

Effects of Forgiveness Therapy on Anger, Mood, and Vulnerability to Substance Use Among Inpatient Substance-Dependent Clients

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Anger and related emotions have been identified as triggers in substance use. Forgiveness therapy (FT) targets anger, anxiety, and depression as foci of treatment. Fourteen patients with substance dependence from a local residential treatment facility were randomly assigned to and completed either 12 approximately twice-weekly sessions of individual FT or 12 approximately twice-weekly sessions of an alternative individual treatment based on routine drug and alcohol therapy topics. Participants who completed FT had significantly more improvement in total and trait anger, depression, total and trait anxiety, self-esteem, forgiveness, and vulnerability to drug use than did the alternative treatment group. Most benefits of FT remained significant at 4-month follow-up. These results support FT as an efficacious newly developed model for residential drug rehabilitation.

The levels of anger and violence observed among alcohol and other substance abusers are far higher than the levels found in the general population (Clancy, 1997; Grisso, Davis, Vesselinov, Appelbaum, & Monahan, 2000; Reilly, Clark, Shopshire, Lewis, & Sorensen, 1994; Reilly & Shopshire, 2000; Tivis, Parsons, & Nixon, 1998). Alcohol and other substance abusers administered the State-Trait Anger Expression Inventory typically have been shown to have higher state and trait anger, to be more likely to express anger to others, and to have less control of their anger (Aharonovich, Nguyen, & Nunes, 2001; DeMoja & Spielberger, 1997). Reducing levels of anger and its related emotions is now seen as an important feature of recovery programs. For example, according to the Project Match 12-step facilitation therapy manual, “Anger and resentment are pivotal emotions for most recovering alcoholics. Anger that evokes anxiety drives the alcoholic to drink in order to anesthetize it. Resentment, which comes from unexpressed (denied) anger, represents a constant threat to sobriety for the same reason” (Nowinski, Baker, & Carroll, 1999, p. 83). The Project Match cognitive-behavioral coping skills therapy manual devotes sessions to “awareness of anger” and “anger management” (Kadden et al., 1995, pp. 62–63).

Marlatt (1985) emphasized the importance of anger and frustration as triggers for relapse in both the intrapersonal and interper-

sonal domains. He noted that 29% of relapses are related to intrapersonal frustration and anger and that 16% are related to interpersonal conflict and associated anger and frustration. A factor analysis of Marlatt’s relapse taxonomy using the Reasons for Drinking Questionnaire showed that the predominant factor was negative emotion. In turn, negative emotion was positively related to alcohol dependence, trait anger, and depression (Zywiak, Connors, Maisto, & Westerberg, 1996). Litt, Cooney, and Morse (2000) reported that those alcoholics who had urges to use after treatment had higher degrees of alcohol dependence, anxiety, and trait anger than those without such urges.

Given the apparent centrality of anger and related emotions such as anxiety and depression in determining urges and relapse, it is not surprising that anger management modules and emotional regulation are often components of treatment programs for substance-dependent patients. However, current approaches to anger in substance abuse treatment programs attempt to teach patients to more effectively manage or express anger rather than actually decrease their anger (Kadden et al., 1995; Nowinski et al., 1999; Zywiak et al., 1996). In addition, these approaches focus on state anger more than on persistent trait anger with comorbid anxiety and depression, which might be more critical in recovery (Litt et al., 2000). Because anger has been the target of these modules in drug treatment programs, one might expect to find a significant amount of research data documenting effective treatments for anger in patients with alcohol dependence.

Although the cognitive-behavioral therapy literature recommends that alcoholics become aware of their anger, learn to delay responding, and learn alternative assertive rather than aggressive responses, there are few data documenting the efficacy of this approach. In fact, Reilly and Shopshire (2000, p. 161) noted that “although studies have indirectly examined anger management

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group treatments in populations with high prevalence of substance abuse, few studies have directly examined the efficacy of an anger management treatment." Reilly and Shopshire did report on an uncontrolled study of a 12-week anger management program for cocaine addicts that resulted in decreased levels of anger and increased anger control. Gerlock (1993) reported that anger management was effective in decreasing anger among posttraumatic stress disorder patients who had high prevalence rates of drug and alcohol problems. And, recently, Litt, Kadden, Cooney, and Kabala (2003) found that both cognitive-behavioral therapy and interactional group therapy for alcohol-dependent clients led to increased coping skills. To our knowledge, there are no available data regarding the effects of anger management on urges to use.

Recently, a number of researchers have worked toward developing a new therapeutic approach to anger termed forgiveness therapy (FT; Al-Mabuk, Enright, & Cardis, 1995; Coyle & Enright, 1997; Enright & Fitzgibbons, 2000; Freedman & Enright, 1996; Hebl & Enright, 1993; McCullough & Worthington, 1995; McCullough, Worthington, & Rachal, 1997; Ripley & Worthington, 2002). This therapy posits that resentment and its accompanying anger are often justifiable responses to severe wrongs. However, FT also acknowledges that this anger and resentment can become problematic in terms of daily functioning. Furthermore, many cultures have recognized forgiveness as an important way to resolve anger and restore hope (Enright & Fitzgibbons, 2000). In helping clients move toward forgiveness, it is essential to differentiate forgiving from condoning, pardoning, reconciling, or forgetting. Forgiveness is a personal decision to give up resentment and to respond with beneficence toward the person responsible for a severe injustice that caused deep, lasting hurt. FT helps the wronged person examine the injustice, consider forgiveness as an option, make a decision to forgive or not, and learn the skills to forgive. Enright and colleagues have recognized four phases in the progress of FT—uncovering, decision, work, and discovery—and have developed treatment and self-help manuals with 20 defined forgiveness units (e.g., see Enright, 2001).

