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Forgiveness Therapy and Complex Trauma: Secular Therapists' Perspectives

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Walden University
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Abstract

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MA, Our Lady of the Lake University, 2018

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Dissertation Submitted in Partial Fulfillment

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Doctor of Philosophy

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Abstract

Treatment-seeking survivors of complex trauma pursue normality and resiliency in their everyday lives. Forgiveness therapy is one treatment modality for such trauma. However, studies linking complex trauma and forgiveness therapy are minimal. The purpose of this generic qualitative inquiry was to improve treatment interventions of secular therapists' use of forgiveness therapy, specifically, Worthington's REACH forgiveness model with complex trauma clients. Two research questions guided this study: "What are secular therapists' perspectives on the use of forgiveness therapy with complex trauma clients" and "What are secular therapists' perspectives on the use of Worthington's REACH forgiveness model with complex trauma clients." For this study, preset questions in a semistructured interview allowed participants to share their perspectives. Purposive sampling recruited 15 secular therapists. Data were gathered through individual phone interviews then analyzed for common themes. This data were refined into three main themes and one subtheme: forgiveness is freedom in complex trauma recovery (subtheme: posttraumatic growth will include resistance), forgiveness therapy minimizes symptoms of complex trauma, and REACH forgiveness is beneficial in complex trauma recovery. According to the data, secular therapists strongly believe that forgiveness therapy is critical for trauma recovery. Furthermore, linking forgiveness therapy to complex trauma has catalytic potential for positive social change for practitioners, organizations, and an ever-increasing population of complex trauma survivors.

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Dedication

This work is dedicated to Adam, my husband, who has been an unwavering source of support and encouragement throughout my doctorate and the trials of life. To my children, Charlie, and Esther, simply put; you are the reason. Your faithful fearlessness in all things serves as an example to all; while this work is dedicated to both of you, you were the inspiration behind every word and every page.

This work is also dedicated to my parents, Charles and Cora Hicks, who have loved me unconditionally and supported every chapter of my life. Additionally, I dedicate this work to Vanessa Emm, my sister, who cheered the loudest, phoned multiple times a day, and eagerly, whereas I think begrudgingly, read my work, draft after draft, enthusiastically.

Finally, and most importantly, I thank God, for He is the one who first taught forgiveness. Nothing is more important than knowing what forgiveness is, as well as what it isn't. In Ephesians 4:32, He writes, "Be kind to one another, tender hearted, forgiving one another, as God in Christ forgave you." May all those burdened by injustice at the hands of others, or even themselves, read this work and find solace in the essential, albeit painful at times, redemption that forgiveness brings.

Acknowledgments

To my chair, Dr. Alice Yick, I thank you for raising the bar higher than I ever thought possible for myself, as well your extraordinary patience, leadership, and expertise. My success was not possible without you. In addition, I'd like to thank Dr. Janella Melius, my second committee member, and University Research Reviewer, Dr. Sean Hogan, for their invaluable contributions and unlimited support.

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Chapter 1: Introduction to the Study

Trauma was once considered an abnormal experience (Knight, 2014). On the contrary, in the United States alone, traumatic life events, such as sexual and physical violence and neglect, occur at high rates and are considered a significant public health problem (Costello et al., 2002; Khoury et al., 2010). In the general population, the incidence of trauma is alarmingly high. A concerning 70% of people worldwide have had or will experience a traumatic event, and multiple traumatic events are much more prevalent (Benjet et al., 2016; Kilpatrick et al., 2013; Kumar et al., 2019). Those who have experienced numerous and repeated victimization or other traumatic events are shown to have complex trauma. Individuals with complex trauma histories, for example, are more likely to have cognitive (including dissociative), affective, physical, behavioral, relational, and self-attributional difficulties in addition to the symptoms of the "classic" form of PTSD (posttraumatic stress disorder; Courtois & Gold, 2009; Kumar et al., 2019). C-PTSD (complex posttraumatic stress disorder; commonly referred to as complex trauma disorder) is a psychological disorder that can develop due to repeated exposure to interpersonal trauma over a considerable length of time (Cook et al., 2005; Cortman & Walden, 2018). The frequency of trauma is the essential distinction between the two disorders. PTSD is caused by a singular traumatic event, whereas C-PTSD is caused by long-term trauma, lasting months or even years, and is commonly referred to as "complex trauma" (Herman, 1992).

Complex trauma differs from an acute or chronic event; it is multifaceted and typically occurs repeatedly and cumulatively over a period of time, often within specific

relationships and contexts (Courtois, 2004). Complex trauma is premeditated, planned, and caused by other humans, such as domestic abuse, poverty, multiple military deployments, or severe child abuse (Courtois, 2004). Trauma exposure dramatically increases the risk of various adult psychological disorders, whereas those subjected to childhood trauma are often more resilient (Costello et al., 2002). Moreover, complex trauma impacts one's confidence in the future due to loss of hope, fears that life could end suddenly or early, limited, or low life expectations, or assume that regular life events will not occur (i.e., access to good work opportunities, access to education, or the ability to have committed, significant and loving relationships; Costello et al., 2002).

Historically, forgiveness has been a resource for victims (survivors) of interpersonal trauma or abuse to reconcile specific experiences with their lives (Wade & Worthington, 2005). Forgiveness is an intrapersonal process that involves cognitive, affective, and behavioral components in which a person releases a negative stance of unforgiveness to adopt a positive or prosocial stance toward the offender or the offense (McCullough et al., 2000; Worthington, 2005). Forgiveness differentiates itself from the constructions of excusing, condoning, forgetting, and reconciliation (Wade & Worthington, 2005). Forgiveness is, therefore, victim-focused, strength-based, and resilient approach to interpersonal offenses. Forgiveness also has a significant connection with both physical and mental well-being (Harris et al., 2007; Toussaint & Webb, 2005).

Forgiveness therapy can be a complicated and easily misunderstood concept (Freedman & Zarifkar, 2016). Forgiveness therapy focuses on and targets anger, anxiety, and depression (Lin et al., 2004). Enright and Fitzgibbons (2000) were among the first to

coin the term forgiveness therapy to describe the specific approach of "helping people overcome resentment, bitterness, and even hatred toward people who have mistreated them and at times cruelly" (p. 4). They stated that the focus of forgiveness therapy addressed the type of anger that devastates someone who has been deeply wronged by another and the anger an individual may feel towards themselves. There are many different types of models of forgiveness therapy. Worthington's 2006 five-step REACH model is one prominent type favored by therapists who specialize in forgiveness and reconciliation (Cosgrove & Konstam, 2008). Worthington's forgiveness technique REACH is an acronym that stands for the following: **R**ecall the hurt, **E**mpathize with self or offender, **A**ltruistic gift of forgiveness, **C**ommitment to forgive, **H**old on to the forgiveness (Worthington, 2005).

This research has positive social change implications. Presently, traditional psychotherapy modalities such as cognitive-behavioral therapy (CBT) or eye movement desensitization and reprocessing (EMDR) for PTSD and C-PTSD based disorders are used. However, they are not well-served due to the complexity of symptoms (Corrigan & Hull, 2015). While supporting empirical literature and interest in forgiveness research continue to grow, it is currently not a preferred treatment method with trauma or complex trauma survivors. Additionally, no trauma studies are using Worthington's REACH model of forgiveness (Wade et al., 2014).

In the behavioral and mental health fields, 90% of clients are healing from trauma experiences, predominately complex trauma (Costello et al., 2002; Khoury et al., 2010). The role of forgiveness in the field of behavioral and mental health is recognized as

therapeutically beneficial for therapists to help clients minimize negativity in their lives, improve mental health, reduce rumination, anger, and psychological difficulties, such as anxiety and depression (Gangdev, 2009; Wade et al., 2013). The purpose of this research was to examine the complexities and prevalence of complex trauma and offer guidance on forgiveness therapy for social workers who routinely deal with people who have suffered major interpersonal traumas. Linking the therapeutic approach of forgiveness therapy to complex trauma has the catalytic potential for positive social change and practice for practitioners, organizations, and an ever-increasing population of survivors.

Chapter 1 introduces the study background, including the literature gap and why this study is essential. This is followed by the problem statement, purpose of the study, specific research questions, conceptual framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance, and concludes with a summary of the introductory chapter.

Background

In the medical and behavioral sciences, the field of traumatic stress studies is steadily becoming a unique, multidisciplinary field (Wilson, 2014). Lander (2015) and Akhtar and Barlow (2018) argued that, in the case of a significant or minor interpersonal injury, the application of forgiveness therapy would strengthen both psychological well-being and physical health. The strength of forgiveness therapy is supported in Wade et al.'s (2014) meta-analysis study on the efficacy of forgiveness as a psychotherapeutic intervention. Eligible studies reported quantitative data on the forgiveness of a specific hurt or injustice following a professional intervention to promote forgiveness directly.

Wade and colleagues (2018) asserted that theoretically grounded forgiveness is a sound and beneficial choice for helping trauma survivors understand and cope with past hurts to improve mental and physical health and achieve resolution.

Moreover, the therapeutic method of forgiveness was given theoretical and empirical importance by Freedman and Zarifkar (2016) while addressing its misconceptions and efficacy with various populations. Traditional psychotherapy approaches for PTSD and complex trauma disorders, such as CBT or EMDR, are not well-served, according to Corrigan and Hull (2015), due to the complexity of symptoms. In addition, they maintained that clients would often leave treatment prematurely; thus, adopting a new modality to retain clients is needed.

A systematic review and meta-analysis from Akhtar and Barlow (2018) comparatively reviewed the two most widely used forgiveness interventions using both Enright's model and Worthington's REACH model. The included studies evaluated the effectiveness of forgiveness with participants reporting PTSD and C-PTSD, which include difficulty with marital hurts, sexual abuse, abortion, civil conflict, and a range of other interpersonal hurt and abuse (Akhtar & Barlow, 2018). Their findings reported that both models effectively improved mental health but needed further research to compare them against other treatment methods of interpersonal hurts and complex trauma. Wade and Worthington (2005) and Worthington and Wade (2019) focused on forgiveness's mental health benefits, its central theme derived from the Judeo-Christian teachings, and how best to promote forgiveness to a broad range of clinical issues, including complex trauma.

As indicated above, the qualitative, quantitative, systematic review and meta-analysis studies support forgiveness therapy's efficacy. However, minimal studies lack the specific link between complex trauma and forgiveness therapy as a viable treatment modality. Thus, it remains unclear how secular therapists use forgiveness therapy, particularly the REACH model, in working with complex trauma clients.

Problem Statement

In the United States, 90% of clients receiving public mental health treatment have experienced trauma and, in most cases, have experienced multiple traumatic events (Goodman et al., 1997; Jennings, 2004; Kilpatrick et al., 2013; Mueser et al., 1998), which is referred to as complex trauma. Complex trauma encompasses all types of child abuse, sexual abuse and trafficking, abandonment, traumatic childhood experiences, group conflict, domestic and family violence, civil strife, conflict or genocide, ethnic dislocation, exploitation, and physical disability (Corrigan & Hull, 2015; Giourou et al., 2018; Morrison & Casper, 2012). Psychotherapy with clients suffering complex trauma often presents complications due to the complexity and number of present and underlying symptoms (Chu & Adams, 1992; Linehan, 2018). These complications are indicative of the deficiencies in the ability to self-regulate enough to apply coping life skills, personal safety, and possible revictimization when recalling the trauma events (Corrigan & Hull, 2015; Courtois, 2004).

Experiencing complex trauma often negatively skews one's belief system as inferior or insignificant, which can lead to difficulties in establishing and sustaining healthy relationships due to deep-rooted feelings of guilt, shame, and failure (Giourou et

al., 2018). Commonly used treatment modalities are CBT, emotion-focused therapy (EFT), EMDR, and psychodynamic therapy (PT). However, they do not always adequately support complex trauma clients, resulting in clients prematurely leaving treatment (Corrigan & Hull, 2015).

Treatment-seeking survivors of complex trauma are pursuing normality and resiliency in their everyday life. This response is, in part, because they have remained in a chronic state of hostility, anger, or even rage while searching for revenge (Akhtar & Barlow, 2018). A further response to resolving hurt is forgiveness, which is defined as a decision to see beyond negative resentment-based emotions, cognitions, and behaviors and to cultivate favorable consideration of an offender, whether it be sympathy, compassion, or pity (Akhtar & Barlow, 2018; Enright & Fitzgibbons, 2000; Wade & Worthington, 2005). Momina and Sarwat (2015) asserted that forgiveness is a necessity, not a choice, and a proactive response to a more positive future. Forgiveness is a coping mechanism aimed at removing and replacing emotional damage with behavior(s) that are not influenced by the trauma, which notably is a central focus in therapy and counseling.

One treatment modality that can be suitable for such trauma is forgiveness therapy (Wade et al., 2013). Forgiveness therapy has been acknowledged as a beneficial treatment for therapists to help clients minimize not only the negativity in their lives but also facilitate the positive to promote mental health wellness and resiliency (Gangdev, 2009). Worthington (2006) developed an acrostic, five-step REACH model that supports the process of self-forgiveness and the forgiveness of others. The REACH model may be

favorable in guiding treatment for those that value forgiveness, and it has both a secular and Christian-tailored version (Worthington & Langberg, 2012; Worthington, 2005).

While forgiveness therapy is acknowledged as a beneficial treatment modality, it has primarily been incorporated among Christian therapists because the concept of forgiveness is steeply rooted in Judeo-Christian teachings. According Smedes (2003), "A healed memory is not a deleted memory. Instead, forgiving what we cannot forget creates a new way to remember. We change the memory of our past into a hope for our future" (p. 93). While forgiveness interventions are effective in promoting mental health wellness and resiliency by reducing rumination, anger, and psychological difficulties, such as anxiety and depression (Wade et al., 2013), what remains unclear is how secular therapists use forgiveness therapy, particularly the REACH model, in working with complex trauma clients.

Purpose of the Study

The purpose of this generic qualitative inquiry was to improve understanding and treatment interventions of secular therapists' use of forgiveness therapy, specifically, Worthington's REACH forgiveness model with complex trauma clients. The REACH forgiveness intervention is an evidence-based and empirically supported treatment modality to help facilitate therapeutic change, but only minimal attention has been applied to its efficacy within secular therapy and complex trauma. To address the gap in the literature, this qualitative study reflected an interpretive paradigm approach. Interpretive research is dialectical and typically has smaller sample sizes to collect rich,

in-depth data describing the experiences and perspectives of those being studied (see Schreier, 2018).

Research Questions

In this study, I sought to answer the following research questions:

RQ1: What are secular therapists' perspectives on the use of forgiveness therapy with complex trauma clients?

RQ2: What are secular therapists' perspectives on the use of Worthington's REACH forgiveness model with complex trauma clients?

Conceptual Framework

The conceptual framework that guides this study was Worthington's (2006) REACH forgiveness model which was developed as an adaptive, easy to teach, learn and later recall while providing flexibility to the practitioner to support diverse populations (see Worthington et al., 2012). Treatment-seeking survivors of complex trauma come with a breadth of negative cognitions; thus, survivors have likely developed core beliefs about self and others that can be characterized by feelings of worthlessness, low self-esteem, vulnerability, as well as mistrust of others (Knight, 2014; McCann & Pearlman, 1990). Unfortunately, too often working with complex trauma clients, the trauma events become the primary focus of the intervention. In contrast, REACH's 5-step model could best align and serve the client because forgiveness is a coping mechanism that removes and replaces emotional damage with behavior(s) that are not influenced by the trauma, which is notably a central focus in therapy and counseling. A more detailed examination

of forgiveness and its attributes to working with trauma survivors will be provided in Chapter 2.

The REACH forgiveness intervention was built under the positive psychology movement and is an evidence-based and empirically supported treatment model used in psychoeducational groups, individual, couple, group, and family therapy (Worthington et al., 2012). This framework is a five-step model that encourages participants to (a) Recall the hurt, (b) Empathize with the offender, (c) Altruism - give the altruistic gift of forgiveness, (d) Commit to forgiveness, and (e) Hold on to (maintain) forgiveness (Worthington, 2006). This five-step acrostic model was the framework from which I conducted my research as it provided a foundational and adaptive process of forgiveness while also offering secular therapists a clear understanding of forgiveness therapy in direct practice with complex trauma clients. The REACH model directly aligns with this research study because the research question specifically explores the use of the REACH model with secular therapists. A greater analysis of the logical connections to the elements of the framework in Chapter 2 is provided.

Nature of the Study

I employed a qualitative research design for this study, specifically using a generic qualitative approach. A generic qualitative approach is described by Caelli et al. (2003) as a study that seeks to discover and understand a process, a phenomenon, or worldviews and perspectives of the people involved. Qualitative research is rich, and the descriptive data collected will help to understand better how secular therapists assess complex trauma and determine treatment models or interventions.

Data for this study was collected through individual phone interviews with participants who consider themselves to be secular therapists, have knowledge of or practice forgiveness therapy, specifically REACH forgiveness, and who are practicing in their state of licensure. Following data collection from 15 study participants, the data was analyzed for common themes, categories, and patterns.

Definitions

The key concepts and other relevant terms are essential for this study and require a concise definition. Therefore, for each term, the following definitions are meaningful as they relate to the purpose of this research.

Christian: One who professes belief in the teachings of Jesus Christ (Merriam-Webster, 2020).

Complex trauma (CT): Complex trauma is premeditated, planned, and caused by other humans; it is multifaceted and typically occurs repeatedly and cumulatively over a period of time, often within specific relationships and contexts (Courtois, 2004).

Complex posttraumatic stress disorder (C-PTSD; complex PTSD): C-PTSD is long-lasting trauma that continues or repeats for months, even years (commonly referred to as complex trauma; Herman, 1992).

Decisional self-forgiveness: A decision to act without malice, self-blame, and self-condemnation against yourself and to treat yourself as having at least the same worth as others (Worthington, 2006).

Emotional self-forgiveness: The emotional substitution of unforgiving emotions with compassionate emotions for self, such as self-empathy, self-sympathy, self-compassion, and self-love (Worthington, 2006).

Forgiveness: A targeted and personal goal for victims to release themselves from vindictive motivations or destructive cyclical behaviors (Enright, 2012).

Forgiveness therapy: An overarching approach to decrease resentment and rumination of an interpersonal hurt or injury (Reed & Enright, 2006).

Positive psychology: The scientific study of positive human functioning and flourishing on multiple levels that include the biological, personal, relational, institutional, cultural, and global dimensions of life (Seligman et al., 2006).

Posttraumatic stress syndrome (PTSD): A mental health condition that's triggered by a terrifying event; either experiencing it or witnessing it (American Psychiatric Association, 2013; Knight, 2014).

REACH forgiveness model: An evidence-based and empirically supported treatment intervention used in psychoeducational groups, individual, couple, group, and family therapy (Worthington et al., 2012).

Reconciliation: Reconciliation is defined as the restoration of trust in an interpersonal relationship through mutual trustworthy behaviors (Worthington & Drinkard, 2000).

Secular therapist: A trained person with a nonreligious worldview who practices scientifically derived principles in establishing professional helping relationships with persons who seek assistance in resolving large or small psychological or relational

problems (religion is not a variable in secular therapy; Sommers-Flanagan & Sommers-Flanagan, 2018).

Self-forgiveness: As defined by Worthington (2006), it is the act of both decisional and emotional forgiveness working together; as defined by Enright (1996), a willingness to abandon self-resentment when the wrong is acknowledged while fostering love, compassion, and generosity toward oneself.

Spiritual: relating to, consisting of, or affecting the spirit; relating to sacred matters (Merriam-Webster, 2020).

Therapeutic interventions: Actions or practices in the context of psychology that enhance another person's psychological, social, or emotional well-being.

Trauma: Actual or threatened death, serious injury, or sexual violence (American Psychiatric Association, 2013).

Assumptions

For this qualitative study, I assumed that the research participant's responses were forthcoming and truthful as they were able to articulate their perspectives based on their own first-hand experience, education, and expertise. I also assumed that the research participants who participated in this study had clinical experience with complex trauma clients as it is the most common and pervasive reason individuals seek counseling and therapeutic guidance. Additionally, I assumed that the study participants had a vested interest in participating in this study to expand the knowledge of helping trauma survivors understand and cope with past hurts, improve mental and physical health, and achieve resolution (Wade et al., 2018). Lastly, the conceptualization for this study is

Worthington's (2006) REACH forgiveness model. I have assumed that the REACH forgiveness model is a valid, reliable, and appropriate conceptual model for exploring the research questions and advancing the knowledge and treatment of complex trauma.

Scope and Delimitations

I aimed to study the current perspectives of secular therapists on forgiveness therapy in response to complex trauma using the conceptual REACH forgiveness model. Scope and delimitations refer to who is included in the participant pool and who is excluded (Ferch, 2000; Myers, 2000). Data for this study was collected through individual phone interviews with participants who consider themselves to be secular therapists, have knowledge of or practice forgiveness therapy, specifically REACH forgiveness, and practice in their state of licensure. The qualitative methodology of this research intends to capture the breadth of participants' experience working in direct practice with complex trauma clients, their response to treatment, and the effects of the use of forgiveness therapy. The transferability of the study results may be possible, yet limited, due to the number of participants in the study. A sample size of 15 was proposed and believed to be sufficient for theoretical saturation. For this study, data saturation occurred by the tenth interviewee; thus, a sample size of 15 interviewees was sufficient to achieve data saturation. Rich and descriptive protocol questions and probes were used to elicit the depth and breadth of the participants' responses.

Limitations

Notable limitations are generalizability and subjectivity because qualitative research does not endorse objective, quantifiable outcomes (Ferch, 2000). Instead, qualitative studies are tools to describe and understand human experiences. Still, researchers inherently maintain their "humanness" during the research process, making it more challenging to escape from the subjective, even for the most experienced researchers (Myers, 2000).

Interview quality and reliability can present challenges during data collection via telephone on account of connectivity or service coverage. If these sometimes unavoidable glitches in technology should occur, it can run the risk of altering the rapport and first impressions between interviewer and interviewee rapport (Archibald et al., 2019). Further, challenges may occur with the recruitment and number of participants who have knowledge of or practice forgiveness therapy, specifically REACH forgiveness, and the biases participants may represent in their personal views of forgiveness therapy, including my own experiences of forgiveness therapy could create biases, which could produce study limitations. Of the possible limitations, connectivity did occur during data collection, as explained further in Chapter 5's section on study limitations. During one interview, I could not capture the participants' responses. The participant accommodated and relocated the interview to a more convenient location with better service coverage, resulting in minimal disruption.

Significance

This study is significant because it contributes knowledge to the field of social work and the provision of therapeutic services to clients. This research will fill a gap in understanding how secular therapists use forgiveness therapy, particularly the REACH model, in working with complex trauma clients. While the treatment modality of forgiveness therapy has been extensively researched, including that forgiveness has been concretely demonstrated in the literature of psychology and counseling, what remains limited is its application and use with complex trauma. Too often, forgiveness therapy comes with various perceptions, barriers, and beliefs (Courtois, 2004).

