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Theoretical and Empirical Connections Between Forgiveness, Mental Health, and Well-Being

Loren Toussaint

Luther College

Jon R. Webb

University of Oklahoma Health Sciences Center

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Abstract

This chapter provides an overview of the state of knowledge regarding the association between forgiveness and mental health. Forgiveness is defined in a multidimensional and comprehensive fashion using an incomplete 3 (self, other, God) by 3 (offer, feel, seek) taxonomy to identify seven dimensions of forgiveness. Theoretical and empirical work is reviewed. Theory suggests that forgiveness has direct and indirect associations with mental health, and developmental and attributional processes may moderate these associations. Empirical work consists of correlational studies (*n*=13), interventions (*n*=4), and experiments (*n*=1) that generally support the notion that forgiveness is associated with mental health. Future work should focus on (a) measurement, (b) careful sample selection, (c) studies that allow for causal inferences, (d) mediators/moderators, and (e) mental health predictors of forgiveness.

Theoretical and Empirical Connections Between Forgiveness, Mental Health, and Well-Being

In this chapter, we review theoretical and empirical studies of forgiveness and mental health. Mental health variables are defined consistent with the DSM-IV (American Psychiatric Association, 1994) and may include symptoms of disorders (e.g., depression) or actual disorders (e.g., major depression). Studies that include relevant mental health variables, such as nonspecific psychological distress and life-satisfaction/well-being, are also included. The terms life-satisfaction and well-being are used interchangeably to describe one's perceived satisfaction with life. The focus of this chapter is to understand connections between forgiveness and mental health, broadly defined, and critically to examine the state of our knowledge in terms of the potentially salutary effects of forgiveness on mental health and well-being.

Considering mental health correlates and outcomes of forgiveness is important for at least four reasons. First, unforgiveness is often a core component of stress resulting from an *inter*personal offense, and stress is associated with decreased mental health. Second, unforgiveness resulting from *intra*personal transgressions may increase levels of guilt, shame, and regret that in turn negatively impact one's mental health. Forgiveness may be one way of coping with *inter*personal and *intrapersonal* stress in a fashion that promotes positive adjustment. Third, the cost of mental illness to society is enormous. For instance, in 1996 alone direct costs exceeded $80 billion (U. S. Department of Health and Human Services, 1999). Fourth, mental health is often linked to physical health, and as such, mental illness may increase costs of physical health care. To the extent that forgiveness can be shown to ameliorate negative mental health consequences of interpersonal and intrapersonal offenses, it will become increasingly recognized as a viable means of treatment and an important protective variable.

Personal Assumptions about Forgiveness

A widely accepted definition of forgiveness has been hard to identify. Perhaps this is the result of the many differing contexts in which forgiveness issues arise, and hence, most definitions are context specific. Forgiveness may involve oneself (Hall & Fincham, in press), others (Enright, Freedman, & Rique, 1998), God (Exline, Yali, & Lobel, 1999), families (DiBlasio & Proctor, 1993), or entire societies and cultures (Sandage, Hill, & Vang, 2003). Given the broad array of contexts in which forgiveness issues may arise and the multiplicity of factors likely involved, a single, comprehensive definition of forgiveness has remained elusive.

We believe that the key to identifying a more unifying definition of forgiveness lies in building a more comprehensive understanding of the construct. In concurrence with Enright et al. (1991), we believe that forgiveness should be conceptualized as a multidimensional construct that contains dimensions of affect, behavior, and cognition. We further underscore important distinctions that have been made regarding different *targets* (i.e., oneself, others, God) and *methods* of forgiveness (i.e., offering, feeling, or seeking) (Enright et al., 1996; Pingleton, 1989; Sandage, Worthington, Hight, & Berry, 2000).

Our definition builds from previous work and is multidimensional and comprehensive. Trait forgiveness involves a *tendency* to offer, feel, or seek changes from negative to positive cognitions, behaviors, and affect pertaining to offenders that include oneself, others, and God. State forgiveness involves a *process* of offering, feeling, or seeking a change from negative to positive cognitions, behaviors, and affect pertaining to *specific* offenses that are perceived to be perpetrated by oneself, others, or God.