Robust results have been found when FT has been applied to certain populations. In a study implementing FT with incest survivors, Freedman and Enright (1996) found an effect size of 1.44 across emotional health variables relative to a wait-list control group. Coyle and Enright (1997) conducted FT interventions with distressed postabortion men and similarly found a 1.42 effect size. These large effect sizes point toward the potential effectiveness of FT interventions. Other randomized trials involving the use of forgiveness interventions with a variety of problems have been conducted (Al-Mabuk et al., 1995; Hebl & Enright, 1993; Osterndorf, 1999; McCullough & Worthington, 1995; McCullough et al., 1997; Ripley & Worthington, 2002; see Baskin & Enright, 2004, for a meta-analysis of forgiveness interventions). FT has been shown to decrease the frequency and severity of anger, anxiety, and depression rather than simply improving individuals' ability to cope with these emotions.

Given the importance of anger and related emotions such as anxiety and depression in the recovery of substance-dependent patients, we expect that patients in residential treatment for substance dependence could benefit from FT. We hypothesized that individuals in residential treatment for alcohol and drug dependence, after receiving treatment augmented by FT, would demonstrate less anger, depression, anxiety, and vulnerability to sub-

stance use and more self-esteem than those receiving residential treatment augmented with a similar amount of a more standard regimen, alcohol and drug counseling (ADC), that was not focused on anger reduction. To test these expectations, we randomly assigned participants, who were clients at a residential facility, to FT or ADC as an augmentation to routine residential treatment.

Method

Participants and Setting

All potential participants were recruited from a drug rehabilitation center that offers intense, structured, residential treatment to individuals suffering from alcohol and other drug dependencies. This center admits clients with relatively severe problems, including (a) history of chronic and severe addiction, (b) comorbid psychiatric diagnoses, (c) previous poor treatment responses, (d) frequent relapses, (e) legal problems related to substance abuse, and (f) low motivation for change. We chose residential treatment patients because of the rehabilitative challenges associated with this group, who tend toward greater psychiatric disorder than those referred to outpatient services regardless of age (Kjelsberg, 2000; Orrell, Yard, Handysides, & Schapira, 1999).

Forty-three potential participants were referred for this study on the basis of the opinion of their therapists that they would be good candidates for FT. If interested, participants were provided with details regarding the study and completed the Enright Forgiveness Inventory (EFI; Enright & Fitzgibbons, 2000) and the Spielberger State-Trait Anger Expression Scale (SSTAEI; Spielberger, 1996). Typical cases involved some sort of abuse, either sexual or physical, usually perpetrated by someone close to the client (e.g., a parent or spouse). If potential participants' score on the EFI was at or below 256, their composite SSTAEI score was 35 or higher, and they voluntarily provided written informed consent to take part in the study, they were randomly assigned to FT or ADC. Three potential participants were eliminated on the basis of their forgiveness and anger scores. Thus, 40 participants were randomized to one of the two interventions. All participants met criteria of the *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition; American Psychiatric Association, 1994) for substance dependence as per their clinicians' evaluations. Seven of these participants completed FT, and 7 completed ADC. Equal numbers of participants dropped out of each treatment condition, resulting in a 35% completion rate for each group. Given the high levels of mobility and chaos that characterize the lives of this client population, this dropout rate is not unusual.

For example, Henggeler, Pickrel, Brondino, and Crouch (1996) conducted a study in which the treatment-as-usual condition had a completion rate of 22%, which was actually higher than the 10% to 18% rate they had expected for youths participating in therapeutic communities. Further, in a large study of substance-abusing adolescents conducted by Szapocznik, Kurtines, Foote, Perez-Vidal, and Hervis (1983, 1986), only 72 of approximately 650 potential participants completed treatment. Similar retention patterns are found with adult substance abusers. In addition, residential cases tend to be the most severe, given that nationally substance abuse treatment is 95% outpatient based and 5% inpatient based.

Seven women and 7 men completed treatment. They ranged in age from 21 to 51 years, with a mean age of 36.6 years. All but one were European American. Regarding highest education level attained, 2 had completed a 4-year college degree, 5 had completed some college, and 7 had completed some high school or graduated from high school. Regarding religious orientation, 3 denoted themselves as Catholic, 2 as Lutheran, and 9 as subscribing to no religion. Regarding the individual participants considering their most significant injurer, 5 chose their mother, 3 chose their father, 4 chose their spouse or former spouse, 1 chose a friend's father, and 1 chose a stranger.