This study is unique because it calls for a more significant examination of Worthington's REACH forgiveness model specific to complex trauma and how it is used in direct practice. For example, in a surveyed sample of 101 clinical social workers, Denton and Martin (1998) found that the vast majority reported that forgiveness was especially helpful in coping with the issues of friendship, grief and loss, shame, self-recrimination associated with chemical dependence, and healing interpersonal injury. Similarly, a survey of 381 members of the American Mental Health Counselors Association supported therapists' responsibility to raise the issue of forgiveness when appropriate (Konstam et al., 2000). Moreover, this study found that 75% of therapists reported using client-focused forgiveness interventions, such as helping clients express and release anger, and 39% reported using offender-focused techniques, such as helping the client develop empathy for the individual who hurt them (Konstam et al., 2000). Moreover, after conducting an abstract search in May 2014, Lander (2015) found 69

papers on forgiveness and only five on forgiveness therapy supporting psychotherapy. Given the burgeoning literature on the positive impact of forgiveness for those who have suffered self or interpersonal injury, the lack of consideration given to forgiveness persists in social work literature (Lander, 2015). Therefore, the findings from this qualitative study can influence and shape education, training, and curricula development on the integration of forgiveness when working with complex trauma clients. Furthermore, Worthington's REACH model can be tailored for the specific and unique needs of this population for social work clinical practice.

This study's social change implications contribute to the growing body of literature on forgiveness therapy and complex trauma that will potentially be valuable to both practitioners and researchers. With better knowledge and understanding of forgiveness therapy and complex trauma, it is possible to envision a more critical role for this therapeutic modality in numerous fields of social work and therapeutic counseling practices where complex trauma is often a defining characteristic (Lander, 2015). This study aims to help mental health providers reshape direct practice interventions with their complex trauma population by providing a richer and more comprehensive look at the benefits of forgiveness. The incorporation of forgiveness therapy into the profession of social work may be facilitated through expanded research, continuing education, supervision, and direct clinical practice. Thus, this study's results have social change possibilities to enhance social work and counseling profession by enriching counselor education programs, their clients, and their communities (Davis et al., 2013).

Summary

With this research, I aimed to refine, advance, and expand the body of knowledge and applicability of forgiveness therapy and complex trauma. Existing literature has demonstrated extensive research on forgiveness therapy's treatment modality by effectively demonstrating its benefits in decreasing negative mood, affect, and overall mental and physical functioning. However, literature and research remain limited to forgiveness therapy perspectives with complex trauma by secular therapists, notably Worthington's REACH model of forgiveness.

Chapter 2 reviews current literature and offers an in-depth examination of forgiveness therapy, its current role, and how it psychologically and physically supports varying degrees of complex trauma such as sexual abuse, neglect, domestic violence, child abuse, and genocide. Additionally, the conceptual framework, Worthington's REACH forgiveness model, is discussed.

Chapter 2: Literature Review

One of the most pervasive psychological disorders currently is complex trauma (Padykula, 2010). Trauma and violence are widespread, dangerous, and costly public health issues. In the United States alone, 90% of clients seeking mental health services report having experienced trauma or complex trauma (multiple traumatic events; Goodman et al., 1997; Jennings, 2004; Kilpatrick et al., 2013; Mueser et al., 1998). Complex trauma results from repeated exposure to extreme stressors that generally begin in childhood or adolescence; they are perpetrated inside the caregiving system or by other adults typically considered to provide stability, safety, and security (Courtois & Ford, 2013). Individuals with complex trauma histories present therapists and other helping professionals with some of the most challenging issues and dilemmas (Courtois & Ford, 2013). Furthermore, individuals with a complex trauma history are often in a biological and psychological mode of survival even when they no longer face the same risk. Courtois and Ford (2013) asserted that complex trauma survivors are psychologically tormented and appear to be prisoners of their own emotions, grappling with rage, sorrow, alienation, distrust, uncertainty, poor self-esteem, humiliation, loneliness, and self-loathing.

Therapy for complex trauma takes, on average, longer than treatment for less complicated cases. Treatment can extend decades, if not a lifetime, for some people, while others may receive therapy on an episodic and as-needed basis (Courtois & Ford, 2013). Moreover, due to the complexity and number of present and underlying symptoms, psychotherapy with clients suffering from complex trauma frequently results

in mental health complications (Chu & Adams, 1992; Linehan, 2018). Traditional psychotherapy approaches such as CBT or EMDR for PTSD and complex trauma-based disorders are not well-served due to the complexity of symptoms (Corrigan & Hull, 2015). Moreover, they emphasized that clients frequently left treatment too soon, thus necessitating a new modality to help retain clients.

Forgiveness therapy is one form of treatment for such trauma (Wade et al., 2013). Therapists can use forgiveness therapy to help clients minimize the negative in their life while enabling the positive to improve mental health (Gangdev, 2009). Worthington (2006) developed the REACH model, a five-step acrostic, secular, and Christian-tailored version that supports the process of self-forgiveness and forgiveness (Worthington & Langberg, 2012; Worthington, 2005).

Forgiveness interventions improve mental health and resiliency by decreasing ruminations, anger, and psychological distress such as anxiety and depression (Wade et al., 2013). What remains unclear is how secular therapists use forgiveness therapy, particularly the REACH model, in working with complex trauma clients. Subsequently, the purpose of this qualitative inquiry is to improve understanding and treatment interventions of secular therapists' use of forgiveness therapy, specifically, Worthington's REACH forgiveness model with complex trauma clients. The REACH forgiveness intervention is an evidence-based and empirically supported treatment modality for facilitating therapeutic improvement; however, its efficacy in secular therapy and complex trauma has received minimal attention.

A comprehensive literature review of the main concepts for this study is discussed throughout this chapter. Moreover, the conceptual framework that guides this study is reviewed. Finally, this chapter concludes with a description of how this study expands the understanding and awareness of forgiveness therapy relevant to Worthington's REACH forgiveness model and the perspectives of this treatment modality with secular therapists working with complex trauma clients.

Literature Search Strategy

I gathered literature for review using Walden University's library, specifically using the following databases: APA PsycNet, NCBI (National Center for Biotechnology Information), PubMed, Wiley Online Library, SAGE Journals, Google Scholar, and Thoreau multi-database. Additionally, Pro-Quest was used to review Walden University dissertations. The phrases and keywords used in the literature search were *forgiveness therapy, forgiveness and therapy, complex trauma, complex PTSD, C-PTSD, complex posttraumatic stress disorder, secular therapists, non-religious, counselors, therapists, Worthington, and forgiveness,* and *REACH forgiveness*. Within the literature search playing with keywords and phrases produced greater results. For example, when searching for forgiveness therapy versus forgiveness and therapy, the addition of "and" connected the words and told the database to look for both; in effect, this brought back more results when searching for forgiveness therapy. This was also the case when searching for complex trauma or C-PTSD. Using quotation marks and the addition of "or" helped refine search results partly because this phrasing is not used nearly as much as the more commonly searched PTSD. Searching "complex posttraumatic stress

disorder" and the connection of complex trauma "or" complex posttraumatic stress disorder, resulted in more topical literature.

Similarly, with Worthington's REACH forgiveness model, information was limited within scholarly libraries, and therefore, I searched the topic differently by including Worthington and forgiveness and REACH forgiveness. The reviewed literature sources were full-text and peer-reviewed. Articles focused on 1995-to-present publication dates while not restricting classical literature to ensure that existing and appropriate literature for review was captured.

After conducting the literature search, I noted that extensive research has been done on forgiveness therapy, but what remains limited is information on its use and application with complex trauma, specifically Worthington's REACH model of forgiveness. Throughout this chapter, there is strong evidence of the efficacy of forgiveness therapy as a therapeutic approach to complex trauma. Forgiveness therapy decreases shame and depression in those who have experienced trauma like sexual abuse, molestation, and child abuse (Huh et al., 2017). Forgiveness therapy is a promising post relationship and postcrisis therapeutic approach for women who have undergone domestic or intimate partner violence (Baskin & Enright, 2004; Reed & Enright, 2006), affords a greater state of emotional and psychological functioning for persons living with a disability (Stuntzner et al., 2019), and can restore normality, trust, and calmness among survivors of genocide (Ordóñez-Carabaño et al., 2020).

Conceptual Framework

The conceptual framework that guided this study is Worthington's (2001) REACH forgiveness model. Worthington developed the REACH forgiveness model to be an adaptive, easy to teach, and easy to learn tool while also providing flexibility to the practitioner to support diverse populations (Worthington et al., 2012). Worthington's (2006) REACH forgiveness model has a companion 2-hour self-directed workbook titled "Your Path to REACH Forgiveness." Within the workbook, Worthington made the following statement about forgiveness:

> Forgiveness can be quick and dramatic. It can reverse the direction you have been traveling. Importantly, forgiveness does not mean forgetting, nor does it mean pretending that the hurt never happened. Forgiveness is just replacing ill-will towards the offender with good-will. Forgiveness also does not mean giving up justice. Forgiving means desiring the ultimate good of the offender, and this can be done without excusing the wrongful action while still pursuing a just outcome. (p. 3)

Forgiveness is not the removal of the offender's consequences, nor the assertion of acceptability for the wrongs done, nor the denial of what occurred (Clinton & Hawkins, 2009), but rather the action that allows the victim to move through the mental and physical suffering caused by the offense. Furthermore, forgiveness is the process of transforming resentment, hate, behaviors of avoidance, or violent retaliation by replacing it with a benevolent attitude toward those who have caused harm (Kimmes & Durtschi, 2016; Strelan & Wojtysiak, 2009).

The REACH forgiveness model is an evidence-based and empirically supported treatment intervention used in psychoeducational groups, individual, couple, group, and family therapy (Worthington et al., 2012). Worthington's REACH forgiveness model is one of the two most researched interventions on forgiveness (Nation et al., 2018). The second is Enright's forgiveness therapy process model that uses a 20-step system; both models aim to move people to a more forgiving state of mind with themselves and others. In addition, Weir (2017) asserted that research shows that whether a person is suffering a minor or significant grievance, learning to forgive those that have hurt you will show significant physical and psychological benefits.

Worthington's (2006) five-step REACH forgiveness model:

1. Recall the hurt.
2. Empathize with the offender.
3. Altruism - giving the altruistic gift of forgiveness.
4. Commit to forgiveness.
5. Hold on to (maintain) forgiveness.

Each letter in the REACH acronym is a significant component of Worthington's process of forgiveness. The model's first step is to recall (R): participants are asked to recall the experience and associated emotions. The second is to empathize (E) with the offender, considering another perspective and probable factors contributing to the offender's actions. This step is achieved without condoning the other person's actions or rejecting the often-strong feelings as a response to the offended person. The third is to explore forgiveness as an altruistic (A) gift to the offender. This step offers the participant(s) the

understanding that forgiveness can be offered freely or justifiably withheld and recall when others have forgiven them. Fourth is committing (C) to forgive, committing to forgiveness, striving for a greater understanding of forgiveness while recognizing it is a process that sometimes needs time to mature entirely. Last is to hold (H) onto forgiveness through trial times or when bitterness and anger return (Worthington et al., 2010).

An intervention using the REACH model is meant to be performed in a group setting but can easily be achieved individually; it can take 6 to 18 hours from start to finish based on the length of time spent on each step (Worthington et al., 2010). Before initiating the intervention, participants are asked to define the injury/offense they would like to forgive. It is recommended that participants pick one less extreme injury when they first work toward the intervention. Worthington (2006) stated that participants first adapt the model to less severe injuries and then apply it to other, more traumatic injuries. Participant workbooks detail the collective tasks for each phase in the REACH forgiveness model. Activities as “optional,” “vital,” and “highly vital.” are labeled. The manual notes that activities labeled “vital” and “highly vital” must be included in the workshop, while activities labeled “optional” fall under the discretion of the facilitator (Worthington et al., 2010; Worthington, 2006).

Nation et al. (2018) provided an example of how best to introduce the process of forgiveness:

1. Imagine holding the grudge or the hurt tightly in your hands with outstretched arms.

2. Having held it so tightly with outstretched arms, you begin to feel its burdening weight physically.

3. The decision to forgive is now in their control; they can symbolically release it to fall to the floor, relieve their arms or not, release it but lower their arms and revisit it another time.

Nation et al. conducted one of the first studies to evaluate the efficacy of an Internet-based, self-directed approach to Worthington's REACH forgiveness model. A total of 130 adult participants (122 females with a mean age of 48 years) participated in the study. Following the pretreatment assessment, only 36 participants of the 130 completed the 7-hour REACH forgiveness module and postintervention assessment; 32 then completed a 3-month follow-up. Participants' postintervention scores showed improvements in overall forgiveness, including reductions in avoidance motivations, anger, and resentment. Additionally, at a 3-month postintervention follow-up, 32 participants felt their decisional and emotional forgiveness compared to pretreatment intervention had either improved or maintained (Nation et al., 2018). This study by Nation et al. has the potential to improve forgiveness-related responses, particularly those involving emotional forgiveness. Methods to increase program resilience and target suitable recipients, on the other hand, require further research and development.

Treatment-seeking survivors of complex trauma come with a breadth of negative cognitions; thus, survivors have likely developed core beliefs about self and others that can be characterized by feelings of worthlessness, low self-esteem, vulnerability, as well as mistrust of others (Knight, 2014; McCann & Pearlman, 1990). Too often working with

complex trauma clients, the trauma events become the primary focus of the intervention. In contrast, REACH's five-step model could best align and serve the client because forgiveness is a coping mechanism that removes and replaces emotional damage with behavior(s) that are not influenced by the trauma, which is notably a central focus in therapy and counseling.

Worthington's five-step acrostic model is the conceptual framework from which I have conducted my research. It provides a foundational and adaptive process of forgiveness while also offering secular therapists a clear understanding of forgiveness therapy in direct practice with complex trauma clients. The REACH model directly aligns with this research study because the research question specifically explores the use of the REACH model with secular therapists. Despite the growing body of research of forgiveness therapy within positive psychology and other disciplines, only minimal attempts have directly linked the REACH model, "forgiveness of others," into direct practice with complex trauma.

Literature Review Related to Key Constructs

Definitions of Forgiveness

Definitions play a crucial role in the growing literature of forgiveness, and literature defines it in various ways. Forgiveness revolves around personal experience; Wade and Worthington (2005) and Worthington and Wade (2019) asserted that a more comprehensive understanding of forgiveness is needed in both the public and professional sectors to understand that forgiveness is an art as well as a science. Forgiveness can help shape how people deal individually and socially with transgressions

and offenses. It shapes one's well-being and mental health; it extends into a person's experiences and societal transactions, and affects relationships between groups (Worthington, 2005).

Forgiveness is an individualized and personal choice where a person who has been hurt or offended by another person can reduce negative actions, thoughts, and emotions (i.e., anger, retribution) towards the offending person by replacing them with more constructive behaviors and emotions such as compassion, tolerance, even, benevolence (Enright, 2012; Enright & Fitzgibbons, 2015; Stuntzner et al., 2019; Worthington, 2005). Moreover, forgiveness is defined as humbly relinquishing vengeance and hate-filled ideology in the face of moral injustices or wrongdoing (Exline et al., 2004), undeservedly canceling the debt caused by interpersonal violence or injustice (Baskin & Enright, 2004), with the willingness to offer undeserved compassion toward an offender. Similarly, Hultman (2007) defined forgiveness as an emotional, mental, and spiritual process to eliminate resentment and anger, with the desire to no longer seek restitution or punishment of the offender.

Collectively, scholars agree that the targeted and purposeful goal of forgiveness is for victims to release themselves from vindictive motivations or destructive cyclical behaviors (Enright, 2012). While forgiveness encapsulates everything that involves the presence of hurt or betrayal between two persons, Svalina and Webb (2011) and Stuntzner et al. (2019) contended that forgiveness can also be synonymous with the need to forgive oneself, events that occur continuously, or a higher being such as God. This

reasoning is partly because some people have experienced “repeated” insults, injustices, or hurts by known or unknown individuals (Stuntzner et al., 2019).

Forgiveness requires changing behaviors, motives, motivations, and emotions (McCullough et al., 2000, 2003, 2007) and has been conceptualized in the literature as involving two reactions to the offender: the release of negative feelings as well as the implementation of grace and mercy (McCullough, 1997, 2000; Witvliet et al., 2001; Worthington, 2005). McCullough et al. (1997) defined forgiveness as “a motivational transformation that inclines people to inhibit relationship-destructive responses and to behave constructively toward someone who has behaved destructively toward them” (p. 321). Moreover, Alim et al. (2019) defined forgiveness as a positive transformation from a host of interrelated emotional and cognitive responses experienced by a victim when referring to their offender or offense.

As the definitions of forgiveness vary, Enright et al. (1992), and more recently Freedman and Zarifkar (2016), agreed that scholars accept that forgiveness differentiates itself from other constructs such as reconciliation (restoring the relationship), pardoning (legally speaking to absolve the offender of their guilt or offense), excusing or justification (lessening blame attached to an offense), and condoning (to justify the crime, hurt, or injustice; Lichtenfeld et al., 2019; McCullough & Witvliet, 2002). While definitions of forgiveness may differ slightly from one another, the presented and current literature demonstrates the core foundational understanding that: responses to offenders tend to be less negative and more positive (Exline et al., 2003; Freedman & Zarifkar, 2016; Karremans & Van Lange, 2004; McCullough et al., 2003; Strelan & Wojtysiak,

2009). Additionally, Goertzen (2002) posited that forgiveness differs itself from defense mechanisms commonly seen in victims, such as dissociation, regression, suppression, repression, and denial because “they involve a refusal to acknowledge the offense” (p. 4). Views about forgiveness’s exact nature vary, as scholars have defined forgiveness in numerous ways throughout literature; however, there is a unanimous consensus that it is suitable for people (Worthington, 2006).

Importantly, current research indicates that forgiveness is a viable and evidence-based treatment for transgressions (Wade et al., 2014). However, not enough research has been conducted to answer specific questions about the efficacy of forgiveness interventions, specifically alongside complex trauma. While definitions of forgiveness differ slightly, and it has traditionally been associated with religion and philosophy, it has made its way into the field of psychology and is becoming an increasingly popular research topic. The power of forgiveness to aid clients in healing from the complexities of complex trauma and interpersonal injury cannot be overstated (Freedman, 2011).

Efficacy of Forgiveness Therapy

Forgiveness therapy’s target focus and overarching goal is to decrease resentment and rumination of an interpersonal hurt or injury. Reed and Enright (2006) conducted an empirical qualitative study on forgiveness therapy outcome effects versus alternative treatment modalities (AT; assertiveness, CBT, interpersonal skill-building, and anger validation) among women who have experienced spousal emotional abuse. Participants were 20 mentally abused women in a Midwest city who had been divorced or

permanently separated from their husbands or intimate partner for at least two years. They varied from 32 to 54 years of age ($M = 44.95$, $SD = 7.01$) (Reed & Enright, 2006). The effectiveness of alternative therapy versus forgiveness therapy was tested at $p < 0.05$. Participants receiving forgiveness therapy demonstrated substantially more significant improvement than alternative therapy participants in depression, anxiety, posttraumatic stress symptoms, self-esteem, environmental mastery, and seeking meaning in suffering, with improvements retained during follow-up (Reed & Enright, 2006). The study's findings showed that forgiveness therapy has significance for the long-term rehabilitation of emotionally abused post-relationship women. Forgiveness therapy is promising as a post-relationship, post-crisis therapeutic approach for women who have undergone complex emotional spousal trauma, as it offers relief from negative psychological implications and encourages the positive qualities of bravery, maturity, and altruism (Baskin & Enright, 2004; Reed & Enright, 2006). Lander's (2015) qualitative case study explored the contributions of forgiveness therapy in social work and practice, in part, to the relative surge in recent decades of the scholarship on forgiveness therapy. Lander (2015) asserts that social workers work in various practice and agency settings and will most commonly encounter clients with complex trauma histories or experienced a detrimental personal injury. Thus, directly addressing forgiveness in therapy is valuable because forgiveness is linked to improved posttraumatic growth. Lander (2015) asserts that, while social work scholars have noticed the surge of interest on the topic of forgiveness in the last 20 years, the study of social work clients and forgiveness therapy remains virtually non-existent (Fehr et al., 2010; Lander, 2015; Yun & Gallant, 2010).

To date, the two most prominent therapeutic approaches to help facilitate forgiveness therapy are Enright's process model of forgiveness and Worthington's REACH forgiveness model (Lander, 2015; McCullough et al., 1997). According to Lander (2015), forgiveness therapy and social work have four points of convergence. First, providing a vision is essential to social work clients because they are commonly exposed to alternative or new perspectives that help facilitate stress and cope with problematic situations. A social work practitioner offers these therapeutic visions to empower clients to act on their inherent abilities to improve their life circumstances. While forgiveness therapy squarely provides the option for resolving past trauma or significant personal injury (Horejsi et al., 2010; Lander, 2015), context is strongly emphasized in social work and forgiveness therapy. The person-in-environment paradigm is fundamental to social work practice; fundamental to forgiveness therapy is the influence of life circumstances and situational factors of the transgressor or harmful behavior (Horejsi et al., 2010; Lander, 2015). The context is the combination of societal, community, and individual, otherwise known as macro, meso, and micro. Thirdly, similar to social work, forgiveness therapy stresses the centrality of emotions while deep emotional interaction is central to social work (Chung, 2010; Enright, 1996; Lander, 2015). Fourth, empathy is essential in forgiveness (Lander, 2015; Wade et al., 2005); both social work and forgiveness therapy reinforce the commanding value of empathy in human relationships. Lander (2015) urges social workers or any persons who deliver mental health services to implement forgiveness therapy into their work to effectively offer mental and physical health well-being to the clients they serve.

Baskin and Enright's (2004) meta-analysis reported nine empirically, quantitative, published studies based on forgiveness models. Each study analyzed forgiveness interventions and their effectiveness within therapy for people who have experienced unjust treatment or violence that resulted in deep emotional pain. Examples of study participants within three of the analyzed studies were (a) participants who had to forgive something, (b) participants who had an emotional hurt over something that happened, (c) participants who had a definite person in mind to forgive, and (d) participants who were not experiencing grief (Hebl & Enright, 1993), (e) college students expressing deprived-parental-love (Al-Mabuk et al., 1995), and (f) participants restoring relationships with significant others or offenders (McCullough & Worthington, 1995). Baskin and Enright (2004) organized the studies into three groups: decision-based, process-based community, and process-based individual interventions. In contrast with control groups, the decision-based interventions showed no impact on forgiveness and other mental health indicators. On the other hand, the process-based group interventions showed substantial effects, and the process-based individual interventions showed significant effects. Subsequently, efficacy in clinical and other settings for the use of forgiveness has been demonstrated (Baskin & Enright, 2004). There are a variety of findings from the results of this analysis. First, forgiveness is not a fixed mental health variable, thus, leaving counselors and therapists questioning consideration of this variable. In addition, anger, depression, or anxiety resulting from injustice or lack of forgiveness has yet been included in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.) as a diagnosis (DSM-5; American Psychiatric Association [APA], 2013; Baskin & Enright,

2004). Moreover, forgiveness can be mistaken as a weakness that can contribute to the concept of waiving the right of one to pursue justice; thus, retribution may be regarded as more appropriate than forgiveness (Baskin & Enright, 2004; Gangdev, 2009).

Wade et al. (2014) reported that using forgiveness interventions resulted in reduced symptoms of stress, anxiety, and depression, while at the same time improving and increasing feelings of hope. Similarly, in review, Akhtar and Barlow (2018), Griffin et al. (2014), and Griffin et al. (2015) asserted that both decisional and emotional forgiveness is directly related to improved positive mental health (i.e., hope, optimism, social support, and life satisfaction) and decreased adverse mental health outcomes (i.e., stress, C-PTSD, anger, anxiety, depression, hopelessness). Consequently, a mental state of unforgiveness is an associated stress response that produces negative mental health symptoms.