Further, we believe that important, distinctive, and core components of the definition of forgiveness that separate it from other forms of adjustment and coping include motivational and

volitional factors. As such, we believe that forgiveness is an internal process undertaken by the victim (Worthington, Sandage, & Berry, 2000), which does not require retribution (Rosenak & Harnden, 1992), restitution (Wahking, 1992), reconciliation, or a return to vulnerability by the victim, yet reserves the right to retain accountability from the offender (Enright et al., 1998).

Review of the Theoretical and Empirical Literature

Theoretical Literature

Interest in the psychological and theological understanding of forgiveness has resulted in numerous publications on the topic. We restrict our review to that work which we feel has good potential for guiding future empirical work through the development of conceptual models grounded in sound psychological theory and research. A particularly useful conceptual model was proposed by Worthington et al. (2001). They conceptualize the interplay between forgiveness and health as involving both direct and indirect relationships. Worthington et al. outline a model of forgiveness and general health, but because of the comprehensive nature of the model, we believe it to be equally applicable to issues of mental health as well. Furthermore, additional insight regarding these relationships is gained through understanding underlying developmental and attributional processes of forgiveness.

Direct effect. The direct effect of forgiveness on mental health (see Figure 1) can be described in terms of unforgiveness, through rumination, involving the emotions of resentment, bitterness, hatred, hostility, residual anger, and fear (Worthington et al., 2001). Left unaddressed, negative emotions can lead to significant mental health problems. There are many ways to address unforgiveness, including retaliation, revenge, justice, denial, and forgiveness (Worthington & Wade, 1999). Forgiveness involves the contamination or prevention of unforgiveness with strong, positive, love-based emotions (Worthington et al.). When describing

the emotions of forgiveness and unforgiveness, Worthington et al., are careful to point out that these are not just subjective feelings, but like all emotions, involve a variety of physiological processes. It is through these physiological changes that forgiveness may likely have its direct effect on mental health and well-being.

Indirect effect. Forgiveness is likely to promote mental health indirectly (see Figure 1) through variables such as social support, interpersonal functioning, and health behavior (Temoshok & Chandra, 2000; Worthington et al., 2001). These mediating variables are commonly associated with improved mental health (Bausell, 1986; Mohr, Averna, Kenny, & Del Boca, 2001; Saltzman & Holahan, 2002). Worthington et al., propose that forgiveness is positively related to these mediating variables that in turn are positively related to mental health.

Upon closer examination, the relationship between forgiveness and mental health may be viewed as indirect in all cases. While the indirect effect described above is clear, the direct effect described above, in actuality, is thought to operate through rumination and its connection to a variety of negative emotions. However, it may still be helpful to keep the distinction between direct and indirect effects. As lack of rumination appears to be an underlying determinant of the ability to forgive (see McCullough, 2000), it may go hand in hand with forgiveness and thus may not be a mediating factor. Social support, interpersonal functioning, and health behavior seem less likely to be intertwined with the ability to forgive and thus more likely to be clear mediators.

Developmental process. Much work has been completed in describing the developmental process of forgiveness. Enright et al. (1998) provide a summary of 20 steps or units of forgiveness and divide the process into four broad phases: uncovering, decision, work, and deepening. Uncovering refers to the awareness of the problem and emotional pain following an offense, including anger and insight. Decision includes realizing the need for an alternate

resolution. Work includes processes such as, reframing, empathy, and acceptance of pain. Deepening includes finding meaning and universality. It is carefully pointed out that the overall process of forgiveness is not likely to be linear (i.e., an orderly progression between steps).

Depending on one's stage of progression through the developmental process of forgiveness, the relationship between forgiveness and mental health may vary. In the earliest stages of the process (i.e., uncovering and decision), forgiveness may actually be related to poorer mental health. As one works through the later phases (i.e., work and deepening), the effects of forgiveness should become more beneficial. In this way, developmental stage may act as a moderator of the forgiveness and mental health relationship (see Figure 1).