Design and Testing Procedure

After random assignment to FT or ADC, each respondent completed the Beck Depression Inventory II (BDI-II), the Coopersmith Self-Esteem Inventory (CSEI), the State-Trait Anxiety Inventory (STAI), and a modified version of the Adult Substance Use Survey that we termed the vulnerability to drug use scale. Tests were administered in random order. The comprehensive testing regimen was congruent with Clark and Winters's (2002) cautions about adequate measurement related to substance use disorders. After the baseline tests, each participant met with the treatment provider, who treated all of the participants in this study for 12 sessions each. All treatment sessions were individual and lasted 1 hr. Treatments were designed to include 12 sessions over 6 weeks. Five participants in each treatment group completed the sessions in 6 weeks, whereas 2 participants in each group required an average of 2 extra weeks to complete their assigned intervention. Each participant began his or her intervention immediately after the pretest. All participants completed the same battery of tests after completing their respective therapies, and a subset of participants repeated this battery 4 months after their last session.

The treatment provider, a therapist who had previously worked in 12-step-based ADC programs and also had worked in other settings, had approximately 20 years of therapeutic experience. This therapist had been using the methods employed in the control treatment for the previous 5 years. Thus, the therapist had a firm foundation in these methods. In addition, the therapist was trained in the FT protocol by Robert D. Enright, with regular meetings beginning 3 months before the start of treatment and continuing until all clients had completed treatment. *Forgiveness Is a Choice* (Enright, 2001), a self-help book intended for the general public, was used as a guide for both the training of the therapist and the treatment of the clients.

All therapy sessions were tape-recorded as a means of checking treatment fidelity. A member of the research team randomly selected 3 sessions for each of 3 participants in both treatment groups (18 total sessions) and examined them in regard to consistency between expected and delivered treatment. It was concluded from this analysis that the therapist had followed the predetermined protocol in every session.

Instruments

EFI. The EFI is a 60-item self-report measure of interpersonal forgiveness in which items are equally divided among six subscales: Positive and Negative Affect, Positive and Negative Behavior, and Positive and Negative Cognition. Scores range from 60–360, with high scores representing high levels of forgiveness. In previous studies, internal consistency has been above .90, and test–retest reliability has ranged from .67 to .91; in addition, the scale's validity has been documented (Enright & Fitzgibbons, 2000; Subkoviak, Enright, Wu, & Gassin, 1995).

BDI-II. The BDI-II is a 21-item self-report measure of symptoms and attitudes related to depression. Scores range from 0–63, with high scores indicating high levels of depression. Widely used in clinical research, the BDI-II has high construct validity and high reliability and is able to reflect changes in severity of depression over time (Beck, Steer, & Brown, 1996).

CSEI. The adult form of the CSEI is a 25-item self-report measure adapted from the school short form. This measure consists of true–false items evaluating attitudes toward the self in the following domains: general self, social, and home–parents. Raw scores are multiplied by 4, generating a range of scores from 0–100. Higher scores indicate higher self-esteem. Validity and reliability have been well documented (Coopersmith, 1981).

STAI. The STAI is composed of separate self-report questionnaires assessing two distinct types of anxiety: 20 state-anxiety items assess how an individual feels at a particular moment, and 20 trait-anxiety items assess how an individual generally feels. Each item is scored from 1–4, yielding a total subscale range of 20–80. Reliability and validity are adequate (Spielberger, Gorsuch, & Luchene, 1970). In the current study, pretest internal consistency was .97.

SSTAEI. The SSTAEI asks participants to rate 10 items regarding state anger and 10 items regarding trait anger. Scores range from 10–40 on each subscale. A high score reflects a high degree of anger. Internal consistency reliability has been reported as .88–.97, and the scale's validity has been established (Spielberger, 1996).

Vulnerability to drug use scale. Because all participants were in residential treatment at the time of the study and because substance use was prohibited by the institution, we could not obtain reliable data on actual drug use by participants. A reasonable compromise, we believed, was to construct a “vulnerability to drug use” scale. This scale represented a revision by our group of Wanberg and Milkman's (1998) Adult Substance Use Survey. The scale assesses the thoughts and feelings of participants about drugs as well as drug choice, preferred route of use, and perceived benefits from the drug. The revised form of this scale assessed thoughts and feelings rather than actual drug use behaviors. After revision, the scale consisted of 10 items to which participants responded on 5-point Likert scales. The score range is 10–50, and higher scores indicate higher vulnerability to drug use. In the present study, the scale's pretest internal reliability was .76.

FT Procedure

FT was provided in 12 individual therapy sessions administered by the same therapist who provided the ADC therapy sessions. The first 11 chapters of *Forgiveness Is a Choice* (Enright, 2001) were used as the manual for this mode of treatment. In general, participants receiving FT read one chapter in preparation for sessions and spent one session on each of the topics listed subsequently. However, the treatment was self-paced to the extent that participants could spend extra sessions on topics that the therapist–participant dyad believed were deserving of further work.

The FT method used begins with the client uncovering anger and resentment caused by another person's injustice. A decision to forgive is then introduced in which the client works on reducing resentment and offering benevolence toward the injurer. At this point, forgiveness is contrasted with excusing or condoning, forgetting, and reconciliation. The client might decide, under certain circumstances, to forgive but not reconcile. The work phase then commences, in which the client reframes who the offender is, seeing him or her certainly as wrong for the hurtful actions inflicted but also perhaps as vulnerable or scared. The key to reframing is to begin seeing the injurer as a person, not because of what happened but in spite of it. Affective exercises focused on empathy and related emotions follow. The discovery phase centers on what has been learned from the hurtful experience and the forgiveness process. A listing of FT session topics appears in Table 1, and details are available from the authors.