Forgiveness Misconceptions

Forgiveness is often perceived as a weakness; however, quite the opposite. Forgiveness demonstrates a strength of character, wisdom, courage, and fortitude to regain personal normality and improved quality of life. Anne Lamott (2000) noted, “In fact, not forgiving is like drinking rat poison and then waiting for the rat to die” (p. 134). One of the greatest misconceptions is that forgiveness equals reconciliation; Wade and Worthington (2005) argue that, when discussing forgiveness, it must be remembered that reconciliation is not forgiveness. However, it is possible to reconcile without truly forgiving the offender. Freedman and Zarifkar (2016) recommend that therapists clarify the distinction between forgiveness and reconciliation and ensure that clients understand

that reconciliation is not required (or always possible) in the process of forgiveness. Clinton and Hawkins (2009) state that "one person can forgive, but it takes two to reconcile" (p. 128). In addition, forgiveness is not the removal of consequences from the offender, nor assert acceptability for the wrongs done, or denial of what occurred (Clinton & Hawkins, 2009) but rather an action that allows the victim to move through the mental and physical suffering as a result of the offense.

Decisional and Emotional Forgiveness

Two independent elements of forgiveness defined by Worthington (2006) are decisional and emotional forgiveness. The goal of deciding to forgive is to adjust one's intentions about one's actions towards an offender so that one's impulses for vengeance and avoidance decrease and one can see the offender as a valued individual (Exline et al., 2003). On the other hand, emotional forgiveness requires substituting unforgiveness-related negative emotions such as counterfactual thoughts, obsessions of control over self and their environment, increased rumination, and fantasies of retribution and retaliation (Kira et al., 2009), with constructive emotions such as perpetrator empathy, sympathy, or love (Worthington, 2006). In addition, a host of mental health advantages and physical health have been correlated with emotional forgiveness (Toussaint & Webb, 2005; Worthington et al., 2007).

Very few empirical studies have looked at decisional and emotional forgiveness. While some theories include decisional and emotional forgiving processes in their model, empirical evidence is rare in these processes' variations (Lichtenfeld et al., 2015). The role of emotion is strongly emphasized when distinguishing the differences between

decisional and emotional forgiveness (Exline et al., 2003; Lichtenfeld et al., 2015; Worthington & Scherer, 2004; Worthington et al., 2007). Emotional forgiveness is substituting negative and ruminating feelings for other-oriented positive feelings, while decisional is behavior and intentional statements of eliminating revenge.

A quantitative experimental study conducted by Lichtenfeld et al. (2015) examined the differences between emotional and decisional forgiveness with the inclusion of forgetting and the cognitive mechanisms involved in forgiveness. The study participants were all female undergraduate students (N = 42; mean age 22.3 years) who participated for course credits at Ludwig Maximilian University of Munich, Germany. Lichtenfeld et al. (2015) indicated that emotions play a pivotal role in the decision-making process and that without emotional participation, decision-making may not even be possible or far from optimal. Moreover, Lichtenfeld et al. (2015) expressed that decision-making research reveals that behavioral choices can benefit from the interchange between emotional and cognitive processes; in the same way, forgiveness can also benefit from emotional involvement when forgiving another person. This study found that emotional forgiveness leads to significantly higher forgetting levels relative to both decisional forgiveness and no forgiveness concerning offense-relevant traits. The Lichtenfeld et al. (2015) study is particularly relevant to psychotherapy and interventions designed to promote forgiveness, in part because this study emphasizes within their findings that it is not enough for an individual to decide to forgive, but rather to incorporate emotions and empathy during the process when pursuing an actual forgiving state either with themselves or toward a transgressor. In combination, emotional and

decisional forgiving works best. In research, decision-making views were once dominated by connecting decision-making to rational processes that are empty of emotion; emotions detract from rational decision-making. (Lichtenfeld et al., 2015). Whereas today, it is widely recognized that emotions support adaptive functions because they prioritize specific goals and, in doing so, mobilize energy and guide behavior (Bagozzi et al., 2000; Damasio & Damasio, 2012; Lichtenfeld et al., 2015). Moreover, Lichtenfeld et al.'s (2015) findings corroborate with the suggestion of Worthington and colleagues (2007) in that decisional forgiveness (intention to respond differently toward an offender) is substantially different from emotional forgiveness (the act of replacing negative emotions with positive emotions). This is not to suggest that decisional forgiveness is not an essential step in the forgiving process, but rather, it demonstrates that there is no distinction between unforgiveness and decisional forgiveness; hence, decisional forgiveness has similar cognitive implications as that of no forgiveness at all (Lichtenfeld et al., 2015; Worthington et al., 2007).

Self-Forgiveness

The earliest psychological definition of self-forgiveness was introduced by Enright and the Human Development Research Group (1996) in which "self-forgiveness is a willingness to abandon self-resentment in the face of one's acknowledged objective wrong while fostering compassion, generosity, and love toward oneself" (Enright & The Human Development Study Group, 1996, p. 116). In a meta-analysis of self-forgiveness and well-being, Davis et al. (2015) define self-forgiveness as "an emotion-focused coping

strategy that involves reducing negative and increasing positive thoughts, emotions, motivations and behaviors regarding oneself" (pp. 329-330).

The impact of self-forgiveness has been studied across a range of populations and varying contexts such as eating disorders (Peterson et al., 2016), drug and alcohol addiction (Gueta, 2013; McGaffin et al., 2013), smoking (Wohl & Thompson, 2011), mothering/parenting (Gueta, 2013), gambling (Squires et al., 2011), eating disorders (Peterson et al., 2016), living with HIV/AIDS (Mudgal & Tiwari, 2015), cancer patients (Toussaint et al., 2014a), hypersexual disorders (Hook et al., 2015), and complex trauma of war survivors, and military service members (Worthington & Langberg, 2012). Self-forgiveness is not easy in research nor practice (Woodyatt et al., 2017). The majority of research on self-forgiveness has been cross-sectional studies that measure the outcome and exposures of participants simultaneously. Conversely, the process of self-forgiveness unfolds differently and at different times, varying on the individual, thus, making self-forgiveness research challenging (Woodyatt et al., 2017; Worthington & Langberg, 2012). Although, in clinical practice, the five steps to REACH forgiveness can be adapted to self-forgiveness and engaging in self-forgiveness, Woodyatt et al. (2017) suggests the following core elements to guide the intervention, 1) define self-forgiveness that is structured to the intervention (focus on one specific event to forgive rather than a global change), 2) use exercises that produce memorable, emotion-focused responses, 3) establish a clear decision or choice to forgive oneself, and 4) enable clients to generalize the changes and the process of transition beyond the particular event that the intervention has centered on (Woodyatt et al., 2017; Worthington & Langberg, 2012).

Trauma

Trauma has been defined in a variety of ways throughout decades of research. The concept of trauma as a distinct symptomology in the behavioral health profession continues to evolve (Briere & Scott, 2014). Trauma survivors are significantly more prone to have developmental issues, health and medical conditions, and mental health disorders, such as classic PTSD and its variant, complex PTSD (CPTSD), as well as mood, anxiety, addiction, and dissociative disorders (Brand et al., 2019; Henning et al., 2021; Wilgus et al., 2016). Posttraumatic stress disorder (PTSD), for example, was not included in the DSM (DSM–3) until 1980 and was, at the time, considered an anxiety disorder (American Psychiatric Association, 2013). Currently, PTSD falls under the category of trauma and stress-related disorders, adjustment disorders, acute stress disorder (formerly classified as an anxiety disorder), reactive attachment disorder, disinhibited social engagement disorder (new diagnosis), acute stress disorder, as well as undefined trauma-and stressor-related disorders (American Psychiatric Association, 2013). In addition, other varieties of trauma and traumatic stress reactions have been found and investigated since the categorization of PTSD over 30 decades ago (Briere & Scott, 2014). Complex trauma and its clinical counterpart, complex PTSD (CPTSD), are increasingly recognized by experts. However, complex PTSD is not presently listed in the DSM–5 and goes beyond the PTSD criteria in that it encompasses emotion dysregulation, a loss of self-integrity, and problems relating to and being intimate with others (Courtois & Ford, 2013; Herman, 1992). In the behavioral health literature on trauma, the following trauma-related words exist interchangeably or in connection to one another:

- Trauma: trauma symptoms, psychological wounding, psychological stress reaction, emotional trauma, psychological trauma, victimization, traumatic stress, traumatic stress reaction, physical stress reaction.
- Complex trauma: complex PTSD, developmental trauma disorder, victimization symptoms, multiple traumas, sanctuary trauma, chronic trauma, serial trauma, disorders of extreme stress (not specified), developmental trauma disorder, cumulative trauma.
- Complex PTSD: complex trauma, borderline personality disorder (BPD) developmental trauma disorder, serial trauma, victimization symptoms, poly-victimization, multiple traumas, chronic trauma, disorders of extreme stress not otherwise specified, developmental trauma disorder, cumulative trauma, sanctuary trauma.
- PTSD: traumatic war neurosis, stress syndrome, shell shock, battle fatigue, combat fatigue, posttraumatic stress syndrome, complex PTSD.
- Traumatic stress: PTSD, psychological stress reaction, traumatic stress reaction, distress symptoms, psychotrauma.
- Historical trauma: historical grief, unresolved historical grief, transgenerational trauma, intergenerational trauma, multigenerational trauma, survivor's guilt, secondary traumatization, epigenetics, psychological wounding, structural violence, historical loss, sociocultural stress, indigenous child trauma, collective trauma, community trauma.
- Secondary trauma: compassion fatigue, vicarious traumatization.

- Traumatic stress: PTSD, traumatic stress reaction, prolonged stress reaction, trauma symptoms, psychological stress reaction, distress symptoms, psychotrauma.
- Re-traumatization: re-victimization, traumatic distress reactivation, trauma re-exposure, serial exposure, sequential trauma, sanctuary harm, system-oriented trauma (SAMHSA launches national registry of evidence-based programs and practices (NREPP), 2007, p. 4; U. S. Department of Health and Human Services, 2016).

Complex Trauma

What is and what makes complex trauma different from other types of psychological trauma? Courtois (2004) asserts that complex trauma typically refers to interpersonal traumatic stressors that are premeditated, orchestrated, and planned by other individuals. The interpersonal nature of complex trauma predictably involves situations in which the traumatized individual cannot escape the traumatic events because they feel physically or psychologically constrained to them (Herman, 1992). Due to this constraint, individuals who have experienced C-PTSD have additional self-regulating disturbances beyond symptoms typically seen with PTSD. These include a disturbing belief system and or somatic (physical) complaints, disorganization, problems with attention or consciousness (i.e., dissociative experiences), difficulty retaining relationships, and difficulty regulating emotional responses (Bendall et al., 2020; Briere & Scott, 2012; Cloitre et al., 2013). According to the ICD-11 (International Classification of Diseases 11th Revision), in addition to the fulfillment of three (impaired) self-organization

clusters: affective dysregulation, negative self-concept, and disrupted relationships, C-PTSD is correlated with recurrent trauma and needs meeting the PTSD criteria (Ben-Ezra et al., 2012; Cloitre et al., 2013; Shrira et al., 2019).

Complex trauma encompasses all types of child abuse, sexual abuse and trafficking, abandonment, traumatic childhood experiences, group conflict, domestic and family violence, civil strife, conflict or genocide, ethnic dislocation, exploitation, and physical disability (Corrigan & Hull, 2015; Giourou et al., 2018; Morrison & Casper, 2012). Complex trauma recovery consists of recovering from numerous traumatic events that accumulate and build within the survivor's heart and mind (Saint Arnault & Sinko, 2019). In the general population, the incidence of trauma is alarmingly high. About 70% of people worldwide have witnessed a traumatic event in their lives, and exposure to multiple traumatic events is an even more common phenomenon (Benjet et al., 2016; Kilpatrick et al., 2013; Kumar et al., 2019). Multiple traumatic events are more common because they cover a broader spectrum of traumas, including all forms of abuse, abandonment, exploitation, group conflict, domestic and family violence, civil conflict, or genocide, ethnic dislocation, and physical disability. In addition, those who have been subjected to different and repetitious victimization or other trauma incidents, known as complex trauma, often show greater complexity levels in symptoms or behaviors than people with just one or short-term traumatic experiences (Courtois & Gold, 2009).

Kumar and colleagues (2019) assert that the symptom complexities of individuals with a history of complex trauma include cognitive dissociation, somatic body disorder, mental, relational, and self-attribution symptoms far beyond the "normal" of "classic"

type of PTSD symptoms, which need to be explicitly assessed to make recovery and treatment more efficient and comprehensive. Complex trauma therapy must involve safety stabilization, protection, and strengthening the capacity to maintain emotions as its primary tasks early in treatment and before any past-focused trauma exploration (Cloitre et al., 2012; Kumar et al., 2019). Traditional psychotherapy modalities such as CBT (cognitive-behavioral therapy), EMDR (eye movement desensitization and reprocessing), in combination with medications such as Prozac, Zoloft, or Paxil for PTSD and C-PTSD based disorders are not well-served due to the complexity of symptoms (Corrigan & Hull, 2015). In trauma-specific therapy, objectives and approaches differ; some focus on the present while others focus on the past, and some combine both (Najavits, 2007). Present-focused techniques usually discuss current and existing coping strategies, symptom management for improved functioning, and psychoeducation. In comparison, past-focused techniques concentrate on sharing the trauma story with a focus on how the individual is currently functioning (mentally, physically, socially), discussing emotions that otherwise were too overwhelming to understand in the past, providing guidance for more effective coping strategies (Najavits, 2007). Mental and behavioral health counselors can best serve complex trauma clients by providing integrated treatments that combine therapeutic models to target presenting symptoms and disorders (U.S. Department of Health and Human Services, 2016; Najavits, 2007).

Genocide and Civil Strife

Genocide severely impacts a country's social fabric, and genocide divides people into three groups - victims, perpetrators, and bystanders. Victim groups perceive

perpetrator group members as equivalently immoral following violent conflicts, thus impeding forgiveness among each group (Beneda et al., 2018). It is a profoundly disempowering and traumatic event to experience genocidal violence. In the wake of genocide, survivors struggle with the desire for revenge, inability to forgive while also fearing repeated victimization, alienation from their fellow citizens, acute loneliness, and the inability to trust. As a result, PTSD symptoms, transgenerational trauma transmission, and survivors seeking revenge have been addressed in the most current literature on victims of genocide (Field & Chhim, 2008; Sagi-Schwartz et al., 2008).

Research has focused on PTSD of Tutsi survivors of the Rwandan genocide, but C-PTSD remains understudied as well as the subsequent intergenerational effects (Shrira et al., 2019). C-PTSD has shown to be prominent among extreme trauma survivors (Hoffman et al., 2018; Nickerson et al., 2017). According to the ICD-11 (International Classification of Diseases 11th revision, posttraumatic stress disorder (PTSD) was amended, and C-PTSD was included as a sibling disorder to PTSD. Future study is needed to better understand how re-experiencing is operationalized in multiple trauma-affected populations (Vang et al., 2021).

For survivors of political violence, the beneficial role of forgiveness for mental and physical health depends on the purpose of forgiveness and the context of the offense. Kira and colleagues (2009) quantitative study with a sample of 501 Iraqi refugees currently residing in Wayne County, Michigan, found that those who forgave the perpetrators of violence, including individuals who collaborated with the regime (i.e., dictator(s)) (measured with the Forgiveness Versus Refusal to Forgive Scale) had

significantly better physical and behavioral health outcomes than the participants who opted not to forgive (Kira et al., 2009). When working with C-PTSD victims of violence, it is beneficial to protect their perpetrators for their physical and mental health to promote self-healing (Kira et al., 2009). This research is a first step in studying the impact of forgiveness and unforgiveness, emphasizing the focus between the dictator and the perpetrators who enforced the dictator's edicts (Kira et al., 2009). Before generalizing Kira et al.'s (2009) findings to all victims and survivors of political oppression, more research on other survivors in different cultures is needed.

A quantitative study from Shrira et al. (2019) interviewed 60 Tutsi parent-child dyads. The 120 participants were divided into 1) suffering from complex trauma, 2) suffering from PTSD, and 3) no clinical symptoms. The first group of parents (33.3%) suffering from complex trauma conveyed repetitive nightmares, panic attacks, and intrusive memories, including feelings of vulnerable helplessness with difficulty maintaining close relationships. The second group of parents (26.7%) who have PTSD conveyed significant loss, continued thoughts of feeling threatened, and reliving the traumatic events over and over. The third group of parents (40%) showed no clinical PTSD symptoms and appeared remarkably resilient, it is difficult after surviving a genocide not to endure distress, but they conveyed that their feelings of loss and grief were not disrupting their lives (Shrira et al., 2019). This study's findings are significant as it highlights complex trauma's debilitating long-term effects while also introducing research on survivors' intergenerational transmission of complex trauma to their children. The horrors endured by surviving Tutsis left their adult children with a permanent injury,

to which the vast majority of them were not yet born when the genocide of 1994 occurred (Shrira et al., 2019). While this study does not incorporate a forgiveness intervention, it does demonstrate the outcome effects that link complex trauma to genocide, group conflict, civil strife, and war crimes.

It is a challenging process to find the right balance between forgiveness and retribution, or reconciliation and justice, in the aftermath of violence on the societal scale of the infamous Rwandan genocide (Kubai, 2016). Reconciling what many believe to be irreconcilable was the subject of Ordóñez-Carabaño et al.'s (2020) qualitative study of lived experiences with women who survived the Rwandan genocide. Study participants (N = 10) were five pairs of victims and their aggressors engaging in a reconciliation-oriented psychosocial intervention (Ordóñez-Carabaño et al., 2020). This author explains the role and relevant elements of the forgiveness process used within this study; truth and listening to one another, overcoming the initial emotional responses by empathy and altruism to fear or anger, commitment to the process of forgiveness, and finally, to hold on to the forgiveness experience (Ordóñez-Carabaño et al., 2020). While this study did not explicitly reference Worthington's REACH model of forgiveness, it mirrors the 5-step acrostic model. This study's after-effects of forgiveness reported that participants had transformed feelings of sorrow to renewed feelings of clean and stable hearts, freedom, happiness, peace, relaxation, rejuvenation, openness, and willingness to forgive others, restoring normality, trust, and calmness. Ordóñez-Carabaño and colleagues (2020) assert that this study's findings indicate that the involvement of forgiveness is significant to reconciliation.

Moreover, this reconciliation-oriented intervention was a turning point for some respondents as it enabled them to leave behind deep pain and hatred, which are some of the many emotional responses of C-PTSD (Ordóñez-Carabaño et al., 2020). Baranowsky and Gentry (2014) assert that complex trauma survivors have difficulty regulating, controlling, and experiencing their emotions, including difficulty inappropriately labeling and accurately comprehending them; many survivors have unmanaged or persistent sadness, including explosive or inaccessible anger and rage. Therefore, integrating forgiveness interventions should be considered within the steps of facilitating reconciliation in a clinical setting (Ordóñez-Carabaño et al., 2020).

Political conflicts and war affect millions of people worldwide every year (Alim et al., 2019). People subjected to traumatic conflicts frequently suffer from mental health, particularly C-PTSD, anxiety, and depression, that have become a significant public health problem (Mölsä et al., 2017; Silove et al., 2017); thus, forgiveness has been identified in several studies as a coping strategy to the effects of such societal conflicts (Doran et al., 2012). As demonstrated in Kandemiri's (2019) qualitative study on the impact and link between forgiveness and mental health. The study participants were ten female post-war Congolese asylum seekers and refugees (Kandemiri, 2019). This study used a purposive snowball sampling method to gain more participants as they were difficult to find, and Kandemiri (2019) indicated that male Congolese asylum seekers and refugees declined to participate. This study finds that forgiveness helped participants facilitate healing their trauma-related mental health symptoms. Respondents reported that through forgiveness, they are better equipped to "let go" of negative emotions and

feelings of revenge that were fueling their mental health instabilities (i.e., anxiety, depression, rumination, rage, and hatred) (Kandemiri, 2019). Similarly, Doran et al.'s (2012) quantitative study reported low trauma-related stress among 63 post-conflict Sierra Leone resident participants who were willing to forgive over those who did not (Kandemiri, 2019).

These studies contributed to the interconnectedness of mental health and forgiveness literature, as existing research has focused more heavily on this population's practical needs such as housing, food, clothing, etc., neglecting their mental health (Kandemiri, 2019). Furthermore, 90% of Kandemiri's (2019) study participants initially reported that they did not know what mental health professionals were or where to find them, which is concerning as most of the participants reported C-PTSD symptoms such as generalized anxiety, hopelessness, and depression. Kandemiri (2019) argues that this should encourage mental health professionals to raise awareness of mental health services available to the community of refugees and asylum seekers, including the significance of counseling, education, and the value of therapy for trauma to support their mental health (Kandemiri, 2019).

Sexual Abuse

It is controversial and often contentious to apply forgiveness as a therapeutic tool for adult survivors of sexual abuse (Giordano et al., 2007). The general claim is that forgiveness is detrimental, and by misconstruing forgiveness, the survivor can potentially suffer more harm (Bass & Davis, 2002; Courtois, 1991). Others, such as sexual abuse theorists, simply dismiss the notion of forgiveness entirely (Lew, 2004). More recently,

child sexual abuse has been deemed an “absolute evil” by Tener and Eisikovits (2015), while Benkert and Doyle (2009) believe that if there is one unforgivable behavior, it is child sexual abuse.

Self-worth is a fundamental human instinct, and yet extremely traumatic experiences, particularly sexual abuse, or violence, can strip away an individual’s fundamental belief as a “valuable being” even further, diminishing their fundamental world assumptions (Ha et al., 2017). Immediate and prolonged effects of sexual abuse are frequently experienced by their victims, such as anxiety, depression, anger, and reduced self-esteem (Demaris & Kaukinen, 2005; Elliott et al., 2004). CBT has been the most prominent treatment for sexual abuse as it aims at reconstructing irrational thoughts and emotions victims experience (Huh et al., 2017). The feminist approach has also been used to treat sexual abuse through empowering victims and raising social awareness, but psychotherapy is not emphasized. Walton (2005) and Giordano et al. (2007) argue that these therapeutic approaches neglect unresolved feelings towards the offender, suggesting that forgiveness therapy is a promising treatment for victims of sexual abuse. In Huh et al.’s (2017) quantitative study of 33 university student survivors of sexual abuse on the effects of forgiveness therapy, their main findings were as follows. Forgiveness therapy significantly decreased victim shame and depression while significantly increasing posttraumatic growth within each participant. This study is important in that it continues to broaden the range and applicability of forgiveness therapy, which otherwise has been restricted to victims of interpersonal trauma (Huh et al., 2017). This research and other related studies demonstrate that forgiveness can benefit the treatment of childhood sexual

abuse survivors in adults. Huh, et al. (2017) stress that more research is required to explain where, how, and with whom forgiveness techniques can be used to facilitate healing and enhance the quality of life of adult survivors of childhood sexual abuse. Moreover, with increased research, therapists will be better equipped to incorporate forgiveness in the counseling process, work more purposefully to foster forgiveness, and strengthen the overall care and treatment of survivors of sexual violence (Huh et al., 2017).