Attributional process. The ability to forgive is thought to be positively associated with personal control in one's life (Benson, 1992; Hope, 1987) and the restoration of a sense of personal power (McCullough & Worthington, 1994). Evidence is beginning to emerge in support of this relationship (Witvliet, Ludwig, & Vander Laan, 2001). Internal locus of control, or perceived personal control, refers to an expectation that outcomes are influenced by one's actions (Peterson, Maier, & Seligman, 1993). As such, Coleman (1998) describes a paradoxical relationship between control and forgiveness. One often feels a loss of control when offended and perceives that unforgiveness will enable control to be regained. Over time unforgiveness actually prevents one from exercising control by continuing to consume (e.g., through rumination) the individual with negative emotions. Given the connection between forgiveness and personal control and the connection between perceptions of control and mental health (Shapiro, Schwartz, & Astin, 1996), it appears that an important indirect pathway from forgiveness to mental health involves perceived personal control (see Figure 1).

Empirical Literature

A small number of correlational, experimental, and intervention studies make up the empirical literature on forgiveness and mental health. While this literature is small in size, the findings from these studies suggest an important role of forgiveness in mental health and psychological well-being. Correlational studies make up the majority of investigations, followed by intervention studies. Finally, only one study was identified that experimentally examined forgiveness and psychological well-being. Correlational studies will be reviewed first. Intervention studies will be reviewed second. The experimental study will be reviewed last.

Correlational studies. Thirteen studies that directly examine the relationships between forgiveness and mental health and well-being were identified. Examining these studies (see Table 1) reveals interesting characteristics. Seven of the studies rely on undergraduate samples and 6 studies utilized other samples from community- and clinic-based settings. College-student samples are convenient and easily accessible, but they come with inherent generalizability issues and other limitations that are particularly important for forgiveness research (i.e., restrictions in age, type of hurt, mental health status). Hence, it is encouraging to find that various populations have been sampled at this early stage of development in the field, and results are consistent across studies using varied samples.

Dimensions of forgiveness that are assessed in relation to mental health have been limited. While all studies included measures of forgiveness of others, only six included measures of forgiveness of self. Only three studies included measures assessing forgiveness of or by God. Only one study assessed seeking forgiveness. Further, most studies assessed forgiveness at the trait level (10 of 13 studies). Only three studies assessed forgiveness as a state. Trait forgiveness was shown to be associated with mental health in nine of the ten studies. Of the three studies

incorporating state forgiveness measures, two showed associations with mental health. More needs to be learned about different types and state-trait considerations of forgiveness in its relation to mental health.

Assessment of mental health outcomes in relation to forgiveness has generally been limited to depression, anxiety, broadly defined mental health, and broadly defined well-being. Nevertheless, findings within this limited range of outcomes appear quite consistent. Nine of thirteen studies examined depression, and all nine showed expected associations with forgiveness. Eight of thirteen examined anxiety, and again all eight showed expected associations with forgiveness. Five of thirteen examined overall mental health and/or well-being, and four of these studies showed expected associations. Other mental health outcomes have received less attention. Only two studies (Kendler et al., 2003; Witvliet, Phipps, Feldman, & Beckham, 2004) exist where variables such as PTSD, phobia, panic, and substance abuse have been considered. Findings from these studies suggest that the connections of forgiveness to mental health reach beyond only depression and anxiety.

The contexts in which forgiveness and mental health have been assessed are limited. For instance, forgiveness and mental health in the context of other health concerns (e.g., traumatic injury, alcoholism, combat-related PTSD) are beginning to receive attention (Hart, 1999; Toussaint & Webb, 2003; Webb, Kalpakjian, & Toussaint, 2003; Webb, Robinson, Brower, & Zucker, 2003; Witvliet et al., 2004), but much more work remains to be done. Many hurts and offenses may be considered traumatic, and the relationship between forgiveness and mental health in the context of traumatic injury or illness should also be examined. Alcohol and substance abuse disorders are often co-morbid with other mental disorders, and these outcomes should also receive further attention. In addition to using assessments of symptoms, it would also

be worthwhile to use diagnostic mental health outcome variables that have been verified by a structured clinical interview (e.g., SCID-I; First, Spitzer, Gibbon, & Williams, 1997).