ADC Procedure

The ADC intervention was provided in the same format of 12 individual therapy sessions. We chose this approach because the therapist, the same individual who provided FT, has consistently used it over several years in the study facility. This intervention involved motivational, cognitive, and supportive techniques within the context of a 12-step-based overall program. The focus was on the therapist teaching and the participant learning skills that would enhance the likelihood of abstinence from alcohol or other drugs. As with FT, the expected session and topic schedule was one per week, but the participant and therapist could make changes as appropriate. A listing of session topics for ADC also appears in Table 1, with details available from the authors.

Analysis

As in previous research of this kind (Al-Mabuk et al., 1995; Coyle & Enright, 1997; Freedman & Enright, 1996; Hebl & Enright, 1993), *t*-test

Table 1
Procedures for Therapy

Session	Topic
Forgiveness therapy	
1	Framework for forgiveness intervention
2	Reviewing psychological defenses
3	Recalling the injury and examination of anger
4	Examining negative emotions
5	Change of heart—considering forgiveness
6	Reframing and role-playing
7	Empathy
8	Compassion
9	Finding meaning in the forgiveness process
10	Absorbing the pain—giving a gift
11	Awareness of decreasing anger and negative emotions
12	Finding new goals and meaning in life
Alcohol and drug counseling	
1	Introduction to therapy and counselor
2	Reviewing alcohol and drug abuse history
3	Examining negative effects of alcohol/drug abuse
4	Making a decision to change
5	The time-out technique
6	Role of self-talk
7	Problem-solving techniques
8	Learning to say “no” to oneself and others
9	Getting support from others
10	Alternatives to drugs and alcohol
11	Other ideas?
12	Completely breaking the habit

change scores were calculated for each variable of interest. Comparisons were made between the pretreatment and posttreatment measures, as well as between the pretreatment measures and the 4-month follow-up measures. On the basis of results of previous studies, we hypothesized that FT would be more effective than ADC. Therefore, we compared the gain scores of the two treatment groups using one-tailed tests.

Results

Cronbach alpha coefficients were used to determine the internal consistency of pretest measures. Coefficients for these instruments were as follows: EFI, .96; STAI, .97; BDI-II, .86; STAEI, .90; CSEI, .76; and vulnerability to drug use scale, .76. Means and standard deviations for all dependent measures within each treatment group at pretest, posttest, and follow-up are shown in Table 2. Table 3 presents gains (*t*-test values) from pretest to posttest and from pretest to follow-up.

The FT group demonstrated significantly greater improvement from pretest to posttest according to one-tailed *t* tests of changes in forgiveness, composite anxiety, trait anxiety, composite anger, depression, trait (but not state) anger, self-esteem, and vulnerability to drug use (see Table 3). At the 4-month follow-up, for which 6 FT participants and 4 ADC participants were available, the two groups exhibited significant differences in regard to improvements in forgiveness, anxiety (and trait anxiety), depression, self-esteem, and vulnerability to drug use favoring the forgiveness condition.

We now turn to a case study that qualitatively illustrates some of the processes and outcomes of FT.

Case Study

Carol¹ lived a life of emotional and interpersonal conflict, struggling with a long list of problems. However, she wanted to address the most serious issue first in therapy, an attack on her that had occurred 11 years in the past. Carol had journeyed from her small town into a nearby large city to buy crack cocaine. She met a man in a bar who claimed to have the drug. They went to a place Carol thought was his apartment that was actually an apartment he was breaking into. After providing Carol with the crack, the man raped Carol with a wine bottle. Afterward he started to pull her into the bathroom with the intention of drowning her. Carol was able to throw the wine bottle through a window and brace her arms and legs against the doorway until police arrived.

After that event, Carol’s drug and alcohol use increased significantly. She was diagnosed with polysubstance abuse, posttraumatic stress disorder, and major depression. In the months and years after the event, Carol became enraged whenever she thought of her attacker.

After coming to an understanding of what forgiveness is and is not, Carol identified the unhealthy ways in which she had handled her anger and the consequences with which she lived daily. Carol decided that she wanted to forgive her offender to make herself healthier. She did the hard work of looking back at what had happened that awful night. For years she had blamed herself for all that had occurred. “If I had not been an addict, then none of this would have happened,” she concluded.

The therapist and Carol worked to carefully reconstruct the events in an attempt to identify the poor choices that she had made that evening. Carol then clearly identified the attacker’s horrible behavior, for which he was solely responsible. This formed the basis for her forgiving him.

A key feature of Carol’s treatment was her insight that her attacker continues to exert a hurtful influence on her every time she takes drugs to escape the painful memories. She began to understand how convoluted the situation was: She took drugs to psychologically distance herself from the attacker, yet he held a certain power over her from which she was not escaping.

Carol made the decision to begin the work of forgiving her offender as a way to permanently put that night behind her. The therapist and Carol talked frequently about forgiveness being a journey that always takes longer than we think it should. She knew that she had been deeply and unfairly hurt and had every right to be angry and resentful for the price she had paid over the years. Carol also knew that she wanted to change.