Similarly, Giordano et al. ‘s (2007) quantitative study with 236 participants self-identified as adult survivors of childhood sexual abuse, ranging from 18-64 years old, supports previous research on sexual abuse. This study examined whether the history of sexual assault, global presence of pain, long-term consequences, and prior childhood sexual abuse treatment experiences predict the survivors’ degree of forgiveness towards the perpetrator(s) (Giordano et al., 2007). Packets were given to each participant containing three self-reporting instruments 1) the Trauma Symptom Checklist - 40 (TSC-40) (Elliott & Briere, 1992), 2) the Interpersonal Relationship Resolution Scale (IRRS) (Hargrave & Sells, 1997), 3) the Childhood Experience Inventory (CEI) (Holeman & Myers, 1998), and a demographic form (Giordano et al., 2007). Four criterion variables of forgiveness (insight, understanding, compensation, open to the act of forgiving) and ten predictor variables (number of offenders, abuse type, relationship to the victim, offender gender, the age gap between offender and victim, victims age at onset, victims age at termination, abuse frequency, use of force, use of threat), each was separately considered in addressing the research question. The authors reported that the constructs

and concepts of this study reduced long-term symptoms associated with sexual abuse, and participants experienced an overall improvement in functioning such as improved positive mental health symptoms and decreased negative mental health symptoms (Berry & Worthington, 2001; Giordano et al., 2007; Raj et al., 2016), including hope (Rye et al., 2005. Results worthy of mention in this study, first, experiences of sexual abuse during childhood appear to affect and influence the forgiveness process of the ten variables that significantly affect forgiveness, eight variables directly linked to childhood sexual abuse experiences. This study revealed that therapy influences the process of forgiveness and supports the growth of understanding forgiveness; in addition, Giordano and colleagues (2007) suggest that when exploring forgiveness for a victim of sexual abuse, the circumstances underlying the experience of sexual abuse are crucial considerations; the more intrusive the abuse, the less forgiving the survivor will be of the offender (Giordano et al., 2007).

Moreover, Ghahari and Rad's (2018) quantitative semi-experimental study examined the effectiveness of forgiveness among 30 self-identified women suffering from depression and anxiety in direct relation to sexual abuse. Each participant reported the abuse occurring before the age of 7 from immediate family members or relatives. Study results indicated that the ability to forgive effectively reduces anxiety and depression among women who are victims of childhood sexual abuse (Ghahari & Rad, 2018). Additionally, these results are consistent with Reed and Enright's (2006) study and Leach et al.'s (2010) study. They both found that forgiveness leads to a significant decrease in negative mood, affect, and overall mental and physical health. In treating

survivors of sexual assault, forgiveness can be a beneficial element that can mitigate psychological symptoms triggered by the offense (Wade et al., 2005). Furthermore, that therapy can further strengthen the forgiveness process for survivors of sexual abuse (Giordano et al., 2007).

Childhood sexual abuse reduces life satisfaction over an individual's life span due to self-blame, shame, and anger (Morton et al., 2018). Cases of sexual abuse after eight years of age (during the development of the prefrontal cortex) impacts executive function, which refers to the area of child development such as moral and communicative behavior and social cognition (Carlson & Moses, 2001; Moriguchi et al., 2010; Morton et al., 2018). A quantitative study conducted by Morton et al. (2018) with data from 5,506 Seventh-Day Adventist participants examined the association of life satisfaction with self/other forgiveness in those sexually abused before and after age 8. Control variables within this study represent life satisfaction; age, gender, ethnicity, education level, and difficulty in covering the costs of food, clothing, and housing for basic needs in the last year (Morton et al., 2018). Predictor variables within this study include sexual abuse before age 8, sexual abuse between the ages of 8-18 or not, and forgiveness of self, others, or God (Morton et al., 2018). Consistent with existing literature, the study by Morton and colleagues (2018) found that childhood sexual abuse, regardless of age at the time of the abuse, negatively correlates with life satisfaction. Anda et al. (2005) indicate that in relation to the developing prefrontal cortex, early stressors cause long-term damage to brain processing, leading to emotional and cognitive functional deficits (Morton et al., 2018; Royse et al., 1991; Whitelock et al., 2013), including C-PTSD,

which can result in sexual behavior issues, anxiety, stress, depression, addiction, and overall dissatisfaction with life (Bremner, 2003; Chu & Lieberman, 2010; Horwitz et al., 2001).

Child Abuse

Approximately 700,000 children are abused each year in the United States. In 2018, the most recent year for national data, an estimated 678,000 children were victims of violence and neglect. In a given year, that is about 1% of children. However, this data is likely not completely accurate due to underreported cases of child abuse and neglect nationwide (National Children's Alliance, 2020). Child abuse is a public health problem, contributing both physically and emotionally to long-term health consequences (Molnar & Fraser, 2020). There is extensive literature linking long-term health and psychosocial effects of child abuse and C-PTSD (Beal et al., 2018). Within this area of trauma, the construct of forgiveness began to burgeon in the '80s, and 90's to explore the potential mediational role forgiveness plays concerning C-PTSD symptoms with child abuse survivors (Snyder & Heinze, 2005).

The trade book by Lewis Smedes in 1984, "Forgive and Forget: Healing the Hurts, We Don't Deserve," significantly precipitated the rise and interest in forgiveness research due to its benefits of self and mental health (Lichtenfeld et al., 2015; Smedes, 1984). Moreover, Smedes, a professor of ethics and theology for 25 years at Fuller Theological Seminary in Pasadena, California, followed up in 1994 with "Shame and Grace: Healing the shame we don't deserve," continuing in 1996 with "The Art of Forgiving: When you need to forgive and don't know how" (Smedes, 1994, 1996).

Moreover, further expansion and research interest of forgiveness therapy in the 1990s was the introduction of the first therapeutic model by Enright and the Human Development Study Group (1996); comprising of 4 main phases and 20 units which include elements of cognition, affection, and behavior (Akhtar & Barlow, 2018). Each step is intentional, and each step is event-specific for the participant to experience decreased adverse effects to more positive effects (Akhtar & Barlow, 2018; Baskin & Enright, 2004; Enright & The Human Development Study Group, 1991; Wade & Worthington, 2005). The surging interest of forgiveness therapy brought an awareness shift to universal hurts and injustice to a more purpose-driven life.

Snyder and Heinze's (2005) quantitative study on the mediational role of forgiveness with 79 child abuse survivors, and Rivera and Fincham's (2014) quantitative study of forgiveness as a mediator of intergenerational violence with 285 young adults, reported that forgiveness does play a mediating role in lessening hostility, anger, guilt, and shame concerning childhood abuse. Both studies noted that while research on forgiveness has increased, limited attention is given to understanding the role of forgiveness between family-of-origin violence and childhood abuse and forgiveness, further studies are needed to examine the links to inform intervention efforts more fully (Rivera & Fincham, 2014; Snyder & Heinze, 2005). Diffusing revenge, hatred, and anger toward a perpetrator(s) or individuals that create conflict can be achieved through forgiveness (Hafina et al., 2019). Children that have experienced family-of-origin (i.e., parent, guardian) violence or abuse (Peterson & Seligman, 2004) in response, in order to separate themselves from any violence committed by their parent(s), may commit acts of

violence or assault; thus, abuse within the family becomes cyclical and generational. Structural family therapy is one of the primary therapeutic approaches to interrupting dysfunctionality within family systems and reoccurring patterns. However, this approach is more likely to deal with current family challenges rather than historical events (Worthington et al., 2007). Worthington's REACH model of forgiveness would explore historical offenses that have yet to find successful resolve (Worthington et al., 2007).

The first primary source of education that forms a child's character is the family, mother, father, and child. It is the smallest unit in society's social life system but most dominantly contributes to a child's psychological development (Hafina et al., 2019; Strelan & Wojtysiak, 2009; Yeager et al., 2011). A quantitative study conducted by Hafina et al. (2019) analyzed the propensity of forgiveness with 39 adolescent participants who experienced emotional abuse by one or both parents. The purpose of Hafina et al.' (2019) research was two-fold, first, to examine the propensity of adolescents to forgive emotional abuse by parents and, second, implications for further research related to guidance and therapy. This study classified general forgiveness into three categories for adolescents who experienced emotional abuse by parents, low, medium, and high, and three motivational aspects of forgiveness; benevolence motivation, revenge motivation, and avoidance motivation (Hafina et al., 2019). The results of this study show that the propensity of forgiving is in the medium range. This medium category illustrates that adolescents who suffer parental emotional abuse and trauma have the desire to do good to those who have harmed them and minimize the desire to reciprocate hurt to those who have hurt them (Hafina et al., 2019). However,

avoidance and withdrawal from the people who have hurt them were still present, as reported by each participant (Hafina et al., 2019). Moreover, Hafina et al. (2019) stated that forgiveness effectively improved adolescent physical and mental health development.

In contrast, Peterson and Seligman (2004) assert that children who have experienced parental violence or abuse will, in turn, commit acts of violence or abuse in order to distance themselves from any violence perpetrated by their parent(s); thus, abuse becomes cyclical within the family. Diffusing revenge, hatred, and anger toward a perpetrator(s) or individuals that create conflict can be achieved through forgiveness (Hafina et al., 2019). The study's findings have implications for therapy and guidance support services in that those who have undergone emotional violence by parents need to build and encourage forgiveness interventions. Forgiveness is an essential quality of character that can be further strengthened and established with therapy guidance (Hafina et al., 2019). Forgiveness is also inclusive to the virtue of temperance, which is the virtue that directs people to refrain from doing anything without first thinking, thus mitigating undesirable consequences that may result (Peterson & Seligman, 2004). Forgiveness is a process of transforming and shifting resentment, avoidance behavior, or reciprocating violence by replacing it with a benevolent attitude toward those who have caused harm (Kimmes & Durtschi, 2016; Strelan & Wojtysiak, 2009). Furthermore, Peterson and Seligman (2004) assert that forgiveness protects individuals from hatred. Forgiveness can function optimally in adolescents through early intervention, not solely by waiting for

mature reasoning capacity to forgive on their own (Akhtar & Barlow, 2018; Kueny & Cardenas, 2018; Worthington et al., 2010).

Domestic and Family Violence

While forgiveness is of interest to researchers and practitioners working within this population, more detailed knowledge about abusive spouses and intimate relationships is needed (Fincham, 2000; Gordon et al., 2004). In part, forgiveness is often conflated with reconciliation (Enright & the Human Development Study Group, 1991; Gordon & Baucom, 1998; McCullough et al., 1998), which presents the desire of those in domestic and family violence situations to reach a forgiving state in order to return to or maintain the investments of the close relationship. Gordon et al.'s (2004) quantitative study evaluated forgiveness as a mediator with 121 women and their intent to return to their partners; each of the 121 participants resided in rural and urban domestic violence shelters. Each participant completed a series of questionnaires assessing demographic details, violence attributions, violence intensity, psychological constraints (or investment), and the partner's forgiveness, and this study found that forgiveness predicted the probability of returning to a partner over and above the other variables studied (Gordon et al., 2004). Given the startling data on domestic violence rates and the cyclical nature of this social problem, it is essential to understand better the processes that predict the intention of women returning to abusive relationships to create a more effective intervention (Gordon et al., 2004). This study concluded that forgiveness among their participants represented a willingness to "move on" rather than truly understand what happened; forcing themselves, thus, to "forgive" or to put the violence behind them;

assumedly, deciding to return less psychologically dissonant (conflicting beliefs) (Gordon et al., 2004).

Moreover, there is a need to develop a more precise understanding of what defines forgiveness in this population as scholars continue to debate that the therapeutic intervention of forgiveness should be more than just placing the betrayal in the past; but rather, a greater contextual understanding of the causes of the betrayal (Enright & the Human Development Study Group, 1991; Gordon & Baucom, 1998; Gordon et al., 2004). It is plausible that women feel the need to reconcile under the moral pressure of forgiveness for two reasons, 1) clinical writings on forgiveness tend to imply that without reconciliation, forgiveness is incomplete or inauthentic, and 2) clinical writings and empirical research guide clinical practice and interventions. As such, it may more closely resemble the "hollow" or "false" forgiveness described by different theorists throughout the literature (Gordon & Baucom, 1998; Gordon et al., 2004; Wallace et al., 2008; Zechmeister & Romero, 2002). What remains limited is whether forgiveness and reconciliation are conflated with women or men in abusive relationships? Alternatively, other forgiveness scholars indicate that forgiveness is distinct from reconciliation (Enright & the Human Development Study Group, 1991; Fincham, 2000; Gordon & Baucom, 1998; Gordon et al., 2004). As mentioned earlier, Freedman and Zarifkar (2016) advise that therapists clarify the distinction between forgiveness and reconciliation to ensure clients understand that reconciliation is not required (or always possible) in the process of forgiveness.

The significant adverse effects such as low self-esteem, depression, victimhood, PTSD, complex trauma, and learned helplessness of spousal or intimate partner violence and abuse have been demonstrated by studies such as Astin et al. (1993), Dutton and Painter (1993), Paul (2004), Sackett and Saunders (1999), and Reed and Enright (2006). Reed and Enright's (2006) quantitative study was one of the first to demonstrate that forgiveness therapy is an efficacious therapeutic strategy for ameliorating the long-term adverse psychological outcomes of spousal psychological abuse. It was one of the first to demonstrate that forgiveness therapy is a useful therapeutic tool for enhancing the long-term adverse psychological effects of spousal or intimate partner violence and abuse. Forgiveness therapy promotes health and mental health improvement to a substantially greater degree than alternative treatments that are more commonly suggested for emotionally abused women and men in the literature (i.e., those that emphasize validation of anger, assertive limit setting, and interpersonal skills) (Enns et al., 1997; Miller et al., 1997; Paul, 2004; Reed & Enright, 2006).

Physical Disabilities

For people with disabilities, it is essential to recognize the value of forgiveness considering the varying levels of discrimination, barriers, and unequal treatment they experience and are required to cope with following or living with a disability (Stuntzner et al., 2019). Disability studies and trauma studies have risen among two of the most critical areas of study in the field of humanities over the past 15 years (Berger, 2004). Yet, surprisingly, trauma research and studies of disability have yet to link with one another, and Berger (2004) argues that trauma is remarkably avoided in the academic

literature on disability studies. The term “disability” is not used in trauma studies; the symptomological effects of trauma are seen as obliterating and horrifying but not deteriorating in a way that disabled professionals may understand. Similarly, the academic literature in disability studies considerably avoids any mention of trauma. Scholars of either discipline do not read or contribute to the other (Berger, 2004). Despite, both areas of study place individual disability and trauma in historical and social contexts; both are concerned with devastating injury and often-permanent repercussions; both intensively concentrate on representational and problematic issues (Berger, 2004). Persons with Disability (PWD) and complex trauma studies parallel one another as both concern the social construct of personal identity and meaning. While the two remain mutually disengaged from one another, inadvertently overlooking shared injustices that foster stigma (Barnett, 2018).

Much like complex trauma, those living with a disability are posited as struggling and resistant to the normative culture (Berger, 2004; Morrison & Casper, 2012).

Stuntzner et al. (2019) presented a case study on the perspectives of forgiveness on people with disabilities; her findings were that persons with disabilities that elected to work on forgiveness reached a better state of emotional and psychological functioning. To demonstrate the relevance of forgiveness to persons with a disability, Stuntzner et al. (2019) provided the example of Willmering’s (1999) qualitative study among persons with spinal cord injury, finding that most of the participants reported forgiveness of self, others, and society as a means to assist them in positive coping and adjustment. Living with a disability is frequently regarded as a negative and unwelcome experience by

"outsiders." These societal "outsider" attitudes can manifest themselves into condescending behaviors, biases, negative remarks, signaling negative messages, ideas, and thoughts about disability to the person living with a disability (Smart, 2009; Snyder & Forsyth, 199; Stuntzner & Dalton, 2015; Stuntzner, 2012). These societal transgressions and offenses may be "face-less" or person-specific, such as friends, co-workers, or family members (Stuntzner et al., 2020). The relevance of forgiveness to a person with a disability can also be relational to the cause of their disability or the perceived cause of their disability (Stuntzner, 2007). Moreover, there may be a need to forgive God or someone else when a disability has been obtained or acquired in ways that are not connected to something (i.e., person or accident) (Stuntzner, 2007). For example, pursuing forgiveness for military service members discharged prematurely due to amputation and complex trauma from war or challenging experiences will now live with mental and physical health conditions they had nothing to do with (Stuntzner & Dalton, 2015).

Similarly, for the person injured or left disabled due to the actions of a drunk driver who sustained no injury, forgiveness should also be pursued to help alleviate the resentment and anger toward the driver, the offending party (Stuntzner & Dalton, 2015). Additionally, Stuntzner (2007) proposed the theoretical model "Stuntzner 's Forgiveness Intervention: Learning to Forgive Yourself and Others" within her comparison study among individuals with spinal cord injury; the model illustrated the possible relationship between forgiveness and disability adjustment. Stuntzner's (2007) model allows for one of two coping mechanisms, 1) forgiveness or 2) adjusting to the disability with the

outcome of achieving a higher psychological and emotional functioning. Conceptualizing the parallels between disability forgiveness and coping are both equally effective processes that can help rehabilitation professionals understand that there is more than one way to consider and practice forgiveness.

Forgiveness has a great deal of applicability and relevance in those living with disabilities (Stuntzner & Dalton, 2015; Stuntzner et al., 2019). As discussed throughout this study and previous research, the intervention of forgiveness significantly improves and reduces depression, anger, and anxiety (i.e., adjustment to disability, self-esteem). Thus, as research suggests the invaluable role that forgiveness plays for those healing from offenses, hurts, and injustice, forgiveness seemingly has the same beneficial potential to persons living with disabilities (Stuntzner & Dalton, 2015; Stuntzner et al., 2019).

Forgiveness and Mental Health

Considerable studies suggest that forgiveness leads to improved positive mental health symptoms and decreased negative mental health symptoms (Berry & Worthington, 2001; Raj et al., 2016), including hope (Rye et al., 2005). Increased forgiveness among older women resulted in higher self-esteem and lowered anxiety and depression (Hebl & Enright, 1993). Al-Mabuk et al.'s (1995) study reported that college students whose parents were high on forgiveness self-rated with high self-esteem and lower anxiety and depression (Al-Mabuk et al., 1995). In addition, forgiveness intervention in a clinical setting reports significant mental health benefits (Raj et al., 2016). The benefits of a clinical setting are further supported by Wade and colleagues (2014) meta-analysis of 54

unpublished and published quantitative studies of forgiveness. This study concentrated on forgiveness interventions for a specific hurt or offense following a professional intervention (Wade et al., 2014). Of the 54 total studies, the published studies were found on the PsycINFO database dating from 1872-2011 using keywords psychotherapy, intervention, forgiveness, and treatment. Unpublished studies were obtained by contacting known researchers in the field of forgiveness. Studies included met the following criteria (1) written in English (2) used a quantitative measure of forgiveness to a specific offense (3) offered in-person intervention by a trained professional (4) examined psychotherapeutic intervention specific to promoting forgiveness, and (5) were published before 2012. Studies were disqualified if they concentrated on the general development of forgiveness, were not offense-specific, self-help, or not facilitated by a therapist, or did not measure the outcome of forgiveness (Wade et al., 2014). Study results: explicit forgiveness treatments reported substantially higher than non-treatment participants or alternative therapies. Forgiveness therapies also resulted in more improvements than non-treatment conditions for anxiety, depression, and hope. Wade et al. (2014) assert that theoretically grounded forgiveness interventions are effective and can support individuals coping with past offenses to find resolve in the form of forgiveness. In addition, treatment methods disappeared by adjusting for significant moderators; individual treatments were demonstrated with Enright-model interventions since there was no research on individual interventions using Worthington's REACH model (Wade et al., 2014).

In a qualitative meta-synthesis, Trevillion and colleagues (2014) examined healthcare expectations and experiences of individuals seeking mental health services who experienced domestic violence (DV). Twelve qualitative studies were reviewed, which provided data on four male and 140 female mental health service users (aged ≥ 16 years). Findings from the 12 primary studies produced similar and consistent themes; mental health services gave minimal consideration to the role of DV and frequently failed to adequately address the client's experiences of violence (Trevillion et al., 2014). Participants with a trauma history had hoped that their therapists would have more directly inquired about their trauma history and suggested more trauma training on compassionate inquiry and assessment. The significance of Trevillion and colleagues' (2014) research is to recognize how users of mental health programs want mental health service providers to respond to DV disclosures and best treatment outcomes that will not be correlated with the often-associated stigmas of mental illness. Mental health and DV are interrelated yet, inadequately addressed by providers. To ensure safe and optimal treatment for this vulnerable group, mental health providers need more specific training and knowledge about DV and the intersection of forgiveness therapy (Trevillion et al., 2014). Forgiveness is uncomfortable in the face of severe interpersonal injuries, but forgiveness does promote resiliency and is an adaptive reflex to such trauma (Wade et al., 2013). The lack of trauma training among mental health professionals is well documented and problematic; failure to properly assess trauma-related symptoms within a session can result in harmful and misdirected treatment (Brand et al., 2016, 2017; Dorahy et al., 2016; Kumar et al., 2019).

Freedman and Enright's (1996) empirical study with 12 female incest survivors was the first to demonstrate the effectiveness and relationship of forgiveness interventions and improved mental health. They reported that following the intervention, each of the 12 participants stated significant decreases of depression and anxiety and improved psychological systems of cognition, hope, affect, even beliefs and behavior toward their offender. (Raj et al., 2016). The sense of optimism experienced by each participant after the intervention is further evidence and encouraging that improved mental health happens when there is a change in forgiveness (Raj et al., 2016).

Similarly, Coyle and Enright's (1997) forgiveness intervention study examined ten men, ranging in age from 21 to 43, who identified themselves as hurt by a partner or spouse's abortion. The findings showed that these men experienced substantial decreases in negative emotions such as anxiety, anger, and grief after completing the forgiveness intervention (Raj et al., 2016). This study's findings have significant implications for clinical practice and that forgiveness is an effective intervention in various populations, such as men who have been virtually ignored in the scientific literature after abortion (Raj et al., 2016).

Forgiveness strengthens mental health by cultivating and supporting empathy, and well-being, whereas unforgiveness is notably a corollary stress response associated with adverse mental and physical health. (Nation et al., 2018; Woodyatt et al., 2017). Six intertwined emotions comprise unforgiveness: hostility, fear, anger, bitterness, hatred, and resentment (Worthington, 2006); hostility is considered the most destructive. The health effect of hostility is the most destructive of them and has been recognized as an

independent risk factor of mortality, especially when there are repeated stressors (Klabbers et al., 2012). Stress and coping theory are often linked to the REACH model because within this theory, individuals are motivated to practice cognitive and emotion-based change to improve their emotional experience of forgiving, ultimately reducing stress-based unforgiveness. Forgiveness is a responsive coping strategy for stress related to a hurtful offense (Nation et al., 2018).

Akhtar and Barlow (2018) conducted a quantitative systematic review and meta-analysis of the two most widely used forgiveness interventions using both Enright's and Worthington's REACH models. Fifteen previous meta-analysis studies were selected for inclusion with sample sizes between 270-500 participants (Akhtar & Barlow, 2018), and each study met the post-test data (i.e., wait-list/no-treatment control). Nine of the studies compared forgiveness therapy with wait-list control, while six of the studies compared forgiveness therapy with no-treatment control. In contrast to those not undergoing any treatment, this analysis focused exclusively on forgiveness intervention vs. control group to test the efficacy of forgiveness treatment, rather than contrasting their efficacy with alternative treatments (AT; assertiveness, CBT, interpersonal skill-building, and anger validation) (Akhtar & Barlow, 2018). Each of the studies produced small, medium, and significant statistical effects in favor of the intervention group to assess reduced negative affect. In depression, for example, there were minimal effects, a mild effect observed for anger and aggression, and a strong effect given for stress, except anxiety, which had no substantial effect. These results demonstrate that forgiveness interventions successfully minimize numerous negative effects that are prevalent to complex trauma. Also, this

study's findings can be generalized to a host of hurts and abuse such as sexual assault, child abuse, injury, disability, civil war, and a variety of other negative interpersonal injustices commonly experienced with complex trauma individuals. Moreover, Akhtar and Barlow (2018) assert strong evidence that both models were effective in improving mental health but that further research is needed to compare them against other treatment methods of interpersonal hurts and complex trauma.