Generally speaking, this small body of literature reveals a relationship between forgiveness and mental health. However, there is a great deal of variability with regard to the magnitude of these associations. Associations have been reported as small as .20 and as large as .70 or greater. An important task is to understand what factors account for such variability. For instance, factors such as age and type of forgiveness have been shown to have an impact, but much remains to be learned here.

Intervention studies. Four empirical reports of forgiveness interventions examining mental health variables were identified in the literature (see Part 6 of this volume for further discussion of forgiveness interventions). A close examination of these four studies (see Table 2) reveals that the effect of forgiveness intervention on mental health (i.e., anxiety and depression) is anything but definitive. Three of the four studies show mixed support for the hypothesis that forgiveness has a positive effect on mental health. However, evidence from intervention studies is qualified by a number of factors at present. First, sample sizes are small. Second, intervention protocols differ widely in terms of length and content. Third, anxiety and depression are the only mental health outcomes assessed. Fourth, very specific transgressions (e.g., incest) have been addressed in these studies so findings likely are not generalizable to other offenses. Apropos, future work should (a) use larger samples, (b) examine the same intervention across different types of offense, (c) examine different interventions within the same type of offense, and (d) broaden the assessment of mental health.

Experimental study. Karremans, Van Lange, Ouwerkerk, and Kluwer (2003) have conducted, to our knowledge, the only published experimental investigation of forgiveness and

well-being to date. This investigation consisted of a series of four studies focusing on factors explaining when and why forgiveness impacts well-being. A cleverly designed set of instructions allowed the researchers to manipulate forgiveness and observe its effects on psychological well-being. Three major findings are important to review. First, results suggested that forgiveness is associated with well-being, but the association is stronger in relationships of strong rather than weak commitment. Second, results showed that "psychological tension" (i.e., cognitive dissonance) mediated the relationship between forgiveness and well-being. Third, tendencies to forgive one's spouse were more strongly related to well-being than were tendencies to forgive others. In sum, these findings suggest that the mental health benefits of forgiveness are (a) dependent on the relational nature underlying the offense and (b) mediated through reductions in psychological tension. This study provides an excellent starting point from which to build additional experimental support for the link between forgiveness and mental health. Future work would do well to employ non-student samples and explore novel ways of manipulating forgiveness levels while controlling for variance in transgressions.

New Research Directions Needed In the Area

Advancing our understanding of the connections between forgiveness and mental health *requires* at least three things. First, forgiveness measurement issues must be addressed. Currently, there are a handful of good measures of trait- and state- forgiveness, but these measures focus almost exclusively on forgiveness of others. Dimensions of forgiveness such as forgiveness of self, feeling forgiven, and seeking forgiveness have all but been ignored in terms of developing sound assessment instruments. The field needs appropriate state-trait and multidimensional measures of forgiveness. Second, selecting samples from diverse populations must be a high priority. This will allow an examination of the extent to which ethnicity or socio-

economic status moderates the relationships between forgiveness and mental health. Social psychologists, sociologists, medical sociologists, and psychiatric epidemiologists could serve as excellent colleagues in our pursuit to understand social factors influencing the forgiveness and mental health relationship. Social survey experts can also assist in attaining nationally representative, probability samples that will allow for generalization of our findings to broader populations. Third, we must continue to focus on the development and execution of interventions and experiments. This is the only way in which we will definitively know that forgiveness causes improvements in mental health and not the opposite. Longitudinal correlational research would also be useful in this regard, but little if any exists showing prospective associations between forgiveness and mental health.