In reframing the situation, she learned that the attacker had been victimized as a child, treated brutally as he had treated her on that atrocious night. She slowly was able to develop some empathy for him. She further reasoned that, despite insensitive treatment by her own family of origin, she did not displace her anger onto others. Her attacker did. “He is in a much worse place today than I am,” she reflected. She began to see him as confused, angry, and vulnerable. This did not diminish her judgment that what he did

¹ Name was changed to protect confidentiality.

Table 2
Means and Standard Deviations for Dependent Variables

Variable	Pretest		Posttest		Follow-up	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Experimental group						
Forgiveness	174.73	58.75	280.15	33.85	296.50	35.38
Anxiety (composite)	109.57	17.69	71.86	12.19	63.33	13.93
State	48.43	9.71	35.00	8.04	33.00	7.43
Trait	56.86	7.36	38.29	5.53	27.50	9.50
Depression	27.85	7.95	5.14	4.95	5.17	4.31
Anger (composite)	45.29	9.96	28.29	3.77	26.83	6.21
State	12.29	3.30	10.57	1.13	11.33	2.80
Trait	28.71	9.82	17.71	3.14	15.67	4.27
Self-esteem	38.57	21.56	68.29	16.34	78.67	7.34
Vulnerability to drug use	41.57	3.65	15.00	5.69	17.83	5.95
Alternative treatment group						
Forgiveness	185.57	18.28	182.71	45.67	112.25	20.40
Anxiety (composite)	111.71	32.32	109.43	23.99	85.50	9.26
State	48.43	9.11	38.29	5.53	27.50	9.54
Trait	58.00	12.07	56.29	10.90	40.75	4.43
Depression	33.29	9.34	21.57	12.31	18.00	7.32
Anger (composite)	45.71	15.74	43.71	8.56	36.00	11.13
State	21.14	9.56	18.85	6.59	15.00	7.44
Trait	24.57	7.39	24.85	5.61	21.00	4.55
Self-esteem	28.57	11.17	46.86	15.44	47.00	9.45
Vulnerability to drug use	38.42	3.91	33.71	3.68	36.75	3.77

Note. Sample sizes varied at the different time points.

was wrong, but it did allow her to develop some compassion for him as a person. It allowed her to start to let go of the anger she held toward him.

A year later Carol's life has changed significantly. She has successfully completed treatment. She has been working with the state department of vocational rehabilitation and will begin job training on completion of her general equivalency diploma. Learning about forgiveness gave her a better understanding of healthy behaviors, resulting in her breaking off a current relationship with a male partner because she could see how unhealthy it was. Thus, she was able to generalize the principles she learned in therapy and apply them to other areas of her life. She remains free of alcohol and drug use.

From pretest to posttest to follow-up, Carol's forgiveness (EFI) score increased from 65 to 271 and then decreased to 256. During the same interval, her depression (BDI-II) score decreased from 18 to 1 to 0. This showed long-term increases in regard to forgiveness and an improvement in psychological health, with a significantly lower level of depression.

Although some therapists might say that forgiving a vicious attacker makes a client vulnerable to further attacks, we have two responses. First, forgiveness and reconciliation differ. Therefore, the client's forgiving does not imply that she would trust or interact with such a perpetrator in the future. Second, past research (Freedman & Enright, 1996) shows that a forgiveness intervention has a positive effect on the long-term emotional health of female sexual trauma victims. By forgiving, the client in the present example was able to shed the identity of victim, with its attached negative emotions, and see herself as a survivor.

Discussion

This study is the first, to our knowledge, to demonstrate the importance of substance-dependent inpatients confronting resentments from the past as an aid to their emotional recovery. Forgiveness, shown to be effective in clinical populations for a decade, may be a key feature of this recovery. An examination of the clinical implications of each dependent variable shows the strength of our findings.

Our participants were initially quite low in terms of forgiveness. The average EFI score within adult nonclinical populations has been reported to be in the 250 range (Subkoviak et al., 1995), whereas the approximate average score in our sample was 175, even lower than found in Coyle and Enright's (1997) population. At posttest, FT participants had an average score of 280, higher than the published norm, and this gain was maintained at follow-up.

Our clients came to the program with trait anxiety and trait anger scores substantially above the published norms for adults; after treatment, however, FT participants exhibited scores comparable to the average (see Spielberger, 1996). In other words, the treatment did not lead simply to a change in anxiety and anger (particularly the reportedly more stable trait anxiety) but to a change toward normal profiles. In contrast, patients in the alternative treatment condition had anxiety scores well above average, especially in terms of trait anxiety, which showed little change at posttest and only minimal improvement at follow-up.