Role of Positive Psychology and Forgiveness

Empirical research supports the connection between forgiveness therapy and positive psychology (Hojjat & Ayotte, 2013; Hojjat & Cramer, 2013). Positive psychology, a branch of psychology, examines human strengths that help individuals live a more rewarding and fulfilling life (Seligman & Csikszentmihalyi, 2000; Warsah, 2020), and forgiveness is one of those strengths (Hojjat & Ayotte, 2013). Positive psychology is a scientific approach to studying human emotions, thoughts, perseverance, forgiveness, wisdom, and interpersonal skills, concentrating on strengths over weaknesses, and within the practice of clinical psychology has firmly taken root (Joseph, 2015; Peterson et al., 2008; Singh et al., 2016). Positive psychology offers the importance of forgiveness to assist individuals in overcoming conflict(s), interpersonal injury, and trauma, which has important implications for the field of counseling and psychotherapy (Warsah, 2020). Of all of the constructs incorporated under the umbrella of positive psychology, forgiveness has gained the most attention and application in therapy settings (Harris et al., 2007; Konstam et al., 2000). Harris and colleagues (2007) assert that the attention gained is part of its straightforward and time-limited approach, is supported under empirical research,

and is a unique approach to otherwise unaddressed pain. Positive psychology's basic philosophy is to 'build what is strong' rather than 'fix what is wrong," which is the conventional psychotherapy approach (Seligman et al., 2006).

Positive psychology challenges people to change their viewpoints to alleviate trauma-related symptoms to end victim helplessness (Held & Bohart, 2002; Lamb, 2005) by not just fixing what is wrong but rather building on what is right (Seligman et al., 2006). Thus, in many situations, forgiveness interventions may directly address counseling goals (e.g., chronic anger, social isolation) more effectively than other approaches (Harris et al., 2007). It was once unusual for a client to intentionally seek therapy or support surrounding forgiveness. However, as more stories are read and seen on television about forgiveness and redemption, that is changing. Nevertheless, most clients will not suggest forgiveness as an approach to anger, anxiety, or depression; thus, requiring the therapist to take an active role here (Enright & Fitzgibbons, 2000).

Forgiveness has been a part of psychology and studied in many populations throughout the last 25 years. (Stuntzner et al., 2019). However, when counseling individuals with complex trauma, forgiveness is not always considered nor encouraged as an approach. Since the emergence of the positive psychology movement and its emphasis on strengths following struggle, difficulties, and/or adverse circumstances (Neenan, 2013; Stuntzner et al., 2019), psychologists, counselors, and other mental health professionals have begun to recognize the value of learning, knowing, and reflecting on causes and characteristics that help individuals move forward after traumatic events (Stuntzner et al., 2019). Moreover, secular therapists have begun exploring forgiveness and forgiveness

therapy as an independent or additional treatment option (Hook et al., 2015; Jeter & Brannon, 2015; Lee & Enright, 2014; Poston et al., 2012); however, it remains limited to how and when secular therapists use approaches directly or indirectly involving forgiveness (Denton & Martin, 1998; Freedman & Chang, 2010; Harris et al., 2007; Konstam et al., 2000; Wade, 2010). Konstam et al. (2000) surveyed 381 therapists (between the ages of 24-79), and 94% reported that it was appropriate to raise the issue of forgiveness and that forgiveness was highly salient. Conversely, the information available to therapists about forgiveness remains limited, and as discussed, there are misconceptions related to a lack of knowledge and education regarding what it means to forgive, the benefits of forgiveness, and how to go about forgiving (Freedman & Zarifkar, 2016; Konstam et al., 2000). Additionally, while many therapists hold "a positive view of the value of forgiveness, they also report a lack of skills specific to facilitating forgiveness as a therapeutic task" (Malcolm et al., 2005, p. 380). One of the most common limitations shared by therapists is, "I was schooled in certain models of therapy, not in forgiveness therapy. Will I have to change my theoretical orientation for this?" (Enright & Fitzgibbons, 2015, p. 136). The response is, no, forgiveness therapy, while it can stand on its own as a unique therapeutic approach, it can also take place within a broad spectrum of orientations, such as psychodynamic orientation that traces past experiences to current issues, or family and systems orientation therapy that explores behavior patterns that influence others (Enright & Fitzgibbons, 2015). Moreover, forgiveness therapy can couple with empirically-based interventions such as mindfulness-based cognitive therapy (MBCT), acceptance and commitment therapy (ACT), dialectical

behavior therapy (DBT), and the most well know and widely accepted cognitive behavioral therapy (CBT) (Carpenter et al., 2018; Freedman & Zarifkar, 2016; Keuthen et al., 2010; Lilja et al., 2016). While not all mental health providers support the treatment of forgiveness, there continues to be a need to resolve the current gap between research developments in the field of forgiveness and current therapy practices (Konstam et al., 2000); it is essential to know what it is, what it is not, even if to pair it with already existing therapeutic techniques.

Summary and Conclusion

This literature review's qualitative, quantitative, and mixed-method studies demonstrate the overarching thread of forgiveness (interpersonal forgiveness and forgiveness therapy) as central to human healing and resilience. While forgiveness is conceptualized as the process of making peace with life, it also opens the therapeutic approach of liberating victims from their past trauma (Huh et al., 2017). There is strong evidence of the efficacy of forgiveness therapy as a therapeutic approach to complex trauma, which is defined as chronic violence or suffering over any period of development, particularly during childhood, which can lead to significantly affecting the individual within all spheres of life (Saint Arnault & Sinko, 2019).

Complex trauma recovery consists of recovering from numerous traumatic events accumulated within the survivor's heart and mind. Forgiveness therapy decreases shame and depression in those who have experienced such trauma's as sexual abuse, molestation, and child abuse (Huh et al., 2017), is a promising post-relationship and post-crisis therapeutic approach for women who have undergone domestic or intimate partner

violence (Baskin & Enright, 2004; Reed & Enright, 2006), affords a greater state of emotional and psychological functioning for persons living with a disability (Stuntzner et al., 2019), and can restore normality, trust, and calmness among survivors of genocide (Ordóñez-Carabaño et al., 2020).

Over the last 20 years, the health benefits of forgiveness have seen a surge in interest from clinicians and researchers, largely to its potential for reducing negative thoughts and emotions stemming from interpersonal hurts (Wade et al., 2013). Understanding what improves mental and physical wellbeing is vitally important and a primary goal in therapy and counseling. But a need remains in incorporating effective ways of strengthening clients to resolve the adverse effects of interpersonal injuries (Akhtar & Barlow, 2018; Luskin et al., 2005). It is suggested that interventions that facilitate positive behaviors and attitudes have a significant role to play in enhancing psychological health (Huppert, 2009).

This chapter has reviewed the constructs of forgiveness therapy's relevance to complex trauma clients. To date, Enright's process model of forgiveness and Worthington's REACH forgiveness model are the two most prominent therapeutic approaches to help facilitate forgiveness therapy (Lander, 2015; McCullough et al., 1997). Despite the growing body of forgiveness therapy research within positive psychology and other strength-based interventions such as resiliency, existentialism, and mindfulness (Backos & Sanders, 2014), minimal attempts have directly linked the REACH model, "forgiveness of others," into direct practice with complex trauma.

Chapter 3 includes a thorough description of how, through a qualitative design, the gap in research was explored to lead to a greater understanding of secular therapists' perspectives of forgiveness therapy with complex trauma clients. Included within the elements of chapter 3 are the research method, design, and rationale for choosing this qualitative design using semi-structured phone interviews. Furthermore, I provide information to readers about a researcher's role, methodology, trustworthiness, and ethical procedures.

Chapter 3: Research Method

The purpose of this generic qualitative study was to explore secular therapists' perspectives on the use of forgiveness therapy with complex trauma clients, particularly the use of Worthington's REACH forgiveness model. To date, there is limited empirical knowledge on the application of forgiveness therapy perspectives with complex trauma by secular therapists, notably, the use of Worthington's REACH model of forgiveness. I explored the perspectives of secular therapists using forgiveness therapy in direct practice with complex trauma clients. Despite the growing body of forgiveness therapy research within positive psychology and other strength-based interventions such as resiliency, existentialism, and mindfulness (Backos & Sanders, 2014), minimal attempts have directly linked the REACH model, "forgiveness of others," into direct practice with complex trauma.

This chapter outlines the qualitative method and procedures that I used to describe each participant's perspectives. Specifically, this chapter covers this study's research design and rationale. In addition, the role of the researcher, an in-depth description of the methods used, and the issues of trustworthiness and ethical procedures specifically relevant to this study will also be addressed in this chapter. Finally, a summary of key points will conclude this chapter.

Research Design and Rationale

Research Questions

The following research questions guided this generic qualitative study:

RQ1: What are secular therapists' perspectives on the use of forgiveness therapy with complex trauma clients?

RQ2: What are secular therapists' perspectives on the use of Worthington's REACH forgiveness model with complex trauma clients?

Central Concepts

Forgiveness, complex trauma, and the REACH forgiveness model are the three central concepts within this study. Enright (2012) defined the first concept of forgiveness as a targeted and personal goal for victims to release themselves from vindictive motivations or destructive cyclical behaviors. The second concept of this study is complex trauma, which is defined as premeditated, planned, and caused by other humans; it is multifaceted and typically occurs repeatedly and cumulatively over time, often within specific relationships and contexts (Courtois, 2004). The third concept is the REACH forgiveness model, which seeks to promote forgiveness experiences with people who wish to move through interpersonal hurts and injury. It is a flexible and adaptable intervention for both groups and individuals (Worthington et al., 2010). The term REACH is an acronym that represents the five key steps that interventionists can use to promote emotional forgiveness in another person. These steps include R- remembering the hurt, E-empathizing with the offender, A-offering a gift of forgiveness that is Altruistic, C-committing to forgiveness, and H- holding on to forgiveness when doubt arises (Leach et al., 2010; Nation et al., 2018; Worthington et al., 2010).

Research Tradition and Rationale

I explored the perspectives of secular therapists regarding forgiveness therapy, specifically REACH forgiveness as a counseling intervention with complex trauma clients. I used an interpretive paradigm approach for this study. This research tradition is highly contextualized and relies on knowledge and data from clinical practice, which can then be applied back in the practice setting (Hunt, 2009; Kahlke, 2014; Thorne et al., 2004). The value of this research tradition is its ability to uncover a broad range of social, cultural, and political influences that may not be understood in advance but are potentially relevant to the phenomenon of interest (Bhattacherjee & Wallin, 2012).

Quality research and analysis necessitates selecting an approach that is consistent with one's assumptions and interpretive lens (Caelli et al., 2003; Richards & Morse, 2013). As described by Caelli et al. (2003), a generic qualitative inquiry is a study that seeks to discover and understand a process, a phenomenon, or the perspectives of the people involved. Qualitative research is rich, and the descriptive data collected will better understand how secular therapists assess complex trauma and determine treatment models or interventions.

From the participants' perspective, a generic qualitative inquiry examines the individual significance of a method or phenomenon (Kennedy, 2016). Caelli et al. (2003) asserted that a generic qualitative inquiry should be inclusive of four characteristics: "(1) the theoretical positioning of the researcher, (2) a congruence between methodology and methods, (3) strategies to establish rigor, and (4) the analytical lens of the researcher" (p. 5). Theoretical positioning refers to the researchers' belief system, including ontology,

epistemology, axiology, and their knowledge and reality viewpoints, including their value framework (Kennedy, 2016). The emphasis on seeking understanding of the perspective views of each participant through rich definition, context, and process rather than measuring intensity, frequency, and quantity is the strength of this qualitative inquiry (Rudestam & Newton, 2015).

Role of the Researcher

Qualitative research aims to understand a phenomenon by allowing researchers to examine how a specific group of people perceive it (Serrat, 2021). In qualitative studies, the researcher is the primary instrument of recruitment, interviewing, data collection, coding, and analysis (Creswell & Creswell, 2009, 2017; Patton, 2015). As a result, it was necessary to examine my own personal lens to ensure that I disclosed and considered all my experiences and biases as I explored the perspectives of secular therapists regarding forgiveness therapy, specifically REACH forgiveness as a counseling intervention with complex trauma clients.

Positionality

Articulating one's worldview is the starting point for every researcher, myself included. Personally, I am a Christian who has procured the benefits of forgiveness and it is a central principle in my life. Professionally, I am a Master's prepared social worker with more than 3 years of experience providing direct therapeutic interventions to clients with significant trauma histories. I introduce the principles of forgiveness and forgiveness therapy with all clients presenting with trauma histories such as sexual abuse, sexual assault, child abuse, molestation, addiction, and couples/marital counseling to reduce and

lessen rumination and resentment of self and the offender. The most common response to forgiveness therapy from the clients I serve is “I never considered that before,” this is in part because forgiveness is a learned behavior; research reminds us that we can cultivate and execute it with practice. As a social worker in direct therapeutic practice, helping my clients forgive themselves and others have significantly set a new path toward self-empowerment, self-healing, and self-liberation. Researchers often study what they have a passion for; forgiveness therapy and complex trauma are of particular interest to me as I have seen it benefit the trauma clients I serve. As my years of direct practice with trauma clients have progressed, I have noted that very few of my clients have ever considered forgiveness of themselves or an offender. Furthermore, when collaborating with colleagues, only a select few say that they are aware of forgiveness therapy for complex trauma, and for those that do, articulate rarely using or introducing it with their clients.

Research bias is significant for many reasons: first, bias exists in all research, regardless of study design, and is difficult to eliminate (Smith & Noble, 2015). Second, bias may arise at any stage of the research process. Third, bias can occur at any point during the research process. Finally, bias impacts the validity and reliability of study results, and data misinterpretation might have significant clinical implications (Smith & Noble, 2015). For this study, I sought to qualify the experience in rich and descriptive detail by looking for the meaning of the material through the perspective of the person experiencing it, not my own. Given my experience and evident interest in this subject matter, I mitigated potential biases by keeping a field journal in which I bracketed data to assure that my perceptions are independent of those of the study participants. Patton

(2015) characterized bracketing as a technique of examining information in its purest form, searching for the significance of the data by preventing the data from being evaluated through a shared knowledge lens. Moreover, respondent validation of responses (invites participants to comment on the interview transcript and whether the final themes and concepts created adequately reflect the phenomena being investigated; Long & Johnson, 2000), constant comparison across participant accounts, and prolonged involvement or persistent observation of participants were all used to reduce bias in this study (see Morse, 2015).

Methodology

Quantitative and qualitative research methods are the most prominent in research, with different underlying worldviews and frameworks. Discovery is the goal of qualitative research, while verification is the goal of quantitative research (Creswell & Creswell, 2017). According to Emmons (2000), researching forgiveness exclusively quantitatively restricts the amount of data gathered and studied. As a result, Emmons proposed that the qualitative design be used in studies of forgiveness to expand what can be learned about forgiveness therapy.

Participant Selection

I recruited 15 participants using purposive sampling for this study using multiple recruitment strategies. For reasons of time, cost, and accessibility, purposive sampling is a practical approach as well as connectivity to a certain group of participants that meet specific demographics (Etikan et al., 2016). In order for participants to be eligible for participation in the study, they had to meet the following inclusion criteria:

- Study participants must be licensed secular therapists practicing in their state of licensure. Secular therapists are defined as those who are in clinical practice where religion is not a variable, and no one religion is promoted over another.
- Study participants must have had experience or had direct therapeutic intervention experience with complex trauma client(s) using REACH forgiveness or other forgiveness interventions. Complex trauma clients include those clients who have experienced all types of child abuse, sexual abuse and trafficking, abandonment, traumatic childhood experiences, group conflict, domestic and family violence, civil strife, conflict or genocide, ethnic dislocation, exploitation, and physical disability (Corrigan & Hull, 2015; Giourou et al., 2018; Morrison & Casper, 2012).

A sample size of 15 was chosen to ensure that adequate data was collected for theme analysis and prevent study elongation (see Rudestam & Newton, 2015). Additionally, determining this study's sample size was based on similar qualitative studies on the topic of forgiveness therapy and consideration for finding participants that will meet the study criteria. I proposed a sample size of 15 participants with the intention of adding more until theoretical saturation was met (see Creswell & Creswell, 2017). According to Richards and Morse (2013), the more usable data collected from each person, the fewer participants are needed. Saturation is the "gold standard" in qualitative inquiry as it indicates no new data, themes, or codes" (Fusch & Ness, 2015; Guest et al., 2006). The researcher determines when saturation has occurred, and I expected that saturation would occur on or before the interview of 10 participants. Saturation for this

study occurred by the tenth interviewee, as I predicted. As a result, a sample size of 15 interviewees was adequate to achieve data saturation.

I recruited participants through the following Facebook groups: (a) Positive Psychology, (b) Therapists Supporting Therapists, and (c) Professional Trauma Therapists. The Positive Psychology Facebook Group has 133,000 members. Therapists Supporting Therapists has 2,800 members and Professional Trauma Therapists has 163 members. Each group has significant memberships, is very active, and is specific to this study. An initial recruitment flyer (Appendix A) was posted with contact information for participatory interest, and a follow-up flyer was posted 2 weeks later. Prior to posting the recruitment flyer, I sent an informal written request to the page administrator(s) for approval to post and solicit study participants. I was granted approval by all three Facebook groups. Positive Psychology and Therapists Supporting Therapists do not have a posting limit. However, the Professional Trauma Therapists Facebook page approved only one post; multiple posts go against their community guidelines. Gelinas et al. (2017) asserted that the use of social media as a recruitment tool for research with human subjects is increasing and will continue to grow. Furthermore, social media is advantageous in this context because it allows researchers to access a more significant portion of the population than would otherwise be feasible, as well as target individuals and groups based on participant criteria, enabling researchers to infer their eligibility for studies (Gelinas et al., 2017). If the proposed sample size of 15 was not reached through social media, I intended to recruit participants from Pacific Counseling and Trauma Center in Folsom, California. It is a private practice in my region that I am familiar with

professionally, as I have referred some trauma clients to them. To address conflicts of interest, power, or boundary concerns, I have no personal relationship with Pacific Counseling and Trauma Center, nor do I have any clients from my practice who are now at Pacific Counseling and Trauma Center. There are 11 certified therapists on staff, all of whom specialize in PTSD and complex trauma. I individually emailed each of the 11 therapists an invitation to participate in the study (Appendix B) as well as the recruitment flyer (Appendix A). When there was expressed interest in participating, I sent them a consent form indicating to return "I consent" via email before the interview, a demographic questionnaire (Appendix C) that was self-administered and completed before the interview, also returned via email, Worthington's REACH forgiveness model as a point of reference (Appendix D), and a selection of dates and times to conduct the phone interview. The above-mentioned process was only slightly deviated from for Facebook recruitment. If someone expressed interest in participating in the Facebook recruitment post, I would send them a direct email to their Facebook account requesting their email address, and once received, I would send them a consent form, a demographic questionnaire, Worthington's REACH model as a point of reference, and a selection of dates and times to conduct the phone interview.

Interview Method

The interviews were conducted by telephone. Studies have shown that interviewees have willingly chosen the phone as their preferred interview method when offered the possibility of face-to-face or telephone interviews (Holt, 2010; Sturges & Hanrahan, 2004). Interviewees are often busy (Holt, 2010), and busy participants are

more likely to agree to a phone interview. Additionally, Vogl (2013) asserted that telephone interviews result in more balanced power distribution between the interview participants as opposed to face-to-face interviews as it provides a degree of confidentiality that can promote free and open communication. Moreover, Vogl (2013) compared 56 in-person interviews to 56 phone interviews. The study discovered no substantial differences between the two modes of communication in terms of conversation duration, rapport, number of words spoken, the proportion of words spoken by interviewees, number of answers, number of pauses, or the need for clarification (Farooq & De Villiers, 2017).

Instrumentation

Individually, participants were interviewed over the phone for no more than 60 minutes. This time frame was adequate for allowing them to share their perspectives on the research questions. The interview protocol (Appendix E) guided the interview with each participant. It also served as a document for taking supplementary handwritten notes during the interview. During the interview, the transcription software Otter.ai was used. This software app transcribes conversations as they occur and categorizes key terms repeated in the interviews, which aids in discovering themes among the participants. Prior to the text recording of the interview session, each study participant provided written consent.

Researcher Developed Instrumentation

In combination with preset questions in semi-structured interviews, I understand that I am the instrument in qualitative research, meaning as the researcher, I cannot

detach myself from the research because I am the instrument of data collection and analysis (Jackson, 1990). Therefore, an interview protocol worksheet guide was developed (Appendix E) in alignment with the research questions to elicit participant perspectives and to serve as a guided script for continuity within each interview. In developing a solid initial interview protocol, I followed the interview protocol refinement (IPR) framework, a four-phase procedure to systematically establish and refine an interview protocol. The four-phase process includes: 1) ensuring interview questions align with research questions, 2) constructing an inquiry-based conversation, 3) receiving feedback on interview protocols, and 4) piloting the interview protocol. Each phase aided in developing the research instrument to be suitable for the participants and congruent with the study's goals (Castillo-Montoya, 2016; Kell, 2015). Congruency ensures that the researchers' interviews are based on the study's purpose and research questions. These four phases, when taken together, provide a systematic framework for creating a well-vetted interview protocol that can assist a researcher in obtaining the rigorous and detailed interview data needed to answer research questions (Castillo-Montoya, 2016). The IRP method aims to strengthen the reliability of interview protocols for qualitative study and increase data reliability from research interviews (Castillo-Montoya, 2016, p. 812).

Recruitment, Data Collection, and Participation Procedures

I specifically recruited participants in two ways. First, through Facebook's social media platform to the following groups: 1) Positive Psychology, 2) Therapists Supporting Therapists, and 3) Professional Trauma Therapists. I will post the recruitment flyer

(Appendix A) for participatory interest that includes study criteria and contact information. Secondly, I recruited from Pacific Counseling and Trauma Center, located in Folsom, California. It is a private practice with 11 licensed therapists who all specialize in PTSD and complex trauma. I emailed the recruitment flyer (Appendix A) to each therapist for participatory interest, including study criteria and contact information. Both recruitment strategies adhered to the same process; if the participant expressed interest, I then sent them a consent form indicating to return "I consent" via email before the interview, a demographic questionnaire (Appendix C) that is self-administered and completed before the interview, also returned via email, Worthington's REACH forgiveness model as a point of reference (Appendix D), and a selection of dates and times to conduct the phone interview, offering convenience and flexibility to the participant.

All participants were reminded at the start of the interview that they have the right to withdraw from participation in the study at any time, their information would be kept confidential, risks and rewards, and that they could get a summary of the results of this study by making a verbal or written request. At the end of the interview, each participant was asked if there was something else they would like to add or feel was overlooked. I thanked them for their time, insight, expertise, and willingness to participate in this research. Data collection occurred through telephone to text transcription. Phone interviews allowed the participant as well as the researcher to select their preferred environment most comfortable for them.