A fourth goal of continuing research efforts should be to understand potential mediators/moderators (e.g., empathy, anger, rumination) of the relationship between forgiveness and mental health. A key variable, in this regard, is rumination. Rumination is associated with a variety of mental health outcomes, especially depression (e. g., Harrington & Blankenship, 2002). Rumination is also associated with forgiveness (Berry, Worthington, O'Connor, Parrott, & Wade, in press; Brooks, Toussaint, Worthington, & Berry, 2004; McCullough, Bellah, Kilpatrick, & Johnson, 2001; McCullough et al., 1998; Thompson et al., in press). Given these associations, two interesting questions arise. First, what is the causal ordering of forgiveness and rumination? Second, what are the unique contributions of each to mental health?

Both of these questions have begun to be addressed. McCullough and Bono (2004) have shown that rumination may play a *causal* role in impeding forgiveness over time, and Brooks (2004) has shown that experimentally manipulating rumination following a transgression lowers subsequent levels of forgiveness. Brooks and Toussaint (2003) have also shown relationships

between forgiveness and depression that are fully or partially mediated by rumination. These studies offer a starting point for future work to examine forgiveness and rumination variables in a fashion that allows for clear conclusions about their causal ordering and their unique contributions to mental health. Given the connection of rumination to key mental health outcomes such as depression and anxiety (Harrington & Blankenship, 2002), it is critical that we begin to better understand the connections it has to forgiveness.

In line with our previous recommendation to better understand mediators/moderators of the forgiveness-mental health relationship, a fifth suggestion is that interventionists and clinicians studying the therapeutic effects of forgiveness should consider mental health variables as moderators. For instance, improvements in depression, anxiety, life-satisfaction, etc. that result from a forgiveness intervention may be more pronounced for victims of a traumatic offense who are suffering from PTSD, as compared to others. In this case, mental health status (i.e., presence versus absence of PTSD) would moderate the effect of forgiveness on depression, anxiety, life-satisfaction, etc.

Despite the fact that all known studies have treated mental health variables as outcomes, our final recommendation is to use these variables as predictors of forgiveness. Perhaps depressed or anxious individuals will be less motivated to engage in the forgiveness process, or they may not have the necessary energy to invest in such a challenging and taxing venture. In either case, it would be interesting to know the mental health profile of a forgiving versus unforgiving person.

Personal Theoretical Perspectives on the Field

Our personal approach to the study of forgiveness focuses on understanding the different targets and methods of forgiveness and their relationship to mental health. Our conceptualization

can be mapped out in an incomplete 3 (offer, feel, seek) by 3 (self, others, God) table that yields seven distinct dimensions of forgiveness that should be investigated. They are (a) forgiveness of oneself, (b) forgiveness of others, (c) forgiveness of God, (d) feeling others' forgiveness, (e) feeling God's forgiveness, (f) seeking others' forgiveness, and (g) seeking God's forgiveness. We leave feeling and seeking forgiveness from oneself as undefined at this point in time. We hypothesize that these seven dimensions of forgiveness may relate differentially to mental health. Toussaint, Williams, Musick, and Everson (2001) showed that forgiveness of self and others were associated with less distress and greater well-being, but feeling forgiven by God was *not* associated with these outcomes and seeking forgiveness from others was indeed associated but in the *opposite* direction. We believe that additional gains in understanding the associations between forgiveness and mental health will come as a result of conceptualizing of forgiveness as multidimensional and examining the associations between specific dimensions of forgiveness and mental health in carefully planned and executed correlational, experimental, and intervention studies.

Conclusions

Our review of the literature on forgiveness and mental health suggests that theory and empirical work are at a beginning point. Vast arrays of theoretical and theological positions exist regarding the relationship between forgiveness and mental health. Empirical evidence, while sparse, is growing in support of the notion that forgiveness may have a salutary effect on mental health. With continued attention to issues of conceptualization and measurement, we can expect continued growth in our knowledge of the exciting relationships between forgiveness and mental health.

