, suggesting forgiveness therapy may be a favorable approach for counseling IPV survivors who were psychologically abused.

Conclusion

Tragically, one in four women experience some form of intimate partner violence within their lifetimes. Without considering the financial, social, and physical ramifications, the psychological side-effects alone of being involved in a psychologically and/or physically violent relationship are staggering. In addition to experiencing acute psychological distress, many survivors may struggle with overcoming long-lasting harm. As necessary and as beneficial as the current services being offered to IPV victims are, their primary focus is on safety planning, supporting, and encouraging women and their children to leave their abusive relationships. Although support groups may be offered to survivors, there appears to be a need for a more intentional approach to treating the chronic, psychological side-effects of IPV survivors. It would be interesting to explore whether or not forgiveness education is an appropriate treatment modality for IPV survivors (those who have been out of an abusive relationship for at least two

years). Perhaps learning about forgiveness and its practical application to previous abusers may increase survivors' hope levels, while decreasing their anger toward offenders.

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