I conducted interviews in a quiet home office with a phone set to speaker mode so that I could take notes on the interview protocol worksheet. I assigned a code number to the interview to organize the data and a code number to the participant to maintain anonymity and confidentiality. In the event of dropped calls or disruptions, the interview will be scheduled at another time upon the participant's approval. The initial interview will at most take one hour to complete. If necessary, I will collect follow-up information through phone calls or e-mails for clarification if additional information or data is required or something was overlooked during the initial interview. If the multiple recruitment approaches does not achieve saturation with the anticipated 15 study participants, I will locate additional Facebook groups, and similar recruitment procedures will be utilized. The Walden Institutional Review Board (IRB) will also be notified of the changes.

Data Analysis Plan

This study's research questions are as follows: "What are secular therapists' perspectives on the use of forgiveness therapy with complex trauma clients?" and "What are secular therapists' perspectives on the use of Worthington's REACH forgiveness model with complex trauma clients?" To analyze the qualitative data, I will use a thematic analysis with a constant comparison technique (Percy et al., 2015). Patterns of perspective and experience will be defined and listed once the data has been gathered through interviews (audio and transcription), field notes from the interview protocol worksheet, and any other sources. The Otter.ai transcription software significantly improves the speed at which keywords, patterns, and themes can be identified. In

addition, it distinguishes between voices and provides time tags, which are both organizational advantages. The first step in the analysis process for this study is data collection, and the data will be thematically analyzed as it is obtained using the constant comparison technique (Percy et al., 2015). For example, the data of the first participant is analyzed, and each subsequent participant's data is compared to the previously analyzed data, and so on. The research alternates between current data and data that has been previously collected, coded, and clustered into patterns. According to Percy et al. (2015), patterns and themes will evolve and alter as the research progresses.

Issues of Trustworthiness

Credibility

Rigor and validity are the perspectives of quantitative study, and reliability and trustworthiness are the perspectives of qualitative research (Cope, 2013). Guba and Lincoln (1994) established four criteria to develop trustworthiness in qualitative research: credibility, transferability, reliability, and confirmability (Cope, 2013).

Although I have considerable experience working with individuals who have experienced complex trauma and with whom I use forgiveness therapy, this is my first qualitative study as a researcher. As a result, to improve credibility, I will make every effort to document and track all information gathered during this study to provide a systematic and comprehensive interpretation of the participant's perspectives.

Transferability

A qualitative study meets the criteria of transferability if the findings are relevant to individuals who do not participate in the study, and the readers can equate the results

with their own experiences or perspectives. Transferability occurs when the reader can directly relate to the results of the study and see similarities to their own experiences (Padgett, 2017). Researchers must provide adequate information on the background of the study and the participants to allow the reader to determine the potential of the results to be appropriate or transferable. In addition, I will use rich and descriptive protocol questions and probes to evoke the depth and breadth of participant responses in an effort to enhance transferability.

Dependability

Dependability applies to the accuracy of the data under similar conditions (Polit & Beck, 2012). Dependability is achieved if another researcher agrees with the decision-making process at each stage of the research process. Essentially, if a study can be replicated in the same way, with similar subjects, under similar circumstances, have similar results and outcomes, the study will therefore be considered to be dependable (Cope, 2013; Koch, 2006). In consideration of other researchers to replicate this study, I will provide a transparent and concise explanation of all methods and procedures as the researcher.

Confirmability

Confirmability refers to a researcher's ability to demonstrate that the data reflects the participants' responses rather than the researcher's bias or opinion (Polit & Beck, 2012). Confirmability is concerned with neutrality and demonstrating that the data and interpretations of the results are not figments of the researcher's imagination but rather explicitly derived from the data (Korstjens & Moser, 2017). As the researcher, I will

demonstrate confirmability by demonstrating how conclusions and assumptions were arrived at, as well as demonstrating that the findings were extracted directly from the data. One example is providing descriptively rich quotes from participants to highlight emerging themes (Cope, 2013). Another example of confirmability is reflexive journaling, in which the researcher may take notes on their own perspective and comment on situational reactions during the research process (Cypress, 2017).

An additional strategy of confirmability, as well as dependability, is the strategy of an audit trail. This entails the inclusion of all notes pertaining to the decisions taken during the research process, reflective thoughts, sampling, research materials used, observations, and data management (Cypress, 2017; Korstjens & Moser, 2017). For this study, the audit trail will take the form of documentation (Appendix E: Interview Protocol Worksheet) and a running account of the process (my reflexive field journal). An audit trail will be established for this study to look at the processes of data collection, analysis, and interpretation.

Ethical Procedures

During the course of this study, ethical procedures for managing and handling written, and verbal data were followed, as was confidentiality. Strict professional quality and consideration was extended to all participants, even if they voluntarily withdrew from this study. An application was submitted to Walden University's Institutional Review Board (IRB) prior to recruiting study participants, requesting permission to conduct criterion-based research. Walden University's approval number for this study is #10-01-21-0854675. Also, prior to participant interviews, all participants were informed

of the nature of the study and were provided complete and descriptive information about the voluntary nature of the study and the ability to withdraw at any time, including risks and benefits of the study. The informed consent process occurred after participant interest and participant criteria was met. All participants were made aware of the expectations of their participation, which include signing an informed consent form, completing a demographic questionnaire, specifying a date and time that worked best with their schedule for a phone interview lasting no more than 60 minutes, and knowing that the interview will be audio recorded for transcription and analysis. The risks of this study are minimal as the participants are not considered a vulnerable population, nor does the study examine a sensitive topic area. The benefits of this study pertaining to the often poorly understood facets of forgiveness therapy and complex trauma are that therapists are uniquely positioned to expand on this growing body of literature. Though there is no financial incentive, participants were thanked for their time and candidness and given the opportunity to receive the study's findings.

As for confidentiality, I will not disclose the names nor any other identifying information of any participant within this study. Each participant was given a code number to further ensure confidentiality. An example would be if they are the first participant interviewed 01, the second participant interviewed is 02, and so on. All audiotapes of the interview, transcripts and other data was stored in a locked cabinet, and all electronic data was secured on a password-protected computer and mobile phone to maintain confidentiality.

Summary

The aim of this generic qualitative inquiry is to explore the perspectives of secular therapists on the use of forgiveness therapy with complex trauma clients, particularly the use of Worthington's REACH forgiveness model. This study, including the perspectives of 15 licensed therapists in direct practice with complex trauma and forgiveness therapy, will contribute to an emerging yet growing body of knowledge and literature. Researching forgiving perspectives and experiences will help therapists better understand the factors that help the clients they serve to forgive (Freedman & Chang, 2010).

Approval from the University's IRB was obtained prior to data collection through participant interviews. Ethical practices were maintained throughout the duration of this study to maintain confidentiality and the handling of all collected data. All participants were treated with the utmost professionalism and appreciation, even if they should voluntarily withdraw from the study. Considering the absence of financial compensation, participants will be thanked for their time and candidness and will be given the opportunity to receive the study's results.

The methods, design, rationale, data collection, and trustworthiness of this study have been outlined in this chapter. Furthermore, the study's core concepts, researchers' role, and the processes necessary to recruit, sample, and analyze data were outlined in this chapter. In Chapter 4, the study results will be addressed in-depth, including demographics of the participants, data collection, and data analysis.

Chapter 4: Results

The purpose of this generic qualitative study was to improve understanding and treatment interventions of secular therapists' use of forgiveness therapy specifically, Worthington's REACH forgiveness model with complex trauma clients, whereas to contribute to the growing body of literature. There remains limited empirical knowledge on applying forgiveness therapy perspectives with complex trauma from secular therapists, particularly Worthington's REACH model of forgiveness. Therefore, I sought to analyze the views of secular therapists who use forgiveness therapy in direct practice with complex trauma clients.

Forgiveness has traditionally been used by victims (survivors) of interpersonal trauma or abuse to reconcile events within their life (Courtois & Ford, 2013). Forgiveness is an intrapersonal process involving cognitive, affective, and behavioral components in which a person releases a negative attitude of unforgiveness to embrace a better or prosocial disposition toward the offender or the offense (McCullough et al., 2000; Worthington, 2005). With better knowledge and understanding of forgiveness therapy and complex trauma, it is possible to envision a more critical role for this therapeutic modality in numerous fields of social work and restorative counseling practices where complex trauma is often a defining characteristic

In this chapter, I outline the study's research findings, including an overview of the setting for data collection, the demographics of the participants, data collection, an in-depth examination of the data analysis process, and a discussion of the evidence

supporting this study's trustworthiness. Finally, this chapter concludes with the study results and summarizes key points.

Setting

I recruited participants for this study in two ways. The first approach was using the social media platform Facebook. I posted an initial recruitment flyer (Appendix A) to three individual Facebook groups: (a) Positive Psychology with 133,600 members, (b) Therapists Supporting Therapists with 2,800 members, and (c) Professional Trauma Therapists with 163 members. Each group had a sizable membership that was very active and purposive to the participant inclusion criteria for this study. The second approach was sending a direct email invitation to Pacific Counseling and Trauma Center to participate in the study (Appendix B).

On October 3, 2021, I posted the recruitment flyer (Appendix A) to each of the following Facebook pages: Professional Trauma Therapists, Therapists Supporting Therapists, and Positive Psychology. Unfortunately, this initial post elicited no responsive interest. However, a week later, a second posting to each of the aforementioned Facebook groups produced participant interest and inquiry. Additionally, the 11 Pacific Counseling and Trauma Center therapists were sent direct email invitations (Appendix B) with respective interests and willingness to participate. On six separate occasions, licensed therapists who had not received a study invitation contacted me regarding study involvement. Pacific Coast and Trauma Center research participants referred the additional six participants stating they had colleagues who would like to contribute. After screening and reviewing the informed consent, all six participants

agreed to participate in the study. Collectively, six participants were referrals, three participants were from Pacific Coast and Trauma Center, four participants were from Professional Trauma Therapists, and two participants were from Therapists Supporting Therapists. Two additional participants expressed an interest in participating but did not meet the inclusion criteria. The final sample size was 15 study participants.

After receiving written confirmation from prospective participants confirming their interest, I emailed a consent form indicating that they should indicate "I consent" on the consent form via email before the interview. In addition, they completed a self-administered demographic questionnaire (Appendix C) before or during the interview, and they were given Worthington's REACH forgiveness model as a point of reference (Appendix D). All participants were also sent a list of dates and times for the phone interview.

Description and Demographic Profile of the Participants

This study's 15 participants were all secular therapists from varying states who met the study's inclusion criteria, which included (a) practicing in their state of licensure and (b) having direct therapeutic intervention experience with complex trauma client(s) using REACH forgiveness or other forgiveness interventions. The following is a summary of the participant's profiles:

- P1 is a Christian, LDS male LCSW, Ph.D., who provides direct therapeutic interventions in private practice. His therapy preference and specialization are child/adolescent, marriage/couples/family, grief and loss, and

behavioral and anger management. His primary counseling theory is the introspective family therapy model.

- P2 is a Christian female LCSW who provides direct therapeutic interventions in private practice. Her therapy preference and specialization are generalist, and her primary counseling theory is humanistic.
- P3 is a Christian, LDS female LCSW who provides direct therapeutic interventions in private practice. Her therapy preference and specializations are child/adolescent, trauma, EMDR / brain spotting, and grief and loss. Her primary counseling theories are empowerment model therapy, dialectical behavior therapy, and solution-focused brief therapy (SFBT).
- P4 is a Christian male LMFT who provides direct therapeutic interventions in private practice. His therapy preference and specializations are trauma, EMDR, and brain spotting. His primary counseling theory is trauma-informed therapy and addictions-informed therapy.
- P5 is a secular female MFT, Psy.D. who provides direct therapeutic interventions in an agency setting. Her therapy preferences and specialization are child/adolescent. Her primary counseling theory or specialization is CBT.
- P6 is a Christian female LCSW who provides direct therapeutic interventions in private practice. Her therapy preference and specializations are child/ adolescent, marriage/couples/family, trauma, and grief and loss. Her primary counseling theory is psychodynamic psychotherapy.

- P7 is a spiritual LCSW who provides direct therapeutic interventions in private practice. Her therapy preferences and specializations are child/adolescent, marriage/couples/family, trauma, EMDR, and brain spotting. Her primary counseling theory is DBT.
- P8 is a spiritual female APCC who provides direct therapeutic interventions in private practice. Her therapy preference and specializations are trauma, EMDR, and brain spotting. Her primary counseling theories are person-centered therapy and equine therapy.
- P9 is a Christian female MA, LMHC, CSAT who provides direct therapeutic interventions in private practice and clinical director in an agency setting. Her therapy preferences and specializations are marriage/couples/family, grief and loss, and trauma. Her primary counseling theory is client-centered therapy.
- P10 is an atheist female LMFT who provides direct therapeutic interventions in private practice. Her therapy preference and specializations are marriage/couples/family, general. Her primary counseling theories are humanistic therapy and attachment therapy.
- P11is a spiritual female LPC, CCPP, who provides direct therapeutic interventions in private practice. Her therapy preferences and specializations are trauma, and her primary counseling theory is Salutogenesis.
- P12 is a Christian female LCSW who provides direct therapeutic interventions in private practice. Her therapy preference and specializations are

trauma, EMDR, and mindfulness. Her primary counseling theory is CBT and narrative therapy.

- P13 is a Hindu female LCSW who provides direct therapeutic interventions in private practice. Her therapy preferences and specializations are marriage/couples/family and trauma. Her primary counseling theory is psychoanalytic therapy, shakti therapy, ketamine therapy, and psychedelic therapy.
- P14 is a nonreligious female LCSW who provides direct therapeutic interventions in private practice and an agency outpatient setting. Her therapy preference and specializations are child/adolescent, marriage/couples/family, trauma, and grief and loss. Her primary counseling theories are CBT, DBT, and person-centered therapy.
- P15 is a Christian female LCSW who provides direct therapeutic interventions in private practice. Her therapy preference and specializations are child/adolescent, marriage/family, adoption, and trauma. Her primary counseling theories are narrative therapy and CBT.

Table 1 provides an overview of the participant demographics, and Table 2 provides an overview of participants' professional credentials; some participants have the same or dual licensure.

Table 1

Participant Demographics

Participant	Gender	Ethnicity	Religious Affiliation	Credentials	Practice Setting	State Licensure
P1	M	Caucasian	Christian, LDS	LCSW, Ph.D.	Private	CA
P2	F	Caucasian	Christian	LICSW	Private	NE
P3	F	Caucasian	Christian, LDS	LCSW	Private	CA, CO
P4	M	Caucasian	Christian	LMFT	Private	CA
P5	F	Caucasian	Secular	MFT, Psy.D.	Private	CA
P6	F	Caucasian	Christian	LCSW	Private	CA, Washington, D.C.
P7	F	Caucasian	Spiritual	LCSW	Private	CA
P8	F	Caucasian	non-religious	APCC	Private	CA
P9	F	Caucasian	Christian	LMHC	Private	WA
P10	F	Caucasian	Atheist	LMFT	Private	CA
P11	F	Caucasian	Spiritual	LPC, CCTP	Private	CA, AZ, IL, TN, GA
P12	F	Black	Christian	LCSW	Private	CA
P13	F	South Asian	Hinduism	LCSW	Private	CA
P14	F	Caucasian	Nonreligious	LCSW	Private	AR
P15	F	Caucasian	Christian	LCSW	Agency	CA

Table 2

Professional Credentials

Professional Credentials		Frequency of Licensure
APCC	Associate Professional Clinical Counselor	1
CCTP	Certified Clinical Trauma Professional	1
LCSW	Licensed Clinical Social Worker	6
LICSW	Licensed Independent Clinical Social Worker	1
LMFT	Licensed Marriage and Family Therapist	1
LMHC	Licensed Mental Health Counselor	1
LPC	Licensed Professional Counselor	1
MFT	Marriage and Family Therapists	1
Ph.D.	Doctor of Philosophy	1
Psy.D.	Doctor of Psychology	1

Data Collection

I obtained a sample size of 15 using a purposeful sampling strategy. The sample size for this study was determined based on similar qualitative studies on forgiveness therapy and consideration for locating individuals who fulfill the study inclusion criteria. The sample size of 15 was set to allow appropriate data collection for theme analysis and to avoid research elongation (see Rudestam & Newton, 2015). In the broader context, larger sample sizes can cause a study to be overly long; saturation occurs in data collection and analysis when new incoming data produces minimal or no new information addressing the research questions. Saturation for this study occurred by the 10th interviewee, as previously predicted in the participant section of Chapter 3. Therefore, a sample size of 15 interviewees was sufficient to achieve data saturation. Notably, the amount of variance in the data was leveling out, and the data was no longer providing new perspectives or explanations (see Burmeister & Aitken, 2012).

Potential participants were provided a recruitment flyer (Appendix A) as well as direct email invitations (Appendix B); all interested participants responded through email. After receiving written confirmation from the prospective participant confirming their interest in participating and obtaining consent, the date and time for the phone interview were agreed upon. The study participants comprised of three individuals from Pacific Coast and Trauma Center, six individuals referred from Pacific Coast and Trauma Center, four individuals from Professional Trauma Therapists, and two from Therapists Supporting Therapists.

The participants were given the option to select the date and hour of the phone interview. I started each call at the agreed-upon hour, and each participant was punctual, dependable, and well-prepared. There was no rescheduling during the data collection process. Prior to the interview, informed consent was obtained. At the start of each interview, I reviewed the nature of the study from the Interview Protocol Worksheet and reviewed and completed any missing Participant Demographics with research participants.

All interviews were conducted in my quiet home office, with the phone set to speaker mode so that audio could be recorded and notes could be taken on the Interview Protocol Worksheet (Appendix E). The audio recordings from each interview were uploaded to Otter.ai for transcription, including audible playback to check for errors and corrections. Each participant was assigned a code number to organize the data and maintain anonymity and confidentiality (i.e., P1, P2, P3).

There were no deviations from the prescribed protocol as outlined in the intended methodology throughout the data collection process. Only one limitation occurred during the phone interview with P11: phone reception. I interrupted the interview and informed the participant that I could not hear or clearly capture her responses. When these often-unavoidable technological issues arise, they can potentially affect the rapport and first impressions between interviewer and interviewee (Archibald et al., 2019). However, she was very accommodating and promptly moved to a better location, causing minimal disruption to the interview.

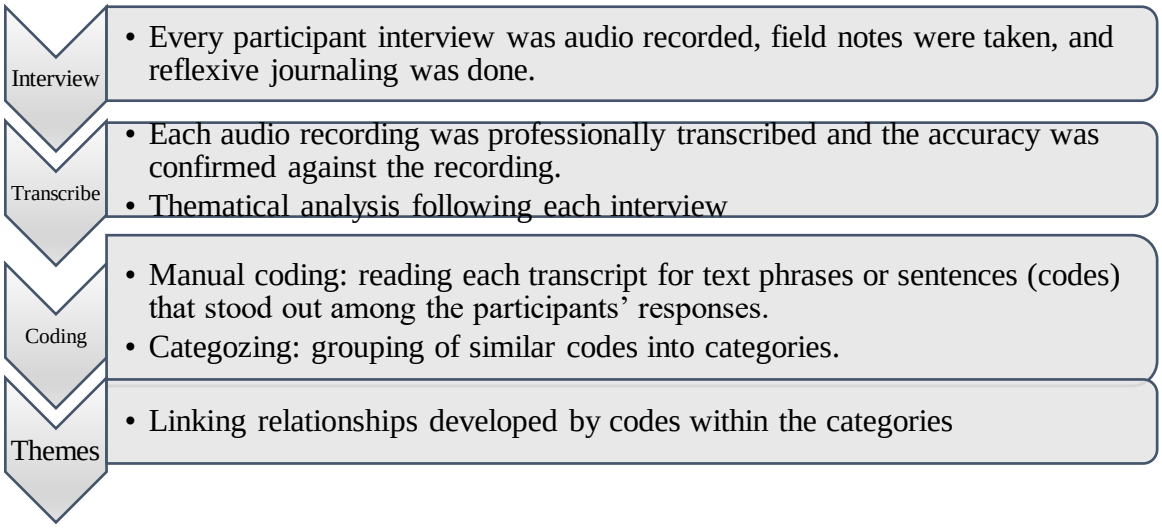
Data Analysis

Each interview was electronically uploaded to Otter.ai.com for transcription. The transcription from audio to text was instantaneous. As a result, I reviewed the textual transcription for obvious errors while concurrently listening to the audio replay. Otter.ai is user-friendly and allows the researcher to make corrections and take notes while listening to the audio and reviewing the transcript. Overall, the transcription contained very few errors, and where there were errors, they were corrected.

Each question on the Interview Protocol Worksheet (Appendix E) was developed in alignment with the research questions to elicit participant perspectives and to serve as a guided script for continuity within each interview. As a result, congruence existed within each interview and with each participant, ensuring that interviews were based on the study's purpose and aligned with the research objectives. Figure 1 provides an overview of the steps in data collection and analysis.

Figure 1

Inductive Data Processing



Coding

Each participant was administered the same set of 10 predetermined questions based on the conceptual framework of Worthington's REACH forgiveness model and guided by the research questions: (a) What are secular therapists' perspectives on the use of forgiveness therapy with complex trauma clients? (b) What are secular therapists' perspectives on the use of Worthington's REACH forgiveness model with complex trauma clients?

Codes for this study emerged as the data was thematically analyzed; this is known as a bottom-up or inductive method of data analysis (Percy et al., 2015). First, I manually selected text phrases or sentences (codes) that stood out among the participants' responses; the phrases and sentences reflected the participant's perspective, which resulted in categories of similar meaning specific to the research questions. The categories were then fused together to further push the data into theme development, thus, producing themes to elicit meaning from the participants' perspectives. According to Morse (2008), a theme is a meaningful "essence" that runs through the data and is the overall topic of the narrative. A total of 104 codes were reduced to seven categories, which were then concentrated into three major themes (forgiveness is freedom in complex trauma recovery, forgiveness therapy minimizes symptoms of complex trauma, and REACH forgiveness is beneficial in complex trauma recovery) and one subtheme (posttraumatic growth will include resistance). The themes are discussed in depth in the Results section. The categories that emerged from the codes are education, role, client-centered, inclusive, resistance, freedom, and effective.

Discrepant Case

One discrepant case was noted; however, it did not significantly influence the results. According to Maxwell (2013), a critical issue in addressing research validity is examining differing definitions and contradictory data—that your research is not simply a self-fulfilling prophecy. The discrepant case concerned participant P14; while all study criteria were met to participate, at the beginning of the interview, she stated that when working with complex trauma clients, she considered the modality of forgiveness to be "like" the modality of radical acceptance. P14 stated, "a lot of the clients that I have come into contact with that have complex trauma or PTSD, a trauma in general, have a really hard time with forgiveness." She further explained, "and so I feel like using radical acceptance has been a lot more helpful for those people." It is important to note that while she addressed the likeness of forgiveness therapy and radical acceptance, she further stated, "using radical acceptance is like unburdening, I guess that is what forgiveness therapy is." Nevertheless, data collected from P14 was consistently like data collected from the other study participants. Furthermore, no participant made a statement that contradicted another participant's statement.