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Table 1

Studies Reporting Correlations between Forgiveness and Mental Health

Study	Sample (*N*; number ♀; M_{Age}; population)	Associations
Berry & Worthington (2001)	39; 20; 23; undergrads	Forgiveness positively related to global mental health (*r* = .52).
Brown (2003)	70; 32; 22.6; undergrads	Forgiveness negatively related to depression (*r* = -.34).
Exline et al., (1999)	200; 140; 19.7; undergrads	Difficulty forgiving God and self positively related to depression and anxiety (*r*s .21 to .31). Difficulty forgiving others positively related to anxiety (*r* = .16).
Kendler et al. (2003)	2,621 twin pairs from Virginia Twin Registry	Forgiveness related to less nicotine dependence and less drug abuse or dependence. Low vengefulness related to less major depression, generalized anxiety, phobia, and bulimia nervosa (ORs = .53 to .90).
Krause & Ellison (2003)	1,316; 763; 74.5; older adults	Forgiven others related negatively to depressive affect, depressive somatic symptoms, and death anxiety, and positively to life satisfaction. Forgiven by God related negatively to depressive affect and positively to life satisfaction (|βs| = .07 to .22).
Maltby et al. (2001)	324; 224; 22; undergrads	Unforgiveness of self and others positively related to depression and anxiety (*r*s = .16 to .27).

Mauger et al. (1992)	237; outpatient clients in counseling	Unforgiveness of self and others positively related to depression and anxiety (*r*s = .16 to .56).
McCullough et al. (2001)	91; 55; undergrads	State unforgiveness was not related to life satisfaction cross-sectionally or longitudinally.
Rye et al. (2001)	328; 222; 19.2; undergrads	State forgiveness (*r*s = .21 to .40) but not trait forgiveness positively related to existential well-being.
Seybold et al. (2001)	68; 22; 46; community residents	Unforgiveness of self and others positively related to depression, state anxiety, and trait anxiety (*r*s = .49 to .77).
Subkoviak et al. (1995)	394; 204; 22.1(50%; undergrads)/49.6(50%; same gender parent)	State forgiveness negatively related to state anxiety (*r*s = -.28 to -.60).
Toussaint et al. (2001)	1,423; nationally representative probability sample of United States adults	Forgiveness of oneself and others negatively related to psychological distress and positively related to life satisfaction. Seeking forgiveness positively related to distress and negatively related to life satisfaction. Associations vary by age. (|βs| = .13 to .42)
Witvliet et al. (2004)	213; 0; 50.8; veterans with PTSD	Unforgiveness of oneself related to PTSD, depression and anxiety. Unforgiveness of others related to PTSD and depression. (βs = .16 to .28)

Note. ♀ = female; *r* = Pearson correlation; β = standardized regression coefficient; OR = odds ratio; |βs| = absolute value of standardized regression coefficient; all forgiveness/unforgiveness measures are dispositional unless otherwise indicated.