The changes observed in depression scores emphasized the benefits of psychotherapy. Clients in both groups showed moder-

Table 3
Dependent Variable Gain Scores

	Experimental group gain score		Alternative treatment group gain score		<i>t</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Changes from pretest to posttest ^a					
Forgiveness	105.71	52.14	8.43	34.59	4.114**
Anxiety (composite)	-37.71	27.36	-2.29	27.46	-2.647*
State	-13.43	12.79	-1.00	16.83	-1.555
Trait	-18.71	8.07	-1.28	11.47	-3.287*
Depression	-22.71	1.00	-11.71	12.38	-1.829*
Anger (composite)	-17.00	8.72	-0.57	14.23	-2.604*
State	-1.71	2.21	-2.29	11.73	0.127
Trait	-14.14	9.15	2.00	10.46	-3.073**
Self-esteem	30.29	14.35	18.28	10.29	1.798*
Vulnerability to drug use	-23.71	7.94	-4.86	4.21	-6.09**
Changes from pretest to follow-up ^b					
Forgiveness	100.83	54.18	40.25	36.89	1.938*
Anxiety (composite)	-43.00	23.38	3.50	42.19	-2.268*
State	-16.33	14.36	-4.5	18.19	-1.152
Trait	-30.00	11.56	-15.75	11.79	-1.896*
Depression	-20.33	4.76	-12.25	7.59	-2.029*
Anger (composite)	-19.33	10.19	-10.75	25.66	-0.753
State	-1.33	1.75	-8.75	16.38	1.135
Trait	-16.00	11.33	-4.50	12.77	-1.498
Self-esteem	37.67	16.17	12.00	18.76	2.313*
Vulnerability to drug use	-24.50	7.94	0.75	6.08	-5.36**

^a Degree of freedom for all *t* values is equal to 12. ^b Degree of freedom for all *t* values is equal to 8.

* $p < .05$. ** $p < .01$.

ate to severe clinical depression at pretest, with the FT clients moving to nondepressed status at both posttest and follow-up. Despite steady improvements in depression in the alternative treatment condition, these participants continued to exhibit clinically depressed patterns at both posttest and follow-up.

The alternative treatment clients continued to have trait anger scores above the norm at posttest, after which they returned to normal levels at follow-up. In other words, the clients did receive clinical benefits in regard to anger amelioration, albeit delayed, from the alternative treatment program.

The clinical results in the case of self-esteem showed the superiority of FT. At pretest, both groups had low scores relative to the published adult norm of 63.8 (Coopersmith, 1981). The forgiveness treatment was effective in bringing the clients up to normal levels, whereas clients undergoing the alternative treatment continued to manifest low self-esteem through the follow-up.

Finally, vulnerability to drug use also differed in the two conditions. Although no published norms exist for this scale, an examination of mean change scores may be instructive. The scale's possible score range is 10–50, and the theoretical average is 30; in this study, the FT clients moved from above the theoretical average (38.57) to substantially below that average at both posttest and follow-up (15 and 17.83, respectively). In contrast, the alternative treatment group stayed consistently in the low to high 30s, exhibiting a continued vulnerability to drug use. This is particularly interesting in that FT did not focus on drug vulnerabilities, whereas the alternative treatment did. Although urges to use substances are

not necessary for relapse, they are important indicators. According to Drummond and Phillips (2002), "Alcohol craving is a key element of the alcohol dependence syndrome" (p. 1465). In addition, Anton and Drobos (1998) noted that "craving for an abused substance is a constant companion of the addicted individual" (p. 553). Indeed, treatment or prevention of urges has been the focus of both pharmacological and psychotherapeutic treatment approaches and could be particularly important in improving patient recovery rates. The large improvements in this area produced by FT affirm the treatment's potential value.

FT is a new approach within substance abuse treatment programs, one in which treatment is centered more on clients' thoughts, feelings, and behaviors about someone other than themselves: an offender who hurt them deeply and unfairly, as we saw when Carol forgave the man who attacked her. In FT, a potential reason for substance use is examined, that of avoiding painful memories of betrayal, violence, or abuse. When patients are allowed to heal, their motivation to abuse substances may be substantially reduced. The present results imply that such a new focus—not as a substitute for traditional therapies, but as an augmentation to them—is worth considering as a way to address core issues of emotional pain. This can lead to a reduction in negative emotions and increases in self-esteem and forgiveness. In Carol's case, it also translated into her making a contribution to society through her work in vocational rehabilitation.

FT may prove effective in the future because it moves to the heart of the matter for some clients. Deep hurts borne out of unfair

treatment seem to play a part in substance use and abuse. Even when clients have many people to forgive, as Carol did with her family of origin and her attacker, we find that they seem to know which person is most crucial to forgive first before moving to other offenders. Substance use, from this perspective, is a *symptom* of underlying resentments and related emotional disruptions. If we fail to realize this, we may end up treating only symptoms rather than underlying causes. Litt et al. (2000) and Marlatt's (1985) contributions concerning anger and other underlying emotions associated with relapse reinforce this important caution.

An important test of the value of FT would be an examination of the effect sizes of the various measures. Because of the temptation to focus only on those dependent measures showing the expected results, the most rigorous test is to aggregate all dependent measures so as to achieve an estimation of the magnitude of the intervention's impact. Our effect size calculations, which followed the meta-analytic procedures outlined by Hedges and Olkin (1985), resulted in an effect size of 1.99 (95% confidence interval = 1.45, 2.52). However, an adjustment was necessary given the known phenomenon of correlation between measures (see Baskin & Enright, 2004; Wampold et al., 1997). With this adjustment, a more conservative estimate of the effect size was 1.58. Given that Lambert and Bergin (1994) estimated a value of 0.8 as a standard magnitude of effective treatments, these FT results are indeed robust.