Evidence of Trustworthiness

Credibility

As a master-level social worker in private practice, I have extensive experience working with clients who have experienced complex trauma and with whom I practice forgiveness therapy. Therefore, during the interview process, I could elicit the breadth of information required to establish credibility in this research study. One method I used to

gather depth of knowledge was to seek clarity in participant responses, including asking participants to elaborate further on their "yes" or "no" responses. In addition, I used probes and, on occasion, reframed the question(s) if the topic or response veered from the interview question or the participants' answer was too vague.

Transferability

Transferability emerges within a study when the reader can directly relate to the study's findings and recognize similarities to their own experiences (Padgett, 2017). Therefore, researchers must provide sufficient information about the study's context and participants so that the reader may assess whether the results are appropriate or transferable. All interviews were conducted precisely in the same manner. All participants were interviewed over the phone, set to speaker mode, and audio recorded. All interviews were uploaded to Otter.ai for transcription, complete with audible playback to check for errors and corrections. Additionally, I used rich and descriptive interview questions that elicited depth across each response to enhance transferability. Furthermore, I attempted to establish reader relatability by describing the participants' perspectives through storytelling and descriptive details to create an illustration for the audience transferable to other settings (Houghton et al., 2013).

Dependability

Data accuracy under similar conditions is referred to as dependability (Polit & Beck, 2012). If another researcher agrees with the decision-making process at each research phase, the research is considered dependable. In essence, if a study can be duplicated in the same way, with comparable participants, in similar contexts, and with

similar results and outcomes, the study is considered dependable (Cope, 2013; Koch, 2006). I have created a transparent and concise trail of all methodologies and procedures, considering other researchers who want to replicate this study. The methods for gathering and analyzing data were carried out in the same way and the same order as the preceding participant. In addition, semi-structured interviews generate a large amount of data in the form of transcripts, looking for and correcting apparent errors that occurred with each transcript, strengthening the data's dependability (Rudestam & Newton, 2015).

Confirmability

Confirmability is concerned with objectivity and establishing that the researcher's data and discussion of results are not created but instead are taken directly from the data (Korstjens & Moser, 2017). I demonstrated confirmability as the researcher by showing how conclusions and assumptions were reached and indicating that the findings were derived directly from the data. One example has been using descriptively rich quotes from participants to emphasize key study themes. (Cope, 2013). The use of an audit trail is another approach for ensuring confirmability and dependability. An audit trail was created for this study to examine data collection, analysis, and interpretation. All notes referring to study decisions, reflective thoughts, sampling, research materials used, observations, and data management ought to be included (Cypress, 2017; Korstjens & Moser, 2017). The audit trail for this study consisted of documentation (Appendix E: Interview Protocol Worksheet) and a process log (my reflexive field journal).

Results

This qualitative study aimed to answer the following research questions: (1) What are secular therapists' perspectives on the use of forgiveness therapy with complex trauma clients? (2) What are secular therapists' perspectives on the use of Worthington's REACH forgiveness model with complex trauma clients? The 15 participants of this study shared and discussed their experience and perspective about forgiveness therapy and complex trauma, as well as their perspective on the effectiveness of Worthington's REACH forgiveness model. Three primary themes and one subtheme emerged from the collected interview data, which include:

- Theme 1: Forgiveness is freedom in complex trauma recovery.
    - Subtheme: Posttraumatic growth will include resistance.
- Theme 2: Forgiveness therapy minimizes symptoms of complex trauma.
- Theme 3: REACH forgiveness is beneficial in complex trauma recovery.

See Table 3 for definitions of each theme.

Table 3

Definitions of Identified Themes

Theme	Definition
Theme 1: Forgiveness is freedom in complex trauma recovery.	Forgiveness therapy is essential in trauma recovery: it catapults the healing process.
Subtheme: Posttraumatic growth will include resistance.	Fundamental misunderstanding about the process of forgiving; self and other. Misconception of condoning or reconciliation.
Theme 2: Forgiveness therapy minimizes symptoms of complex trauma.	Elevates symptoms of hurt, anger, and shame. Provides growth of self, and improves relationships with others, even offender. Unburdening of symptoms.
Theme 3: REACH forgiveness is beneficial in complex trauma recovery.	Aligns with other trauma work and beneficial in complex trauma recovery processes, and helps client organize the steps of recovery. Aids in the resolution of trauma triggers, and connection of the altruistic gift is key for trauma survivors.

Findings on Research Question 1

Two main themes and one subtheme emerged as findings to RQ1: "Forgiveness is freedom in complex trauma recovery," is the first theme, with a subtheme of "posttraumatic growth will include resistance." The second theme is "Forgiveness therapy reduces symptoms of complex trauma."

Theme 1: Forgiveness is Freedom in Complex Trauma Recovery

During the interviews, all participants stressed the vital, often slow, but necessary importance of forgiveness therapy in trauma recovery. Additionally, when asked where they first learned about forgiveness therapy, all participants stated, "personal interest," indicating that incorporating the therapeutic approach of forgiveness was motivated by personal interest. While forgiveness therapy is available through continuing education, workshops, or seminars, it is not academically taught in Master of Social Work programs, counseling, or licensing programs.

Participants reported that forgiveness is paramount in the process of removing and replacing emotional damage with behavior(s) unaffected by the trauma, which is a central theme in therapy and counseling. Without forgiveness, trauma survivors get "stuck" in "looping" holding patterns, and when they are in a holding pattern, they are operating on-resistance, so the process of release is essential for growth. P15 told the metaphorical story of "the dog's mouth," which she frequently tells her adolescent clients to help them understand how forgiveness works, it is:

> If a dog bit your hand and clenched its teeth into you, most people's instinct is to pull their hand away, but that will only make the dog bite down harder and make your injury worse. So really, what you need to do is shove your fist into the dog's mouth—then they will open their mouth, and you can take your hand out. This description I give to people who have experienced trauma to help show that you must go into the dog's mouth to come out and be okay. I think that forgiveness is part of going into the dog's mouth. It is really being able to process and understand what happened in order to let it go, to be able to forgive either the person who inflicted the trauma on you or to forgive yourself, especially with youth; a lot of youth blame themselves for the trauma that occurred.

The distinction between being in a state of forgiveness or being in a state of unforgiveness is that unforgiveness consumes your thoughts, physical health, emotional health, and healing. P4 expressed her experience with forgiveness and complex trauma, stating, "I feel like it catapults the healing, and I have seen it clear blockages for people." Furthermore, the role of forgiveness in trauma recovery can be multifaceted in terms of forgiveness of self and/or the offender. P4 further elaborated how trauma survivors could achieve a state of forgiveness:

> For the most part, there are aspects that individuals who have suffered trauma have to work through forgiving, such as forgiving another, forgiving themselves. That is all core to them getting to a more healed place. I would even say it is the cat's meow of everything involved in trauma processing. But fundamentally, there is always a sort of a trauma-related dance that the individual must work through—

such as forgiving the other and or forgiving themselves. And I would; I would even go so far as to say forgiving God.

Subtheme: Posttraumatic Growth Will Include Resistance

This subtheme emerged from theme 1 in further addressing the research question of therapists' perspectives of forgiveness therapy with complex trauma clients. Forgiveness is freedom, as stated in theme 1, but it is also met with client resistance due to misunderstanding or misconception. As a result, participant responses linked posttraumatic growth (PTG) with inclusion (forgiveness is necessary) and resistance (misconception of forgiveness) during forgiveness therapy. While lesser-known, posttraumatic growth is the sibling term to resiliency and refers to the positive psychological changes that occur in individuals due to a traumatic experience. Some examples of PTG statements conveyed by Tedeschi et al. (2018) include, "Despite all the bad things that happened, I realize that I feel much more connected to other people or myself now," or "After what happened, I find myself focusing more on what is important to me rather than what others want me to do." The forgiveness process necessitates active participation in changing behaviors, motives, motivations, and emotions (McCullough et al., 2000, 2003, 2007).

When it came to conveying forgiveness to clients, all participants stated that they always meet resistance, with the most common reason being misconception. For example, P11 stated her experience with client resistance when introducing forgiveness therapy to her trauma clients:

> If I could say, I would say it happens 100% all the time, and that is an aspect of posttraumatic growth. Trauma survivors often get stuck in their traumas because they know how to survive there and how to navigate. So, trauma is a safe place for them. But they don't know how to orient towards joy or calmness or safety or predictability or dependability. That is terrifying to them. So, it is not just forgiveness. That is an aspect of trauma work.

Additionally, forgiveness is an action that allows the victim to work through the mental and physical anguish brought on by the offense; it is not the removal of the offender's consequences, showing tolerance for the wrongs committed, or rejecting what occurred (Clinton & Hawkins, 2009). Forgiveness is frequently misunderstood as a sign of weakness; nevertheless, this is far from the case. Instead, forgiveness exhibits character strength, wisdom, courage, and fortitude in pursuing personal normalcy and a better quality of life. P13 stated, "I absolutely get an initial resistance without question because many people, even though they have the logical understanding that forgiveness is about themselves and not the other person, a lot of natural resistance comes into play in the beginning." Moreover, P7 added that when a client has a misconception about forgiveness, it is generally believed that forgiving diminishes what happened. This is because so many people "cannot" or "do not want to let go" of that piece of the trauma. As an example, P1 shared his experience with client resistance:

> Many patients whom we are trying to help forgive do not understand forgiveness; I think it is their first problem. They think forgiveness means condoning the sin or condoning the abuse and reconciliation, right? But it does not mean you are

letting go of that abuse. So, what it means is that you will not let it affect you for the rest of your life.

All participants described their trauma and forgiveness work as client-centered, stating, “the clients determine their treatment goals, I do not.” Participants noted that they listen for shame-based cognitive distortions, determine treatment planning through assessments, and often plant the seeds of forgiveness to include psychoeducation. P10 stated that in her humanistic therapy model (client-centered), she is not inclined to move into the forgiveness process unless she hears language from her trauma client, such as, “I’d like to forgive, or I’d like to be able to forgive.” P12 reported that forgiveness is frequently “the lingering piece” that has not been resolved is still holding on and is something the client is having difficulty letting go of.

Following a thorough review of all interviews, there was a unanimous and firm agreement that there is no specific trauma for which they would not introduce forgiveness. P7 reported that she views forgiveness on a spectrum and meets the client where they are at. But, she continued, “sometimes they are not able to forgive. So, I just sit there and create space for that.”

Theme 2: Forgiveness Therapy Minimizes Symptoms of Complex Trauma

This may be one of the most important findings of this study. At the same time, broad statements cannot be made, according to participants, applying forgiveness results in a reduction of complex trauma symptoms for clients through the general improvement of presenting problems such as depression and anxiety. As previously stated in Chapter 2, forgiveness is recognized as therapeutically beneficial in the field of behavioral and

mental health for therapists to help clients minimize negativity in their lives, improve mental health, reduce rumination, anger, and psychological difficulties such as anxiety and depression. (Gangdev, 2009; Wade et al., 2013). When participants were asked for examples of positive outcomes from forgiveness therapy, participants shared stories of their clients feeling unburdened, liberated, tolerant, lessened the rumination of anger and pain, and freedom due to reaching a state of forgiveness. Conversely, participants shared positive client outcome stories of suicide, marriages, sexual trauma, rape, molestation, family of origin dynamics, and grief and loss.

For example, P8 recounted how forgiveness benefited a client who had lost both of his parents to cancer at an early age; forgiveness therapy allowed for acceptance while minimizing the anger and pain for this client. P9 also recounted that she had seen numerous positive outcomes from forgiveness therapy, many of which were marriages that were repaired, restored, and reconciled, most often after multiple affairs, infidelity, and even what many consider unforgivable. The natural proclivity for trauma forgiveness is characterized by a desire to do good to those who have harmed them while minimizing the desire to harm those who have harmed them (Hafina et al., 2019).

Moreover, participants shared their positive outcome experiences with clients about forgiveness, such as “unburdening myself” and “less fearful,” “observing how self-forgiveness can liberate the emotions and feelings of anger,” and “at that moment, the client began to shift. For example, P4 told the story of a client overcoming her husband’s suicide. This client was suffering severe panic attacks, generalized anxiety disorder in significant proportions, could not work, and could not sleep, and through the trauma work

was able to identify her own need to forgive him, and letting him go, letting go of the offense and nature of his death.

P12 shared the story of a young female client who had multiple layers of complex trauma due to sexual trauma and victimization while serving in the Peace Corps. This client had lost normalcy in her life and was so "stuck" in her trauma that she could not leave her home and could not hold a job. She shared that the client realized that she needed to let go of her feelings of anger, hate, and frustration toward her victimizer. So, when she got to that point, she was able to do that; a lot of the things started to sink in for her. From that point on, she started working again; she was able to leave the house, while she still dealt with a lot of anxiety; it felt like that was a turning point for her to operationalize and apply forgiveness to regain her day-to-day functioning.

Forgiveness is the process of transforming and shifting resentment, avoidance behavior, or violent retaliation by replacing it with a benevolent attitude toward those who have caused harm (Kimmes & Durtschi, 2016; Strelan & Wojtysiak, 2009). Furthermore, Peterson and Seligman (2004) claim that forgiveness shields people from hatred. Adolescent forgiveness can function optimally through early intervention, rather than simply waiting for mature reasoning capacity to forgive independently (Akhtar & Barlow, 2018; Kueny & Cardenas, 2018; Worthington et al., 2010).

Finally, P7 disclosed the story of a young woman molested by her father and how the nature of the offense altered her emotions and attitudes, such as, "my body is dirty" and "I want a new body." However, through the process of forgiveness, those feelings and emotions were no longer tethered to her. Through the process of forgiveness, she was

able to let go of her anger and the shame of what happened to her and her body. It did not diminish what she endured, but the client expressed that it was the first time she felt freedom from the experience. Forgiveness is a valuable character trait that can be strengthened and established with the assistance of therapy (Hafina et al., 2019). Moreover, according to Peterson and Seligman (2004), forgiveness includes the virtue of temperance, which directs people to refrain from doing anything without first thinking about it, thereby mitigating the negative consequences that may result.

Findings on Research Question 2

Theme 3: REACH Forgiveness is Beneficial in Complex Trauma Recovery

The importance of interview findings for RQ2 is to highlight that none of the study participants were familiar with Worthington's REACH forgiveness model with complex trauma clients. As a result, a handout summarizing the REACH forgiveness model was provided as a point of reference prior to the interview. In addition, all participants were asked if they believed REACH forgiveness would be effective with complex trauma clients? All 15 participants reported "yes." Excerpts from the interview transcripts show what participants said about REACH, such as "it provides preliminary resolution of some of the major triggers within the complex set of circumstances," I think it would be a great model for trauma patients," "absolutely yes," "I think it is a great way to explain maybe or to provide some dialogue or language for a client," and "I like it a lot. Ooh, yes, this is nice; I think the piece that stands out for me, that I feel is important for peace for trauma survivors, is to connect into this altruistic gift—wow, choosing to extend that to another human being. powerful."

Worthington's forgiveness technique REACH is an acronym that stands for the following: Recall the hurt, Empathize with self or offender, Altruistic gift of forgiveness, Commitment to forgive, Hold on to the forgiveness (Worthington, 2005). While P8 was not familiar with REACH, she practices in a trauma center and equates the REACH model to how she approaches her trauma work. She stated:

> It goes right along with the trauma work that we do here, too; empathize, like, I love Gestalt stuff. So, I am very familiar with empty chair work. So yeah, kind of that. Yet adding the forgiveness piece. So, yeah. And then the commit part, in that I see positive cognitions that we use, so yep, it is right along with the trauma work I know now, yes definitely.

The first step, Recall the hurt, elicited notable hesitation from four participants. Two participants felt that this step was too soon or too fast for complex trauma clients, while others suggested shifting or removing items within the 5-steps to provide flexibility, implying that "one size does not fit all." For example, P5 stated, "recall the hurt; I am not sure with complex trauma because so many people struggle with being able to sit with it." However, she continued to add, "I think a model like this could work and let people know that one size does not fit all; there are lots of different models." Similarly, P2 believes the model is sound, with the only reservation being that the first step, "recall the hurt," was a little too quick; clients must first resolve their anger.

Furthermore, P13 stated, "my initial reaction is that I think it is interesting, I think the hesitation is on top, I love the idea of resourcing, I would almost add resourcing first, and see it in practice, but otherwise yeah, I do like this model of forgiveness." Lastly, P11

commented on the REACH model's flexibility, saying, "Yeah, I like the model, it's a good model, and it would be effective with trauma clients so long as it can be edited for whatever the client's needs are - model flexibility." While notable responses, it is critical in trauma work to collaborate with clients and tailor treatment structure, process, and outcomes. This will benefit the effectiveness and quality of treatments as well as the speed with which they are conveyed (Cloitre, 2015).

Summary

This research study intends to improve treatment interventions through examining the perspectives of secular therapists' direct use of forgiveness therapy, specifically, Worthington's REACH forgiveness model with complex trauma clients. To achieve the goal of this research study, I gathered data from 15 licensed therapists who work compassionately with complex trauma clients. Furthermore, the information was collected through one-on-one phone interviews with each participant, which were audio-recorded independently and then transferred to professional software audio to text transcription and analyzed. During the data analysis process, a total of 104 codes were reduced to seven categories: education, role, client-centered, inclusive, resistance, freedom, and effective. This data was then refined into three major themes and one subtheme, which are as follows: forgiveness is freedom in complex trauma recovery (subtheme: posttraumatic growth will include resistance), forgiveness therapy minimizes symptoms of complex trauma, and REACH forgiveness is beneficial in complex trauma recovery.

Participants of this study all emphasized the critical, albeit slow, but necessary role of forgiveness therapy in trauma recovery, as well as the importance of forgiveness in the process of removing and replacing emotional damage with behavior(s) unaffected by the trauma, which is a central theme in therapy and counseling. Based on their own experiences, participants in this study support and expand on this body of literature, which further links forgiveness therapy to complex trauma as a beneficial treatment plan.

Furthermore, the data interpretation indicates that secular therapists strongly believe that forgiveness therapy is essential for trauma recovery. The following chapter includes the interpretation of the findings, an assessment of the study's limitations, recommendations for additional research, and an examination of the study's implications for positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to promote understanding and treatment interventions of secular therapists' use of forgiveness therapy, particularly Worthington's REACH forgiveness model with complex trauma clients. Using a qualitative approach assisted this study in conveying the perspectives of secular therapists. Additionally, the characteristics of this approach emphasized the participants' perceptions, feelings, and experiences to elicit understanding and meaning, resulting in richly descriptive findings.

The results of this study revealed that participants were resolute about the importance of linking forgiveness with complex trauma and that there is no trauma to which they would not introduce forgiveness. Additionally, while none of the participants in this study were familiar with Worthington's five-step REACH model of forgiveness, they reported it would be an effective and valuable tool for working with complex trauma clients. Furthermore, the organizational acronymic steps are helpful for clients who have experienced trauma.

Complex trauma survivors are psychologically tormented and appear to be prisoners of their own emotions, grappling with rage, sorrow, alienation, distrust, uncertainty, poor self-esteem, humiliation, loneliness, and self-loathing (Courtois & Ford, 2013). Therapists can use forgiveness therapy to help clients reduce the negative aspects of their lives while allowing the positive elements to flourish (Gangdev, 2009). In addition, forgiveness interventions improve mental health by reducing anger, and psychological distress, such as depression and anxiety (Wade et al., 2013). Participants in this study reported and affirmed that forgiveness therapy plays an integral part in trauma

recovery; it is not a fast process, but it effectively untethers the clients from their trauma. The findings are discussed considering the previous literature on this topic presented in Chapter 2 in the following section.

Interpretation of the Findings

The data presented in Chapter 4 reflected participant perspectives on forgiveness therapy and Worthington's REACH forgiveness model with complex trauma clients, which addressed this study's research questions. The findings interpret the participants' perspective in response to the research questions listed below.

RQ 1: What are Secular Therapists' Perspectives on the use of Forgiveness Therapy with Complex Trauma Clients?

Forgiveness therapy's target focus and overarching goal is to decrease resentment and rumination of interpersonal hurt or injury. The first theme, "forgiveness is freedom in complex trauma recovery," is consistent with Ordóez-Carabao et al.'s (2020) qualitative study of lived experiences with Rwandan genocide survivors. According to the aftereffects of forgiveness in this study, participants experienced a transformation from sorrow to renewed feelings of freedom, happiness, peace, relaxation, rejuvenation, openness, restored normalcy, trust, and calmness. Furthermore, as forgiveness is one of the three central concepts explored in this study, forgiveness is defined by Enright (2012) as a targeted and personal goal for victims to break free from vindictive motivations or destructive cyclical behaviors. The findings of this study revealed that freedom in complex trauma recovery from forgiveness is a viable and well-supported outcome.

The interpersonal nature of complex trauma involves situations in which the traumatized individual cannot escape the traumatic events because they are physically or psychologically bound to them (Herman, 1992). The subtheme "posttraumatic growth will include resistance" emerged from the data as an essential component of the findings and contributes to the existing literature about the misconceptions of forgiveness. When introducing forgiveness to their clients, all study participants stated that resistance was always present. Notably, resistance corresponds to the widespread misconception that forgiveness equals reconciliation. According to Wade and Worthington (2005), when discussing forgiveness, it is essential to remember that reconciliation is not the same as forgiveness. Forgiveness is a process of emotional posttraumatic growth in the aftermath of a significant violation. It is a morally charged, active process that requires acceptance and change (Purcell et al., 2018). Therapists, as stated by Freedman and Zarifkar (2016), should clarify the distinction between forgiveness and reconciliation and ensure that clients understand that reconciliation is not required (or always possible) in the forgiveness process.

This study's findings support those of Lander's (2015) qualitative case study, which investigated the contributions of forgiveness therapy in social work and practice and discovered that addressing forgiveness in therapy is significant because it is associated with improved posttraumatic growth. Moreover, this speaks to the theme of this study, "forgiveness is freedom," because improved posttraumatic growth reflects improved life purpose and value of living. In essence, forgiveness in the face of complex trauma leads to freedom, freedom from emotional pain, anxiety, depression, and anger.

The second theme to emerge from this study was “forgiveness therapy reduces symptoms of complex trauma,” which is consistent with previous research indicating that forgiveness of self or others leads to improved positive mental health and has a significant connection to physical health (Berry & Worthington, 2001; Harris et al., 2007; Raj et al., 2016; Toussaint & Webb, 2005). Some of the more complex symptoms conveyed by survivors of complex trauma include panic attacks; intrusive memories; repetitive nightmares; feelings of vulnerable helplessness; difficulty maintaining close relationships; and difficulty regulating, controlling, and experiencing their emotions, including difficulty appropriately labeling and accurately comprehending them (Raj et al., 2016; Shrira et al.,2019). In addition, many survivors experience unmanageable or persistent sadness, as well as explosive or unorganized anger and rage (Baranowsky & Gentry, 2014; Corrigan & Hull, 2015; Shrira et al.,2019).

Participants expressed that using forgiveness reduces complex trauma symptoms for clients by improving the most common presenting conditions such as anxiety and depression. Additionally, the benefits of forgiveness in a clinical setting are supported by Wade and colleagues (2014) meta-analysis of 54 quantitative studies concentrated solely on the beneficial outcomes of forgiveness. As Weir (2017) said, research demonstrates that whether a person has a minor or significant grievance, learning to forgive oneself or those who have hurt you has significant physical and psychological benefits. Kira and colleagues’ (2009) quantitative study found that those who sought forgiveness of self and their offenders had significantly better physical and behavioral health outcomes than the participants who opted not to forgive. Forgiveness has been linked to many mental and

physical health benefits; this resilient therapeutic approach is a victim-focused responsive coping strategy for stress related to a harmful offense (Nation et al., 2018; Toussaint & Webb, 2005; Worthington et al., 2007).