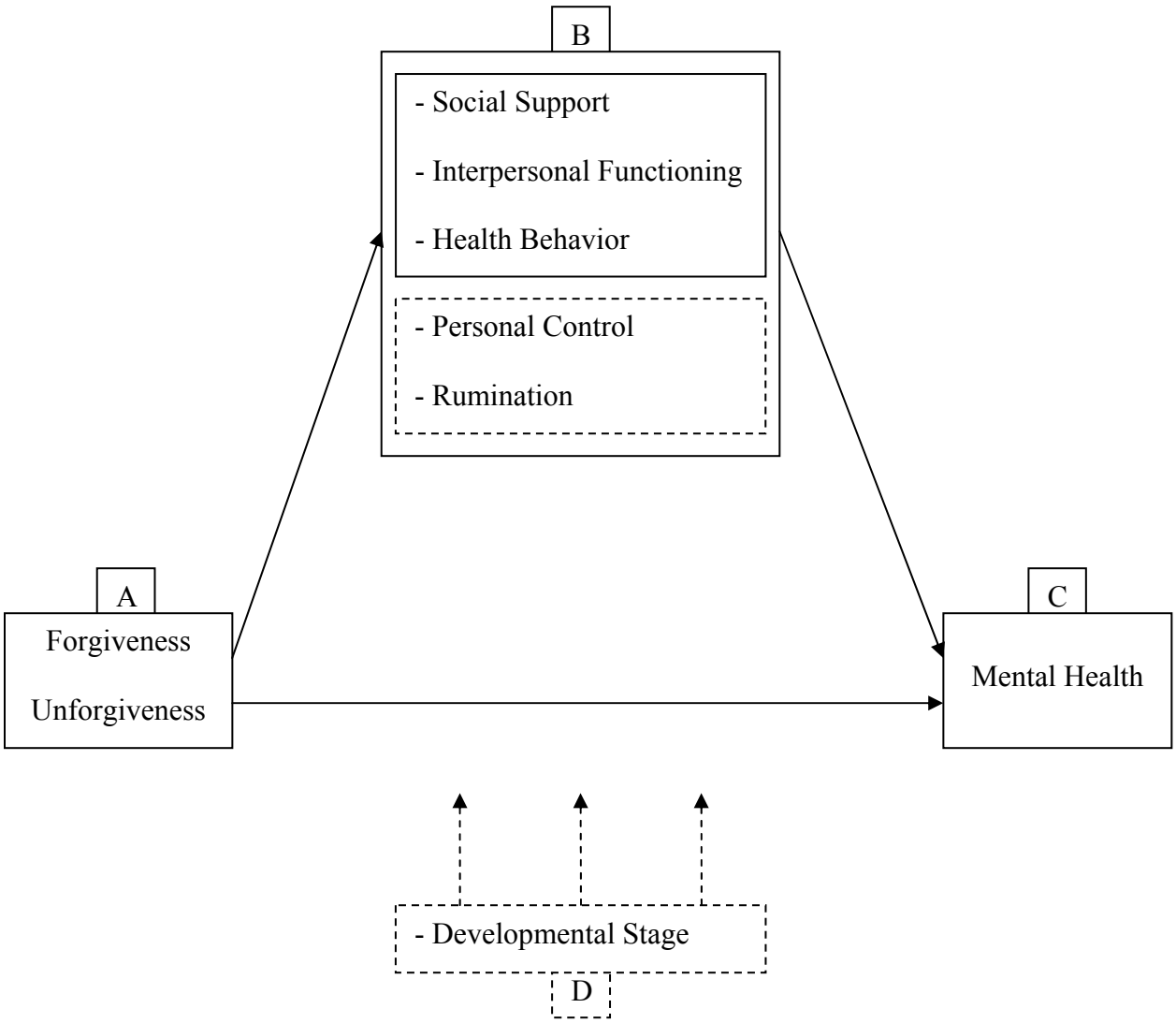
Table 2

Studies of the Effect of Forgiveness Interventions on Mental Health

Study	Sample	Intervention	Outcomes	General Findings
Al-Mabuk et al. (1995) Studies 1 & 2	N_1 = 48 (♀=37); N_2 = 45 (♀=29); M_{Age} = 20; love-deprived undergraduates	Study 1: 4 sessions, 2 weeks Study 2: 6 sessions, 6 weeks	Depression and anxiety	Study 2 yielded improvements in trait anxiety but not state anxiety or depression
Coyle & Enright (1997)	N = 10 (♀=0); M_{Age} = 28; hurt by abortion decision of partner	12 sessions, 12 weeks, 90 minute sessions	State anxiety	Intervention yielded improvements in state anxiety
Freedman & Enright (1996)	N = 12 (♀=12); M_{Age} = 36; incest survivors	17 units, average 14.3 months, 60 minute sessions held weekly	State and trait anxiety; depression	Intervention yielded improvements in anxiety and depression
Hebl & Enright (1993)	N = 24 (♀=24); M_{Age} = 74.5	8 sessions; 8 weeks, 60 minute sessions	State and trait anxiety; depression	Improvements in anxiety and depression not attributable to intervention.

Note. ♀=female

Figure 1. Effect of Forgiveness on Mental Health



Note. Adapted from Worthington et al. (2001); dotted lines represent modifications to the model.