When these statistically significant results and the clinical implications of clients' scores on the dependent measures are considered, the present study shows important benefits of FT in terms of the emotional regulation of substance-dependent clients in residential treatment, supporting initial affirmation of this newly developed model for treating such clients. However, because this study provides the first empirical demonstration of these effects, certain cautions are in order.

First, because of the small sample size, one cannot generalize the findings beyond the present group of participants. In fact, it is rare that any clinical research allows for generalizations. However, the sample size was more than sufficient to detect meaningful statistical differences, a major goal of all treatment studies. Future replications and extensions of this research will allow for examination of generalizability.

Second, it is as yet unclear the extent to which resentments in a client's past are typical or are relatively rare. In our case, only 3 of 43 potential participants were eliminated from consideration because of their forgiveness and anger screening scores. Determining prevalence levels of preexisting pain among clients in need of FT is an important next step. We suspect that such levels will be high. If so, FT may be indicated for many clients.

Third, 14 of 40 clients completed their respective interventions. Perseverance on the part of our clients was a factor in this study's results, as it is in most drug rehabilitation studies (Szapocznik et al., 1986). How to increase that perseverance so that clients can complete their therapy is a vital question to pursue in the future.

Fourth, follow-up data beyond 4 months would be valuable in ascertaining the long-range stability of our findings, even though it has been shown that the first few months after treatment represent a critical period that predicts relapse (Walfish, Massey, & Krone, 1990). Forgiveness interventions do offer the promise of long-term emotional stability, as seen in the research of Freedman and

Enright (1996), who showed that emotional regulation in incest survivors was stable over a 14-month postintervention period.

Fifth, it is unclear what experimenter effects were operating given that a single therapist delivered both treatments. Enright and Fitzgibbons (2000) hypothesized that all efficacious forgiveness treatments will involve therapists who value the approach. It should be noted that the therapist here had used the ADC control treatment as his primary intervention for years before this study. Thus, he probably had enthusiasm for both approaches.

In terms of future research, we recommend a comparison of FT with other anger-focused therapies. Programs that attempt to reduce or eliminate long-standing resentment should be compared with those that emphasize here-and-now anger management and behavior control. This kind of comparison would help shed light on whether it is elimination of resentment or control of one's affect and behavior that is the key to emotional health.

References

- Aharonovich, E., Nguyen, H. T., & Nunes, E. V. (2001). Anger and depressive states among treatment-seeking drug abusers: Testing the psychopharmacological specificity hypothesis. *American Journal of Addictions, 10*, 327-334.
- Al-Mabuk, R. H., Enright, R. D., & Cardis, P. (1995). Forgiveness education with parentally love-deprived late adolescents. *Journal of Moral Education, 24*, 427-443.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Anton, R. F., & Drobos, D. J. (1998). Clinical measure of craving in addiction. *Psychiatric Annals, 28*, 553-560.
- Baskin, T. W., & Enright, R. D. (2004). Intervention studies on forgiveness: A meta-analysis. *Journal of Counseling and Development, 82*, 79-90.
- Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Beck Depression Inventory manual*. San Antonio, TX: Psychological Corporation.
- Clancy, J. (1997). *Anger and relapse: Breaking the cycle*. Madison, CT: Psychosocial Press.
- Clark, D. B., & Winters, K. C. (2002). Measuring risks and outcomes in substance use disorders prevention research. *Journal of Consulting and Clinical Psychology, 70*, 1207-1223.
- Coopersmith, S. (1981). *Manual of the Adult Self-Esteem Scale*. Palo Alto, CA: Consulting Psychologists Press.
- Coyle, C. T., & Enright, R. D. (1997). Forgiveness intervention with postabortion men. *Journal of Consulting and Clinical Psychology, 65*, 1042-1046.
- DeMoja, C. A., & Spielberger, C. D. (1997). Anger and drug addiction. *Psychological Reports, 81*, 152-154.
- Drummond, D. C., & Phillips, T. S. (2002). Alcohol urges in alcohol-dependent drinkers: Further validation of the Alcohol Urge Questionnaire in an untreated community clinical population. *Addiction, 97*, 1465-1472.
- Enright, R. D. (2001). *Forgiveness is a choice*. Washington, DC: American Psychological Association.
- Enright, R. D., & Fitzgibbons, R. P. (2000). *Helping clients forgive*. Washington, DC: American Psychological Association.
- Freedman, S. R., & Enright, R. D. (1996). Forgiveness as an intervention goal with incest survivors. *Journal of Consulting and Clinical Psychology, 64*, 983-992.
- Gerlock, A. A. (1993). Veterans' responses to anger management intervention. *Advances in Mental Health Nursing, 15*, 393-408.
- Grisso, T., Davis, J., Vesselinov, R., Appelbaum, P. S., & Monahan, J. (2000). Violent thoughts and violent behavior following hospitalization

- for mental disorder. *Journal of Consulting and Clinical Psychology*, 68, 388–398.
- Hebl, J. H., & Enright, R. D. (1993). Forgiveness as a psychotherapeutic goal with elderly females. *Psychotherapy*, 30, 658–667.
- Hedges, L. V., & Olkin, I. (1985). *Statistical methods for meta-analysis*. San Diego, CA: Academic Press.
- Henggeler, S. W., Pickrel, S. G., Brondino, M. J., & Crouch, J. L. (1996). Eliminating (almost) treatment dropout of substance abusing or dependent delinquents through home-based multisystemic therapy. *American Journal of Psychiatry*, 153, 427–428.
- Kadden, R., Carroll, K., Donovan, D., Cooney, N., Monti, P., Abrams, D., et al. (1995). *Cognitive-behavioral coping skills therapy manual*. Washington, DC: U.S. Department of Health and Human Services.
- Kjelsberg, E. (2000). Adolescent psychiatric in-patients: A high risk group for premature death. *British Journal of Psychiatry*, 176, 121–125.
- Lambert, M. J., & Bergin, A. E. (1994). The effectiveness of psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 143–189). New York: Wiley.
- Litt, M. D., Cooney, N. L., & Morse, P. (2000). Reactivity to alcohol-related stimuli in the laboratory and in the field: Predictors of craving in treated alcoholics. *Addiction*, 95, 889–900.
- Litt, M. D., Kadden, R. M., Cooney, N. L., & Kabela, E. (2003). Coping skills and treatment outcomes in cognitive-behavioral and interactional group therapy for alcoholism. *Journal of Consulting and Clinical Psychology*, 71, 118–128.
- Marlatt, G. A. (1985). Relapse prevention: Theoretical rationale and overview of model. In G. A. Marlatt & J. R. Gordon (Eds.), *Relapse prevention* (pp. 3–67). New York: Guilford Press.
- McCullough, M. E., & Worthington, E. L., Jr. (1995). Promoting forgiveness: The comparison of two brief psychoeducational interventions with a waiting-list control. *Counseling and Values*, 40, 55–68.
- McCullough, M. E., Worthington, E. L., Jr., & Rachal, K. C. (1997). Interpersonal forgiving in close relationships. *Journal of Personality and Social Psychology*, 73, 321–336.
- Nowinski, J., Baker, S., & Carroll, K. (1999). *Twelve step facilitation therapy manual* (NIH Publication No. 94–3722). Washington, DC: U.S. Department of Health and Human Services.
- Orrell, M., Yard, P., Handysides, J., & Schapira, R. (1999). Validity and reliability of the Health of the Nation Outcome Scales in psychiatric patients in the community. *British Journal of Psychiatry*, 174, 409–412.
- Osterndorf, C. (1999). *Effects of forgiveness education intervention with adult children of alcoholics*. Unpublished doctoral dissertation, University of Wisconsin–Madison.
- Reilly, P. M., Clark, H. W., Shopshire, M. S., Lewis, E. W., & Sorensen, D. J. (1994). Anger management and temper control: Critical components of post-traumatic stress disorder and substance abuse. *Journal of Psychoactive Drugs*, 26, 401–407.
- Reilly, P. M., & Shopshire, M. S. (2000). Anger management group treatment for cocaine dependence: Preliminary outcomes. *American Journal of Drug and Alcohol Abuse*, 26, 161–177.
- Ripley, J. S., & Worthington, E. L. (2002). Hope-focused and forgiveness-based group interventions to promote marital enrichment. *Journal of Counseling and Development*, 80, 452–463.
- Spielberger, C. D. (1996). *State-Trait Anger Expression Inventory professional manual*. Odessa, FL: Psychological Assessment Resources.
- Spielberger, C. D., Gorsuch, R. R., & Luchene, R. E. (1970). *State-Trait Anxiety Inventory*. Palo Alto, CA: Consulting Psychologists Press.
- Subkoviak, M. J., Enright, R. D., Wu, C. R., & Gassin, E. A. (1995). Measuring interpersonal forgiveness in late adolescence and middle adulthood. *Journal of Adolescence*, 18, 641–655.
- Szapocznik, J., Kurtines, W. M., Foote, F., Perez-Vidal, A., & Hervis, O. (1983). Conjoint versus one-person family therapy: Some evidence for the effectiveness of conducting family therapy through one person with drug-abusing adolescents. *Journal of Consulting and Clinical Psychology*, 51, 889–899.
- Szapocznik, J., Kurtines, W. M., Foote, F., Perez-Vidal, A., & Hervis, O. (1986). Conjoint versus one-person family therapy: Further evidence for the effectiveness of conducting family therapy through one person with drug-abusing adolescents. *Journal of Consulting and Clinical Psychology*, 54, 395–397.
- Tivis, L. J., Parsons, O. A., & Nixon, S. J. (1998). Anger in an inpatient treatment sample of chronic alcoholics. *Alcoholism: Clinical and Experimental Research*, 22, 902–907.
- Walfish, S., Massey, R., & Krone, A. (1990). Anxiety and anger among abusers of different substances. *Drug and Alcohol Dependence*, 25, 253–256.
- Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K., & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, “all must have prizes.” *Psychological Bulletin*, 122, 1–13.
- Wanberg, K. W., & Milkman, H. B. (1998). *Criminal conduct and substance abuse treatment: Strategies for self-improvement and change: The provider's guide*. Thousand Oaks, CA: Sage.
- Zywiak, W. H., Connors, G. J., Maisto, S. A., & Westenberg, V. S. (1996). Relapse research and the Reasons for Drinking Questionnaire: A factor analysis of Marlatt's relapse taxonomy. *Addiction*, 91(Suppl.), S121–S130.

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