From their own experiences, the participants in this study supported and expanded on this body of literature, which further links forgiveness therapy to complex trauma as a beneficial treatment plan. Furthermore, the interpretation of the data indicates that secular therapists strongly believe that forgiveness therapy is an essential component of trauma recovery. P1, for example, stated that forgiveness in trauma work is "everything," and once a client reaches an understanding of their forgiveness, one can see their countenance change, their outlook on life changes, everything changes, and they are generally happier people. Furthermore, the participants shared that, while complex trauma keeps a person in a mental holding pattern which constantly rules daily choices and behaviors, forgiveness interrupts that holding pattern and allows for more freedom. Forgiveness is essential in reducing and eliminating shame, anger, anxiety, and depression.

RQ 2: What are Secular Therapists' Perspectives on the use of Worthington's REACH Forgiveness Model with Complex Trauma Clients?

Traditional and most common types of psychotherapy, such as psychodynamic, EMDR, behavioral, CBT, humanistic, or structural family therapy, address current issues rather than historical events. On the other hand, Worthington's REACH forgiveness model investigates historical offenses that have yet to be successfully resolved (Worthington et al., 2007). Furthermore, as previously mentioned, traditional psychotherapy is not well-served due to complex trauma survivors' complex symptoms

(Corrigan & Hull, 2015). In contrast, the REACH forgiveness model concentrates on forgiveness experiences with trauma survivors who want to heal from interpersonal hurts and injuries. It is also a flexible and adaptable intervention that can be used by both groups and individuals (Worthington et al., 2010). Participants in the current study agreed with those sentiments.

REACH is a five-step acronym that promotes emotional forgiveness in another person and self (Worthington et al., 2010). These steps include R-remembering the hurt, E-empathizing with the offender, A-offering a gift of forgiveness that is Altruistic, C-committing to forgiveness, and H-holding on to forgiveness when doubt arises (Leach et al., 2010; Nation et al., 2018; Worthington et al., 2010). Even though none of the participants in this study had any personal or clinical experience with Worthington's REACH model of forgiveness, all agreed after reviewing it that it was an excellent tool for working with complex trauma clients. This is not surprising given that no trauma studies have been conducted using Worthington's REACH model of forgiveness (see Wade et al., 2014). Participants of this study stated that REACH would help organize the trauma process and provide dialogue and language for the client to understand. Strange and Takarangi (2015) contended that trauma memories are frequently stored in fragments, disconnected from a clear narrative, and people tend to remember more trauma than they experienced, a phenomenon known as "memory amplification" (p. 1). When compared to other types of memories, trauma memories are somewhat disorganized. People's memories of traumatic events, like their memories of more mundane events, are easily distorted.

The REACH model was immediately associated with Gestalt therapy by P8, a trauma therapist. She stated that each step of the REACH model coincided with her trauma work, but she had no idea it came in the form of a model and that it felt similar to Gestalt work and the empty chair. However, the piece of forgiveness is what currently lacks in Gestalt therapy (Harris, 2007). Gestalt therapy is a client-centered, humanistic form of psychotherapy that focuses on a person's current life and challenges rather than on past experiences. According to Harris (2007), humans have an innate desire to finish or complete their experiences, and Gestalt theory states that "when the preoccupation of the old incompletion is resolved, then one can move on to current possibilities" (Harris, 2007, p. 110). Given the growing interest in forgiveness as a therapeutic tool, it is surprising that there are so few references to forgiveness and how to work with forgiveness in therapy in the Gestalt therapy literature. Both Gestalt and REACH seek to assist clients in overcoming intense hurt and anger due to past violations and betrayal (Enright & Fitzgibbons, 2000). Thus, combining the two would undoubtedly improve client outcomes.

P5, P12, and P13 all agreed that the first step, Recall the hurt, came a little too quickly for a complex trauma survivor; nevertheless, they all agreed that this model would be effective and beneficial to incorporate into their complex trauma work. Recall's hesitancy of this first step speaks to the prevention and awareness of not revictimizing trauma clients. Regrettably, treatment settings and therapists can unintentionally create retraumatizing situations. Compassionate inquiry into a client's history, for example, may appear similar to a perpetrator's interest many years before. Confrontation with

counselors about substance abuse behaviors may be interpreted as provocation leading up to an assault by someone who has been physically assaulted on multiple occasions (Frueh et al., 2005; U. S. Department of Health and Human Services, 2016). Holding a different viewpoint, P7 and P5 conveyed that R-recall the hurt was an appropriate first step because trauma survivors often have a difficult time sitting with the injury. Another significant study finding was participant perspectives on A, offering an altruistic gift of forgiveness; several participants expressed that this was a powerful step to take toward another human being. The altruistic gift is defined by Freedman and Enright (2019) as something given to others without expecting anything in return. This giving, which can be lavish, is done for the sake of the other(s) and not for any expected reward to the self. Such altruism is not a sign of weakness but of inner strength and determination not to be defeated by what has happened (Freedman & Enright, 2019).

REACH forgiveness focuses on forgiveness experiences with trauma survivors to help ease their burdens related to the offense, abuse, or interpersonal injury (Worthington et al., 2010). Participants in the study were receptive and enthusiastic about the REACH model, noting that the organizational five steps would help trauma clients structure their recovery process. Participants also stated that while this model encourages forgiveness of others, self-forgiveness is essential in complex trauma recovery. Furthermore, participants had never considered the altruistic gift an inclusive step in the forgiveness process and considered it a powerful step. Several participants suggested possible modifications may be required because trauma recovery is not a “one-size-fits-all” approach and that seeing it used in a clinical setting would be beneficial. Despite minor

variations in perspective, when asked if they would use Worthington's REACH model of forgiveness with complex trauma, all study participants responded with an overarching and receptive yes.

Reflections of Unanticipated Findings

This study revealed that secular therapists have positive perspectives on forgiveness therapy as a therapeutic approach to complex trauma. Furthermore, the findings of this study revealed that Worthington's REACH forgiveness model was regarded positively as an effective psychoeducational tool for treating complex trauma. Yet, given the literature's support for the efficacy of forgiveness therapy and complex trauma, these positive findings were unanticipated. The background for this study and the research problem originated from personal experience with trauma clients and collaborative work with colleagues on trauma and forgiveness. Most of the clients I have served and continue to serve had never considered forgiveness in relation to the trauma they had experienced, with several claiming that previous therapists had never discussed or introduced them to forgiveness. Furthermore, there was minimal knowledge or application of forgiveness therapy in trauma work among colleagues.

While my personal experience was limited to my wheelhouse, I was able to identify a gap in the existing literature on the subject. However, I did not anticipate such positive attributions and responses to forgiveness therapy and complex trauma, especially Worthington's REACH model of forgiveness from participants.

Limitations of the Study

A notable limitation of this study occurred during participant recruitment. I specifically recruited participants in two ways: Initial recruitment flyers were posted to three Facebook groups: Positive Psychology (133,000 members), Therapists Supporting Therapists (2,800 members), and Professional Trauma Therapists (163 members). The second was direct email invitations to Pacific Counseling and Trauma Center (11 therapists). Although there were many potential participants, it did not resonate with the general population of the aforementioned Facebook groups. Therefore, it is possible that those who expressed interest and participated in the study identified as trauma specialists and were more closely aligned with the study's questions and objectives. It may be that the sample was skewed for the following reasons: participants may not recognize the importance of forgiveness therapy in trauma recovery, participants were unfamiliar with Worthington's REACH model, nature of the research, validity of social media recruitment, and possibly that participants did not identify as trauma specialists or feel confident enough in their trauma training to participate. A recommendation for future research or replication of this study is to recruit participants from a larger population of therapists, or even from a specific population of therapists, based on specialization, experience, race, gender, or religion.

Another limitation that could have affected the findings was interview quality and reliability during data collection via telephone in terms of connectivity or service coverage. If these sometimes-unavoidable technological disruptions occur, they have the potential to alter the rapport and first impressions between interviewer and interviewee

(Archibald et al., 2019). This limitation was previously mentioned in the data collection section of Chapter 1. For example, I had to interrupt the phone interview with participant P11 because I could not hear or clearly capture her responses. However, she was accommodating and quickly relocated the interview to a better location, causing minimal disruption.

Recommendations for Future Research

Because a single qualitative study cannot sufficiently investigate forgiveness therapy, notably Worthington's REACH forgiveness model in the context of complex trauma, this researcher suggests that this study be replicated, even quantitatively. This suggestion is made because the findings gain greater validity when studies are replicated, and the results are the same or similar. Higher validity means that results and study findings are more likely to be applicable to a larger population.

This study's findings revealed that secular therapists have positive forgiveness therapy perspectives as a therapeutic approach to complex trauma. Furthermore, this study's findings indicated that Worthington's REACH forgiveness model was viewed positively as an effective psychoeducational tool for treating complex trauma. However, while the REACH model encourages forgiveness of others, research is needed to understand better self-forgiveness, which is critical in complex trauma recovery and was articulated by several study participants. Researchers could replicate this study, but rather than REACH, they could use Worthington's Six-Steps to Forgiving Yourself, model.

Forgiveness and forgiveness therapy have received relatively little attention in social work literature, and empirical studies are virtually nonexistent (Yun & Gallant,

2010). Further incorporation of forgiveness therapy into the profession may be influenced by research focusing on the processual approach of social work clients who receive forgiveness-promoting interventions in social work settings (Lander, 2015). Some examples of process-focused research could examine how clients perceive their engagement and participation in forgiveness therapy as consensual and respectful of their fundamental right to self-determination. Alternatively, do clients report that their rage and other negative emotions have subsided? Furthermore, do clients see seeking forgiveness, as opposed to justice, as putting themselves in danger by undermining their self-belief? Finally, do clients perceive forgiveness therapy to be effective in piercing the physical and psychological barriers that keep them safe from recurrent harm? (Lander, 2015).

Another area of forgiveness research that could be pursued is a more specific category of complex trauma, such as child abuse, sexual abuse, human trafficking, rape, abandonment, traumatic childhood experiences, or domestic and family violence. Finally, research recommendations could include employing the REACH model to elicit the perspectives of clients who have undergone the forgiveness process. Examine how long the victim's state of forgiveness lasts after REACH forgiveness.

Recommendations for Social Work and Positive Social Change

The widespread prevalence of trauma in the behavioral health field is well known; the focus of this research is to promote awareness of the value of forgiveness therapy and complex trauma, as well as Worthington's REACH model of forgiveness with complex trauma, because there have been no trauma studies exploring the REACH model prior to

this study (Wade et al., 2014). This study is a continuation of other qualitative studies, such as Reed and Enright's (2006) study on the effects of forgiveness therapy on depression, anxiety, and posttraumatic stress for women following spousal emotional abuse; Lander's (2015) qualitative case study on the contributions of forgiveness therapy in social work and practice; and Lichtenfeld et al. (2015) study on the differences between emotional and decisional forgiveness. Within each of the studies mentioned, Reed and Enright (2006) revealed that forgiveness therapy tends to be less negative and more positive in survivors' responses to their offenders; Lander's (2015) study revealed that forgiveness therapy offers relief from negative psychological implications; moreover, that forgiveness therapy is a promising post-crisis therapeutic approach; and Lichtenfeld et al.'s (2015) study highlighted the importance of incorporating emotions and empathy into the process of forgiving oneself or another. This continuation and critical examination of forgiveness therapy and complex trauma contributes to and fosters positive social change in the field of social work.

Engage, assess, intervene, and evaluate are the four core competencies of social work practice (Twitchell et al., 2021). These core competencies correspond to the four critical phases of the Generalist Intervention Model (GIM), which is commonly used in social work practice settings. A recommendation to the field of social work is to incorporate the evidence-based approach of forgiveness therapy into social service models of practice, policy, programs, and field experience and directly into assess (assessment) and intervene (intervention) phases of GIM. The assessment stage is when a social worker begins developing intervention strategies and employs their abilities to seek

out their client's strengths, assist them in recognizing them, and begin the healing and helping process. If the client presents with complex trauma, relating forgiveness may be assessed at this stage. In the intervention stage, the social worker works with the client to develop a plan to address the issues identified in the assessment stage to accomplish goals to resolve the targeted issues (Twitchell et al., 2021). Affirming the client's emotional or decisional forgiveness and using Worthington's REACH forgiveness model as a treatment plan may be assessed at this stage. To best meet the needs of the clients they serve, the social work profession relies on cross-collaboration and interdisciplinary efforts. When applicable within these two stages (assess and intervene), the recommendation of incorporating theoretically grounded forgiveness therapy is supported as a sound, and beneficial choice for helping clients cope with past hurts and traumatic events in order to improve their mental and physical health and achieve resolution (Wade et al., 2018).

Social workers use their clinical experience to inform research, implement evidence-based interventions, evaluate their practice, as well as use research findings to improve practice, policy, and service delivery (Wike et al., 2019). Furthermore, social workers are familiar with both quantitative and qualitative research methods and the ethical implications of each. Thus, a further recommendation for social workers is to incorporate forgiveness therapy into the most popular and widely used cognitive-behavioral therapy (CBT) model. According to Corrigan and Hull (2015), the complexities of complex trauma are not always well-served by the CBT model in clinical and behavioral settings; however, this recommendation integrates both CBT and

forgiveness therapy for improved therapeutic outcomes. The findings of this study have demonstrated that forgiveness therapy is a valuable, if not essential, therapeutic approach for treating the symptoms of complex trauma. As a result, practitioners, organizations, and a growing population of survivors have the opportunity to effect positive social change and practice.

Hernandez et al. (2012) emphasize the pivotal role that social work plays in the therapeutic application of forgiveness. They believe that forgiveness is essential in social work roles and tasks across the spectrum of practice. As the research suggests, I, too, urge social workers, who provide a significant portion of mental health and human services, to be "aware of the implications of forgiveness and non-forgiveness and how it can affect the well-being" of those they serve. With a better understanding of forgiveness therapy and complex trauma, it will be easier to envision it playing a more critical role in a wide range of fields of social work and therapeutic counseling practices where complex trauma is a prominent characteristic (Lander, 2015)—as a result, influencing the approach and practice of trauma work results in positive social change. This study has heightened the awareness of forgiveness therapy's impact and benefits to complex trauma. This study has also heightened awareness among study participants by introducing them to Worthington's REACH forgiveness model, thereby broadening the possibilities and practice of forgiveness. Finally, this study serves as a positive social change catalyst in social work training, supervision, continuing education, and peer support with this awareness.

Conclusion

Within the field of behavioral health, forgiveness research is exciting. The findings of this study contribute to the literature of forgiveness research and counseling practices by providing an initial inquiry into the perspectives of secular therapists who use the therapeutic approach of forgiveness. Furthermore, given the link between complex trauma and forgiveness therapy as a treatment modality to remove and replace emotional damage caused by the trauma, it appears critical for researchers to continue investigating best practices for therapists working with clients on this prevalent epidemic.

This qualitative study sought to better understand the perspectives of 15 secular therapists. According to the findings, forgiveness therapy is critical, paramount, and necessary in complex trauma work, contributing to the growing body of evidence that forgiveness is a powerful therapeutic approach that therapists can use to assist their clients in finding relief from their pain (Freedman & Zarifkar, 2016).

Forgiveness is a complex concept that is easily misunderstood; more opportunities for educating therapists on the process and approach to forgiveness is required (Freedman & Zarifkar, 2016). The role of a therapist is critical in educating clients about the forgiveness process and supporting clients in their decision to forgive as well as throughout the forgiveness journey. When that journey begins, it must be understood that: forgiveness requires effort and hard work; it is a choice; it is not forgetting or condoning; it is not reconciliation; and, finally, it is a verb, not a noun, implying that action is required rather than the passage of time. Nevertheless, freedom, empathy, and peace will arrive at the end of the journey, or even during it.

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Appendix A: Recruitment Flyer

PARTICIPANTS NEEDED

FORGIVENESS THERAPY & COMPLEX TRAUMA

"Forgiveness Therapy and Complex Trauma: Secular Therapists' Perspectives".

This study aims to improve understanding and treatment interventions of secular therapists' use of forgiveness therapy; specifically, Worthington's REACH forgiveness model with complex trauma clients.
You are invited to describe your experiences and perspectives.

This research is part of the doctoral study for Andrea Hardman, a Ph.D. student at Walden University.

About the study & participation:

- Interested in conveying your perspective
- 30-60-minute phone interview
- You are a licensed therapist, practicing in your state of licensure.
- You have direct therapeutic intervention experience with complex trauma client(s) using REACH forgiveness or other forgiveness interventions.

Appendix B: Invitation to Participate in the Study

Dear Potential Participant,

My name is Andrea Hardman, and I am a doctoral candidate at Walden University, Barbara Solomon School of Social Work and Human Services. I am conducting dissertation research on the perspectives of secular therapists on the use of forgiveness therapy; specifically, Worthington's REACH forgiveness model with complex trauma clients.

Complex trauma is a relatively new field of study with limited research, and evidence suggests that forgiveness may play a significant role in the healing process for people who have experienced C-PTSD. The purpose of this study is to improve understanding and treatment interventions of secular therapists' use of forgiveness therapy; specifically, Worthington's REACH forgiveness model with complex trauma clients, whereas to contribute to the growing body of literature. With better knowledge and understanding of forgiveness therapy and complex trauma, it is possible to envision a more critical role for this therapeutic modality in numerous fields of social work and therapeutic counseling practices where complex trauma is often a defining characteristic. I am seeking voluntary participants to interview who meet the following criteria:

1. You have direct therapeutic intervention with complex trauma clients using REACH forgiveness or other forgiveness interventions.
2. You have an interest in conveying your perspective and a willingness to participate in the study as it is designed.
3. You are willing to participate for a phone interview lasting no longer then 1 hour.
4. You are a licensed therapist, practicing in your state of licensure.
5. You are willing to provide follow-up information (If needed)

Please contact me at your earliest convenience to schedule a date and time for a phone interview. I will also include a consent form and demographic questionnaire; both can be returned via email. If you have any questions concerning participation in the study, don't hesitate to reach me by phone or email.

If you do not meet the participant requirement or you are not interested in participating but know someone who might be, please feel free to pass this invitation on to them.

Sincerely,
Andrea Hardman, ASW, Doctoral Candidate Walden University

Appendix C: Participant Demographics

Please choose the answer(s) that best describe you.

Gender
☐ Male
☐ Female
☐ Other_____

Ethnicity
☐ White or Caucasian
☐ Black / African American
☐ American Indian or Alaska Native
☐ Latino or Hispanic
☐ Asian
☐ Pacific Islander or Hawaiian
☐ Other (specify) _____

What is your religious affiliation?
☐ Christian (i.e., Lutheran, Methodist, Baptist, Non-Denominational, Presbyterian, etc.)
☐ Catholic
☐ World Religion (i.e., Buddhist, Judaism, Sikh, Islam, etc.)
☐ Secular / I do not have a religious affiliation
☐ Other
☐ Prefer to not respond

Please list your professional credentials
☐ Marriage & Family Therapist
(MA, MFT, LMFT, LCMFT)
☐ Social Worker
(ASW, MSW, LGSW, LCSW, LCSW-C, LISW, LSW)
☐ Psychologist: Masters Level
(MA, MS, LGPC, LCPC)
☐ Psychologist:
(Ph.D., PsyD, EdD)
☐ Other_____

In what therapy setting do you work?
☐ Private practice
☐ Government or agency setting
☐ Hospital
☐ Church or religious institution
☐ Other _____

What is the state(s) in which you are licensed_____?

Do you have a therapy preference or specialization?
☐ Child / Adolescent
☐ Marriage / Couples / Family
☐ Trauma (PTSD, C-PTSD)
☐ EMDR / Brain spotting
☐ Grief & Loss
☐ LGBTQ+
☐ Behavioral / Anger management
☐ Other (specify) _____

Which is your primary counseling theory?
☐ Humanistic
☐ Cognitive
☐ Behavioral
☐ Psychoanalytic
☐ Systemic
☐ Other _____

How did you learn about forgiveness therapy?
☐ Academia
☐ Continuing Education
☐ Personal Interest
☐ Other_____

Appendix D: Worthington's REACH Forgiveness Model

R = Recall the hurt.

To heal, you have to face the fact that you've been hurt. Make up your mind not to be snarky (i.e., nasty, and hurtful), not to treat yourself like a victim, and not to treat the other person as a jerk. Make a decision to forgive. Decide that you are not going to pursue payback, but you will treat the person as a valuable person.

E = Empathize

Empathy is putting yourself in the other person's chair. Pretend that the other person is in an empty chair across from you. Talk to him. Pour your heart out. Then, when you've had your say, sit in his chair. Talk back to the imaginary you in a way that helps you see why the other person might have wronged you. This builds empathy, and even if you can't empathize, you might feel more sympathy, compassion, or love, which helps you heal from hurt.

A = Altruistic gift.

Give forgiveness as an unselfish, altruistic gift. We all can remember when we wronged someone—maybe a parent, teacher, or friend—and the person forgave us. We felt light and free. And we didn't want to disappoint that person by doing wrong again. By forgiving unselfishly, you can give that same gift to someone who hurt you.

C = Commit.

Once you've forgiven, write a note to yourself—something as simple as, "Today, I forgave [person's name] for hurting me." This helps your forgiveness last.

H = Hold onto forgiveness.

We write notes of commitment because we will almost surely be tempted to doubt that we really forgave. We can re-read our notes. We did forgive.

Psychologist Everett L. Worthington, Jr., Ph.D., a pioneer researcher in the field of forgiveness, constructed this 5-step model to facilitate the process of forgiveness for self and others. It is one of the techniques most favored by counselors specializing in forgiveness and reconciliation.

Appendix E: Interview Protocol

Date of Interview:
Time of Interview:
Interviewer:
Interviewee:
Code number:
Start time:

Introduction to study: The role of forgiveness in the field of behavioral and mental health is recognized as therapeutically beneficial for therapists to help clients minimize negativity in their lives, improve mental and physical health, reduce rumination, anger, and psychological difficulties, such as anxiety and depression. Complex trauma (premeditated, planned, and typically repeats itself) encompasses, child abuse, sexual abuse, human trafficking, traumatic childhood experiences, group conflict, domestic and family violence, civil strife, genocide, ethnic dislocation, and physical disability.

1. How and when did you learn about forgiveness therapy?
   (i.e., academia, continuing education, personal interest)
2. What role do you believe forgiveness plays in trauma recovery?
3. How do you determine that forgiveness therapy is an appropriate goal for your trauma client?
4. Is there a specific trauma that you would not introduce forgiveness?
5. Have you experienced client resistance when introducing forgiveness therapy?
   If yes, what was the client's resistance reasoning?
   (Religion, nature of offense, or misconception)
6. Can you give an example of a client's positive outcome with forgiveness therapy?
7. How did you learn about REACH forgiveness therapy with complex trauma?
8. Have you ever provided your client with the REACH self-directed workbook?
9. In your opinion, is REACH forgiveness effective with complex trauma clients?
10. Is there anything more you'd like to say or add regarding forgiveness therapy and complex trauma that I haven't asked about?

Thank you for giving of your time and taking part in this interview. Your perspective on this topic is greatly valued. You may submit a review of the study's findings either verbally or in writing. You can request a copy of the study's findings verbally or in writing at any time.

End time: