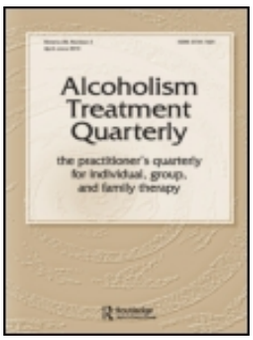

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Treating Adult Children of Alcoholics Through Forgiveness Therapy

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This study examined two forms of group therapy for adult children of alcoholics; a forgiveness intervention was compared to a conflict resolution intervention. Twelve adults were randomly assigned to the treatment conditions and completed the 12-week interventions. At the end of 12 weeks, the conflict resolution group received the forgiveness intervention whereas the original forgiveness group received no further treatment. Measures of forgiveness, depression, anxiety, self-esteem, anger, and positive relationships were administered before and after each intervention. Both groups showed significant psychological improvements suggesting forgiveness therapy is a viable option for adult children of alcoholics. The therapeutic implications are discussed.

KEYWORDS Adult children of alcoholics, forgiveness, intervention, well-being

Alcoholism often affects more people than the individuals suffering from the disease. All members of a family, especially children, can be negatively affected by one family member's alcoholism. For children, the negative effects of having an alcoholic parent can carry into adulthood. Adult children of alcoholics (ACOA) are people who grew up with at least one alcoholic parent. Although individuals within the ACOA population vary greatly in their

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psychological and behavioral functioning, research indicates that compared to children who did not grow up with an alcoholic parent, ACOA exhibit higher depression, anger, and anxiety, as well as poorer self-esteem and interpersonal relationships (Hall & Webster, 2007; Lease, 2002; Lee, 2006; Lewis-Harter, 2000; Rangarajan, 2008; Tweed & Ryff, 1991; Watt, 2002). Professionals working with ACOA need effective interventions for helping their clients restore psychological well-being after the experience of growing up in a family affected by alcoholism.

Research demonstrates forgiveness can address the psychological difficulties common to ACOA, suggesting forgiveness therapy (Enright & Fitzgibbons, 2000) could be particularly helpful for this population. Although children of alcoholics often experience hurtful treatment within their family of origin (Brown, 1988; Lewchanin & Sweeney, 1997; Worthington, Scherer, & Cooke, 2006) therapeutic interventions for ACOA typically focus on self-discovery and restructuring how one understands the family of origin (Bolger, 1999; Brown & Schmid, 1999; Lawson & Lawson, 2005; Lee, 2006; Ruben, 2001) without an explicit focus on forgiveness. The current study addressed a gap in the current literature by testing the effects of a forgiveness intervention with ACOA on levels of depression, anger, anxiety, self-esteem, and quality of interpersonal relationships. Identifying effective intervention strategies provides practitioners with options to tailor treatments to the needs of individual ACOA clients.

Adult Children of Alcoholics

For over three decades ACOA have been the focus of attention in the psychological literature. Clinical descriptions appeared first (Woititz, 1984) that described some of the problems ACOA encounter as a result of a parent's alcohol abuse. Empirical research then followed investigating differences between ACOA and non-ACOA (e.g., McNeill & Gilbert, 1991; Tweed & Ryff, 1991). Although some research found ACOA and non-ACOA differ on indicators of psychological health, other research found the two groups did not differ (Seefeldt & Lyon, 1992; Wright & Heppner, 1991). Contradictory findings sparked debate about using ACOA as a diagnostic category (Fulton & Yates, 1990; Shemwell, Dickey, & Wittig, 1995).

Despite contradictory research findings and debate regarding ACOA as a useful diagnosis, there is consensus that ACOA are at risk for a variety of negative outcomes (Lewis-Harter, 2000). Of particular interest in the current study are the findings indicating ACOA experience greater depression, anger, and anxiety in addition to poorer self-esteem and interpersonal relationships than non-ACOA. Tweed and Ryff (1991) compared the psychological well-being of ACOA and a group of non-ACOA with similar sociodemographic characteristics. Although they found few differences between the two groups, the ACOA did exhibit higher depression and anxiety. Hart

and McAleer (1997) found ACOA exhibit higher levels of anger in than a group of non-ACOA and concluded interventions for ACOA should help clients acknowledge anger rather than suppress it. Hall and Webster (2007) also found ACOA experience greater anger than non-ACOA. In their study a subgroup of ACOA, those who had experienced traumatic events, self-reported greater anger: irritability than the comparison groups. With regard to self-esteem, Rangarajan (2008) found that parental alcoholism had a detrimental effect on children's self-esteem. Rangarajan argued risk factors such as low self-esteem may be more important for the design of interventions than the knowledge a client is an ACOA. Larson, Holt, Wilson, Medora, and Newell (2001) investigated differences among ACOA and non-ACOA in romantic relationships. They found ACOA experienced greater dating anxiety along with lower relationship commitment and relationship satisfaction than non-ACOA. Bosworth and Burke (1994) investigated the reasons ACOA sought treatment. Low self-esteem, problems with intimate relationships, and anger were the top three reasons the study participants entered treatment. An interested reader can see Lewis-Harter (2000) for a review of the psychological risks associated with being in the ACOA category.

For many ACOA hurtful experiences in the family of origin might underlie the psychological difficulties they experience. Brown (1988) noted ACOA in group therapy often share stories of disappointment, embarrassment, and pain resulting from the dysfunctional family. Worthington et al. (2006) noted that transgressions are common in families with an alcohol-dependent member. Children with an alcoholic parent can grow resentful and angry from a lack of attention and care as well as the alcoholic parent's embarrassing behavior. Research supports these claims. Children in families affected by alcoholism are at risk for emotional, physical, and sexual abuse (Lewchanin & Sweeney, 1997). The psychological health of many ACOA may only improve if therapeutic interventions help them resolve underlying hurts.

Treatment approaches for ACOA often center on discovering, constructing, and accepting the self; restructuring concepts of the family of origin as dysfunctional and/or pathological; and the initiation of prosocial behavior in work and family settings (Bolger, 1999; Brown & Schmid, 1999; Lawson & Lawson, 2005; Lee, 2006; Ruben, 2001). An explicit focus on forgiving alcoholic parents for unfair and hurtful behavior is not present in current therapies. Lewchanin and Sweeney (1997) did present one treatment approach that emphasizes the need to grieve early losses. They posit having an alcoholic parent results in poor parent—child bonds that in turn prevent the child from satisfying early needs and interfere with healthy development. They argued treatment must help ACOA grieve the losses they experienced. Even though Lewchanin and Sweeney focus on loss and grief, they do not promote forgiveness as a means of coping.

Forgiveness

Forgiveness is a moral coping response to an instance of unfair and hurtful treatment. Definitions of *forgiveness* vary; however, there is consensus that forgiveness involves movement from negative to positive thoughts, behaviors, and emotions (McCullough & Witvliet, 2002). In the current study, we used the definition of *forgiveness* developed by Enright and Fitzgibbons (2000): forgiveness is the abandoning of resentment toward an offender and the incorporation of such positive responses as compassion toward that offender.

Psychological interventions promoting forgiveness have been effective in helping a variety of populations heal emotionally from deeply hurtful and unfair actions of others including adults in drug and alcohol treatment (Lin, Mack, Enright, Krahn, & Baskin, 2004), divorced individuals (Rye et al., 2005), children with divorced parents (Freedman & Knupp, 2003), married couples (DiBlasio & Benda, 2008), and at-risk youth (Gambaro, Enright, Baskin, & Klatt, 2008). These studies demonstrate forgiveness interventions can help people improve their psychological well-being through increased self-esteem and hope and decreased anger, depression, and anxiety (see Baskin & Enright, 2004 for a meta-analytic review).

Some authors have begun to write about the role forgiveness has in helping individuals and families affected by alcohol abuse. Larsen (1992) was one of the first authors to specifically advocate forgiveness for ACOA. Worthington et al. (2006) also noted unforgiveness is common in families with an alcoholic member and proposed using forgiveness to help family members cope more effectively. Collins' research (2007) found participants who had recovered from alcohol dependence had higher levels of forgiveness than participants who were alcohol dependent. Benda and Belcher (2006) tested a model of alcohol abuse and found forgiveness reduced the relationships that exist between abuse, distress, depression, and the abuse of alcohol and other drugs. Worthington et al. and Benda and Belcher noted the need for more research investigating how forgiveness can help individuals affected by alcohol abuse.

Results of an intervention explicitly promoting forgiveness have not been reported in the literature for ACOA. We believe a forgiveness intervention may be particularly helpful for ACOA who experienced hurtful treatment in their family of origin for two reasons. First, forgiveness is associated with positive emotional regulation (Enright & Fitzgibbons, 2000). As noted above, research demonstrates people experience improvement in depression, anger, anxiety, self-esteem, and interpersonal relationships as they forgive. Because these same variables have been shown empirically to affect ACOA, a forgiveness intervention may be appropriate for this population. Second, the forgiveness process includes steps that the literature indicates are important for ACOA. For example, Hart and McAleer (1997) suggested interventions

should help ACOA acknowledge, rather than suppress, anger. Uncovering anger related to unfair treatment is an important part of the forgiveness process (Enright & Fitzgibbons, 2000).

Our goal is to ascertain whether forgiveness may be an effective approach with this population. If it is, then clients have one more therapeutic choice. The current study attempted to answer four research questions: (1) Can ACOA learn to forgive a hurtful member of their alcoholic family through a group intervention? (2) What are the psychological outcomes when they forgive? (3) Is a forgiveness intervention more or less effective than a group that focuses on conflict resolution? and (4) Are the effects of the interventions maintained for 12 weeks?

METHOD

Participants

Twelve adults participated in the current study. They ranged in age from 22 to 49 years ($M = 38.55$ years). The sample was primarily women; 11 participants were female (91.67%) and one was male (8.33%). Eleven were White (91.67%) and one was Native American (8.33%). All had completed either some college work or a 4-year degree. Three (25%) had some graduate education or had completed graduate degrees.

Participants were selected from among 27 people who responded to local advertisements and flyers in a midsize midwestern city. After an initial screening, described in the Procedures section, 19 participants met the study requirements and were enrolled in the study. Seven participants left the study for personal reasons including moving away, not enough time to participate, and pregnancies. Twelve participants, six in each group, were assessed at the pretest and completed the first portion (12 weeks) of the study. Nine participants completed both portions (24 weeks). The sample size for the current study was similar to other successful therapeutic interventions on forgiveness (see, e.g., Gambaro et al., 2008; Lin et al., 2004). Thus, statistical power was likely adequate for detecting meaningful differences between groups. Kraemer and Thiemann (1987) reported a .80 power level can be reached for a directional test using a .05 significance level and a total sample size of 10 participants. The current study slightly exceeded this minimum sample size.

Instruments

Seven instruments were administered in the current study. One instrument, The Children of Alcoholics Screening Test, was used only as a screening tool. All other instruments assessed psychological well-being and were used as outcome measures.

Forgiveness inventory. The Enright Forgiveness Inventory (EFI; Enright, Rique, & Coyle, 2000) assessed a person's degree of forgiveness. The EFI was a 60-item objective scale consisting of three subscales: cognition, behavior, and affect. The EFI used a 6-point Likert-type scale, possible responses ranged from *strongly disagree* to *strongly agree*. Scores on this scale ranged between 60 and 360; higher scores represented more forgiveness toward the offender. Sample items for each of the three subscales included "I feel positive toward him or her (the offender)," "Regarding the person (offender) I do or would show friendship," and "I think he or she (offender) is worthy of respect." Internal consistency was found to be 0.90 or higher for the total EFI and each subscale and test–retest reliability ranged from 0.67 to 0.91 (Enright & Fitzgibbons, 2000). The EFI has established validity with adults, university students, and high school students (Enright et al., 2000). For the current research, participants were asked to focus specifically on a family of origin member who had hurt them deeply when responding to the EFI. In this study, Cronbach's alpha for the EFI was 0.95.

Anxiety inventory. Anxiety was measured by the Spielberger State-Trait Anxiety Inventory (STAI; Spielberger, Gorusch, Lushene, Vagg, & Jacobs, 1983). The STAI is a 40-item self-report questionnaire consisting of two subscales, state anxiety and trait anxiety, that each have 20 items. This scale uses a 4-point Likert-type scale ranging from *not at all* to *very much so* on the STAI State scale and *almost never* to *almost always* on the STAI Trait scale. The composite scale has a range from 40–160. High scores reflect high anxiety. Sample items include "I feel upset" and "I lack self-confidence" for the State and Trait scales respectively. The test–retest reliability ranged from 0.16 to 0.62 on the STAI State and 0.73 to 0.86 on the STAI Trait (Spielberger et al., 1983). The low test–retest correlations for the STAI State scale were expected because the scale reflects the influence of situational factors. Internal consistency of the STAI State and STAI Trait ranged from 0.83 to 0.92, and 0.86 to 0.92, respectively. Both scales have adequate convergent and discriminant validity (Spielberger et al., 1983). In the current study, Cronbach's alpha was 0.85 for the total STAI.

Depression inventory. The Beck Depression Inventory II (BDI-II, Beck, Steer, & Brown, 1996) was used as a measure of depression. The BDI-II has 21 items designed to measure multiple aspects of depression. Each item has four statements ordered in increasing severity and scored on a scale ranging from 0–3. A sample item is "I don't feel disappointed in myself (0), I am disappointed in myself (1), I am disgusted with myself (2), I hate myself (3)." The BDI-II has strong convergent validity with the Hamilton Depression rating scale, and test–retest reliability was reported to be 0.93 (Beck, Steer, & Brown, 1996). The BDI-II has high internal consistency, 0.91 (Beck, Steer, Ball, & Ranieri, 1996). In the current study, Cronbach's alpha coefficient was 0.88.

Anger inventory. Anger was measured using the Spielberger State-Trait Anger Expression Inventory (STAXI; Spielberger, 1996). Each scale is a 10-item self-report measure. Respondents answer items using a 4-point Likert-type scale ranging from 1 (*almost never*) to 4 (*almost always*). Scores for each scale range from 10–40 with higher scores indicating more anger. Sample items for the State and Trait scales include "I feel angry" and "I have a fiery temper," respectively. The internal consistency of these scales ranged from 0.82 to 0.93, and concurrent validity has been established (Spielberger, 1996). In the current study, Cronbach's alpha was 0.80.

Self-esteem inventory. Self-esteem was measured using the adult form of the Coopersmith Self Esteem Inventory (CSEI; Coopersmith, 1981). This scale consists of 25 true-false items. Sample items include, "I'm a lot of fun to be with" and "I can't be depended on." The sum of the answers is multiplied by 4, generating a range of possible scores from 0–100. A high score indicates high self-esteem. The upper quartile in a group can be considered indicative of high self-esteem, the lower quartile indicates low self-esteem, and the interquartile range is generally indicative of medium self-esteem. Research finds the scale has a split-half reliability coefficient of 0.87, and test–retest reliability estimates were 0.80 for males and 0.82 for females (Coopersmith, 1981). Coopersmith found the CSEI demonstrated adequate convergent validity. In the current study, internal consistency for dichotomously scored instruments was 0.89.

Positive relations with others. The Positive Relations With Others scale (PRO; Ryff, 1989) assessed the relationship between the participants and the family members who hurt them. The PRO is a subscale of the Ryff Well-Being Scale (Ryff, 1989). Respondents rate themselves on 14 items using a 6-point Likert-type scale ranging from *strongly agree* to *strongly disagree*. Higher scores indicate more positive relationships. A sample item is "People would describe me as a giving person, willing to share my time with others." Internal consistency for this scale was found to be 0.91, and test–retest reliability was 0.83. The scale also demonstrates good convergent and divergent validity. In the current study, Cronbach's alpha was determined to be 0.87.

Children of alcoholics. The Children of Alcoholics Screening Test (CAST; Jones, 1983) was used to screen potential participants. The CAST is a 30-item self-report instrument, that uses a yes–no scale. "Yes" answers are added together to yield a scale range of 0–30. Sample items include "Have you ever heard your parents fight when one of them was drunk?" and "Did you ever wish a parent would stop drinking?" Respondents with a score of six or higher are considered children of an alcoholic (Jones, 1983). Jones (1983) established construct validity by showing the CAST discriminated children of alcoholics from children of nonalcoholics on all items. Sheridan (1995) found the scale has adequate convergent validity and an internal reliability of 0.98.

Procedures

A randomized experimental-alternate treatment group design was used for the current study. Participants were randomly assigned to be in the forgiveness group, hereafter referred to as Group A, or a conflict resolution group, hereafter referred to as Group B. Both interventions were 12 weeks in length. At the end of the initial intervention, Group A received no further treatment whereas Group B received the forgiveness intervention.

To qualify for the study, participants had to be raised in an alcoholic environment, be low in forgiveness, and be high in either anxiety or depression. These conditions were met by a score of 6 or above on the CAST, a score of 256 or below on the EFI, and either a score of 72 or above on the STAI, or a score of 14 or above on the BDI-II. Those who met the requirements were asked to continue in the study. Participants were randomly assigned to Groups A and B, and all participants were tested one week prior to the initial interventions (pretest) and one week following the interventions (posttest) on all dependent measures. After the posttest Group A received no further treatment, and Group B started the 12-week forgiveness program. When Group B finished the forgiveness program, the outcome measures were administered a final time to all participants (posttest 2). The questionnaires in each test packet were randomly ordered to counteract order effects.

Intervention procedure. The forgiveness intervention was based on the forgiveness process model (Enright & Fitzgibbons, 2000). The alternative intervention was based on *Getting to Yes: How to Negotiate Agreement without Giving In* (Fisher & Ury, 1991), a national best-selling book on conflict resolution. Each intervention consisted of 12 weekly 90-minute group sessions. Participants were given manuals from which material concerning the weekly topic was read and appropriate questions for individual reflection were answered and discussed.

The forgiveness intervention asked participants to focus on one family member who deeply hurt them, and to apply the material of the intervention to one particular hurtful incident. The intervention had four phases. First, it sought to help the participants uncover the effects of the deep hurt on their cognitive, behavioral, and affective patterns. For example, participants were asked to examine the degree of anger they were still carrying because of the identified incident. Second, participants were asked to consider how they wished to respond to the injury. For example, they considered how they responded in the past, evaluated the effectiveness of their strategies, and thought about forgiveness as an option for the future. Third, the participants were encouraged to consider shifting cognitive, behavioral, and affective patterns toward the offender. The major cognitive approach involved reframing the offender. The reframed perspective broadens the context in which the participant (injured party) sees the offender. For example, the offender, originally seen exclusively as a hurtful person, may be reframed as a person who

has been emotionally hurt himself or herself. Affect, then, may move from anger and rage toward the offender to include the emergence of compassion and empathy. Participants also examined ways they inadvertently displaced the pain of the incident to the offender and to others. They were also invited to consciously choose not to pass the anger on to the offender, or others. In this part of the intervention, participants also considered giving a moral gift to the offender such as mercy, generosity, or compassion. Finally, participants were asked to become aware of any emotional release that may have resulted from their work. They may have become aware of meaning in their suffering and realized a new purpose in their lives. A complete description of the forgiveness intervention can be found in Enright and Fitzgibbons (2000).

In the alternative intervention participants learned the principles of conflict resolution and negotiation, which emphasized the probability that in their families of origin, they were exposed to ineffective and hurtful ways of resolving conflict. The format of the sessions was identical to the forgiveness intervention format: participants read topic material, privately answered reflection questions, and shared those answers with others in the group. In contrast to the forgiveness intervention, questions for reflection in this intervention asked participants to apply the topic material to current situations and problems, rather than to a past hurtful situation caused by a family member. Thus, it facilitated general problem solving of individual life situations, and forgiveness was not an overt focus. An extra chapter, dealing specifically with emotions, was added to the original intervention in the 4th week. This was done in response to the requests of Group B members for help with the emotional side of the situations being considered.

Three sessions in each intervention (nine total) were selected randomly, tape-recorded, and reviewed by a counseling psychologist who looked for inconsistencies among the recorded sessions, the written manuals, and the proposed procedures. The reviewer did not find any inconsistencies, indicating both groups received the interventions as indicated in the written manuals and described procedures.

RESULTS

Table 1 presents the means and standard deviations for all dependent measures by group and test time. Gain scores from pretest to posttest were generated for each participant's score on each dependent measure. The Mann–Whitney nonparametric test was used to investigate differences between the Group A and Group B gain scores. No statistical differences were found between the two groups on any of the variables after the initial 12-week intervention. See Table 2 for gain scores, test statistics, and p values.

A second question of interest emerged: Were there no between-group differences because both interventions were ineffective, or because both in-

TABLE 1 Means and (Standard Deviations) for Dependent Variables

	Experimental Group (Group A) ($n = 6$)			Alternate Treatment Group (Group B) ($n = 6$)		
Variable	Pre	Post-1	Post-2	Pre	Post-1	Post-2
Forgiveness (EFI)	203.17 (36.09)	241.50 (30.40)	223.80 (45.69)	207.67 (52.11)	246.67 (84.75)	252.50 (51.32)
Self-esteem (CSEI)	34.67 (25.51)	53.33 (28.13)	49.60 (36.18)	30.67 (9.69)	43.33 (27.41)	66.00 (33.39)
Depression (BDI)	19.50 (10.25)	10.00 (8.05)	15.20 (11.21)	19.17 (11.41)	14.33 (8.57)	4.00 (.82)
Anxiety (STAI)[a]	101.83 (28.99)	81.83 (27.28)	87.00 (29.98)	93.40 (13.54)	89.67 (13.63)	71.75 (16.34)
Anger (STAXI)[b]	40.80 (11.39)	30.50 (7.48)	30.60 (8.20)	40.67 (3.20)	34.00 (4.60)	29.75 (4.50)
Positive relations with others (Ryff)	45.17 (12.14)	54.00 (13.61)	57.00 (9.19)	46.33 (10.84)	56.00 (8.92)	64.50 (9.04)

EFI = Enright Forgiveness Inventory; CSEI = Coopersmith Self Esteem Inventory; BDI = Beck Depression Inventory; STAI = Spielberger State-Trait Anxiety Inventory; STAXI = Spielberger State-Trait Anger Expression Inventory.

[a]Due to an error in data collection $n = 5$ for anxiety variable. [b]Due to an error in data collection, $n = 5$ for anger variable.

TABLE 2 Gain Scores, Mann–Whitney *U* Values, *p* Value of Experimental and Alternate Treatment Groups

Variable	Pre–Post 1 Experimental (Alternate Treatment) Group A (Group B)			Pre–Post 2 Experimental (Alternate Treatment-Turned-Experimental) Group A (Group B)		
	Gain score	Mann-Whitney *U* Z statistic	*p* value	Gain score	Mann-Whitney *U* Z statistic	*p* value
Forgiveness (EFI)	38.0 (39.0)	−.48	.31	24.8 (68.3)	−2.2	.01*
Self-esteem (CSEI)	18.7 (12.7)	−.72	.23	13.6 (32.0)	1.1	.13
Depression (BDI)	−9.5 (−4.8)	−.88	.19	−6.6 (−19.0)	−1.6	.05*
Anxiety (STAI)	−20.0 (−11.8)	−1.1	.14	−18.2 (−30.0)	−.75	.43
Anger (STAXI)	−12.6 (−6.7)	−1.4	.08	−12.0 (−10.3)	−.14	.44
Positive relations with others (Ryff)	8.8 (9.7)	−.16	.44	11.4 (20.5)	−.98	.16

* = $p < .05$; EFI = Enright Forgiveness Inventory; CSEI = Coopersmith Self Esteem Inventory; BDI = Beck Depression Inventory; STAI = Spielberger State-Trait Anxiety Inventory; STAXI = Spielberger State-Trait Anger Expression Inventory.

terventions produced positive change? An examination of the data in Table 1 suggests both groups improved during the initial 12-week intervention. This became an important question in light of the Hebl and Enright (1993) forgiveness intervention in which a forgiveness intervention and a support group intervention for senior women proved effective. To answer this question, the Wilcoxon signed-ranks test was used to analyze within group change for both groups. As shown in Table 3, the forgiveness group improved on five of the six dependent measures from pretest to posttest: forgiveness, self-esteem, depression, anger, and positive relations with others. The conflict resolution group improved on two of the six measures during this same period: anger and positive relations with others. Although the mean scores for the other measures were moving in a positive direction, the changes were not significant. Effect size estimates, r^2, for all significant within group analyses ranged from .26 to .41 indicating the interventions accounted for 26% to 41% of the observed change. The combination of significant p values and effect size estimates indicates that both groups benefited from their respective interventions.

TABLE 3 Wilcoxon Z Value and p Value of Within Group Comparisons

	Group A					
	Pretest-Posttest 1			Pretest-Posttest 2		
Variable	Wilcoxon Z	p value	r^2	Wilcoxon Z	p value	r^2
Forgiveness (EFI)	−2.20	.01*	.41	−2.02	.02*	.41
Self-esteem (CSEI)	−2.20	.01*	.41	−1.83	.03*	.30
Depression (BDI)	−2.21	.01*	.41	−0.94	.17	NA
Anxiety (STAI)	−1.57	.06	NA	−1.21	.11	NA
Anger (STAXI)	−2.03	.02*	.32	−1.83	.03*	.28
Positive relations with others (Ryff)	−1.78	.04*	.26	−1.75	.04*	.28
	Group B					
	Pretest-Posttest 1			Pretest-Posttest 2		
Variable	Wilcoxon Z	p value	r^2	Wilcoxon Z	p value	r^2
Forgiveness (EFI)	−1.15	.12	NA	−1.83	.03*	.28
Self-esteem (CSEI)	−0.95	.17	NA	−1.46	.07	NA
Depression (BDI)	−1.21	.11	NA	−1.83	.03*	.28
Anxiety (STAI)	−1.46	.06	NA	−1.60	.06	NA
Anger (STAXI)	−2.20	.01*	.41	−1.83	.03*	.28
Positive relations with others (Ryff)	−1.75	.04*	.26	−1.83	.03*	.28

* = $p < .05$; EFI = Enright Forgiveness Inventory; CSEI = Coopersmith Self Esteem Inventory; BDI = Beck Depression Inventory; STAI = Spielberger State-Trait Anxiety Inventory; STAXI = Spielberger State-Trait Anger Expression Inventory.

We next compared pretest and posttest 2 scores for Group A using the same Wilcoxon signed-ranks test to determine if Group A maintained its pattern of psychological improvement over the next 12-week period, during which the participants received no additional treatment. The results are shown in Table 3. Significant improvement was found on four of the six psychological variables from pretest to posttest 2. Depression was the only variable that did not maintain a significant change for the 12-week period. Therefore, the data indicate that many of the psychological benefits derived from participation in the forgiveness intervention were maintained for at least 12 weeks.

We then examined the change in Group B from pretest to posttest 2 using the Wilcoxon signed-ranks test to assess whether receiving the forgiveness intervention during the second 12-week interval produced additional positive changes. Results showed Group B made positive progress on two variables—forgiveness and depression—and maintained positive change from the first 12 weeks on anger and positive relations with others. The addition of the forgiveness intervention appeared to help the participants continued progress.

Case Study

Charles, a 43-year-old male, was randomly assigned to Group A. The deep hurt he identified to work on during the intervention involved his mother calling him to inform him of her suicide in progress, saying he was the "only love(r) she has ever loved and if she could not have him in life, she would follow him in death." He rated this as causing him a great deal of hurt. Charles' mother was an alcoholic who sexually abused him. Charles was also physically abused by his stepfather. Charles described himself before the intervention as someone who was not very nice to be around. He enjoyed making people uncomfortable, and people stayed away from him. His life style consisted of working overtime whenever he could in a factory and otherwise staying in his apartment and overeating. He was divorced twice and drank to excess. Charles received psychotherapy for short periods at several different times. At pretest Charles scored low on forgiving his mother (149 on the EFI), low on positive relations with others (28 on the Ryff scale), fairly low on self-esteem (52 on the CSEI), and clinically depressed (32 on the BDI-II). Charles' anger was high (55 on the STAXI) as was his anxiety (110 on the STAI).

Charles attended every session and wrote in his journal every week. Although Charles was a dedicated and open participant in every session, several sessions seemed to be particularly important for him. The first was the session on psychological defenses (Session 2) during which he cried as he realized that he had had a vasectomy at age 30 so that he would never have children. He had done this as a response to the abuse he had experienced as a child. He received support from the group for

revealing his emotional life to the point that he did. Charles wrote in his journal that he had a deep night's sleep after that session for the first time that he could remember.

Another important session for Charles was the reframing session (Session 8). In this session participants were asked to look at the lives of their wrongdoer and look for possible reasons the wrongdoer could act in such a hurtful manner. Charles remembered that his mother had been raised by an officer in the Austrian Nazi army (his grandfather), who had committed suicide when Charles was a teenager. Charles wrote in his journal, "Actually dragging up my mom's past was very painful for me, and it sent me into a mood-tailspin this week. Just the thought of the whole picture and I am uptight and sullen. I've yelled at the neighbor through the wall, I've gotten cross with the slackers at work and even nipped at one of my only friends on the phone.... I remember being depressed like this last winter, but then it lasted for months. I don't feel like this will last for very long.... I feel that it's [forgiveness] the correct tool for me to use in my healing process. And I do think it will be a long process, but not one I will be giving up on anytime soon."

Charles' posttest scores showed improvement in forgiveness (from 145 to 191 in the EFI) toward his mother, in self-esteem (from 52 to 84 on the CSEI), and in Positive Relations with Others Scale (from 28 to 35 which continued to 55 at the 12-week follow-up). He went from scoring in the clinically depressed category on the BDI-II at pretest (32) to scoring in the minimally depressed category at posttest (4) and follow-up (2). He went from scoring in the 99th percentile of angry males in his age group at pretest (55) to the 1st percentile at posttest (32) and follow-up (20). His anxiety levels went from 110 (~95–100 percentile) at pretest to 72 (~30–50 percentile) at posttest and 43 (~5–10 percentile) at follow-up on the STAI.

Six months after the intervention, Charles reported that he lost 20 pounds and people actually like being around him. He told others who shared their anger and bitterness with him they do not have to carry around their hatred. A year later, Charles reported that he started a business with a partner that was going very well. Charles' family-of-origin members were still active alcoholics, and Charles was cautious about the amount of time he spent with them. Although some anger remained, his hatred was gone; and he looked forward to the day when he and his brothers could talk about their shared past.

DISCUSSION

Brown (1988) reported that in group therapy every ACOA has a painful or embarrassing family memory or disappointment to share. Forgiveness of family members is rarely considered as a treatment goal in the psychological literature, although intimate personal relationships are an acknowledged problem area for ACOA. Some of the literature on ACOA is beginning to

articulate and demonstrate the potential benefits of forgiveness within families affected by alcohol abuse (Larsen, 1992; Worthington et al., 2006). The current study investigated forgiveness as a treatment approach for ACOA.

Although no between-group differences were found when directly comparing the forgiveness and conflict resolution programs, both groups appeared to benefit psychologically from the treatments. From pretest to posttest 1, the forgiveness program in Group A produced significant improvements on five of six variables. These participants experienced increases in levels of forgiveness ($r^2 = .41$), self-esteem ($r^2 = .41$), and positive relations with others ($r^2 = .26$) while experiencing decreased levels of anger ($r^2 = .32$) and depression ($r^2 = .41$). The Group A participants received no further treatment after the forgiveness intervention. The positive results of the forgiveness program were maintained at the 12-week follow-up (posttest 2) on four of the six variables: forgiveness, self-esteem, anger, and positive relations with others. The conflict resolution intervention in Group B produced significant improvement in two of the six variables. They experienced an increase in positive relations with others ($r^2 = .26$) and a reduction in anger ($r^2 = .41$) from pretest to posttest 1, with subsequent increase in forgiveness and decrease in depression after engaging in the forgiveness program. At posttest 2, Group B was close to the norm of 259 for the forgiveness scale (Enright et al., 2000) and was nondepressed. Cohen's *d* (Cohen, 1988), another measure of treatment magnitude, has been used in other forgiveness intervention studies. For example, in a meta-analysis, Baskin and Enright (2004) reported the effect size of group forgiveness therapy to be $d = .82$ and $d = .59$ for forgiveness and nonforgiveness dependent measures, respectively. The effect sizes reported here correspond to Cohen *d* values of over 1.0 (Wampold, 2001, p. 53). These effect sizes can be considered large and are comparable to those reported in other forgiveness intervention studies.

The results of the current study are consistent with Hebl and Enright (1993) and with the theory articulated in a meta-analysis by Ahn and Wampold, (2001), which claims different types of mental health interventions are equally effective. If we look at the means in Tables 1 and the mean gains in Table 2, we can conclude that both interventions produced therapeutic outcomes for ACOA. Does this make forgiveness therapy superfluous? We think not because it opens an avenue that some may find more attractive than other therapies. Ahn and Wampold's conclusion suggests the effectiveness of different therapies is truly consonant with client-centered approaches in which the individual needs of clients guide the therapeutic approach.

The continued change Group B experienced from pretest to posttest 2, after receiving the forgiveness program, has three possible explanations: (1) the change was the result of more time spent in an active intervention, (2) the content of the forgiveness intervention, and/or (3) Group B had a great deal of cohesion, leading to strong benefits from participating in the group.

We believe the first explanation is the most feasible. This explanation is supported by Baskin and Enright (2004) and by Enright and Fitzgibbons (2000) who analyzed what little data existed on brief forgiveness therapy. They concluded that the longer the intervention, at least to a point, the more effective the treatment. They concluded at least 10–12 weeks with individual treatment is necessary to induce change in participants and suggested group interventions may require even longer treatment times. The additional 12 weeks of treatment Group B received seems like a possible explanation for the continued change from pretest to posttest 2.

Improvements in the forgiveness variable could be explained by participants' scores moving toward the established mean for the scale. This explanation at first seems viable when considering participants needed to score below the mean on the forgiveness variable to be included in the study. The normative mean for the forgiveness scale is 259 (Enright et al., 2000), and the means for the two groups may have moved toward 259 at posttest. However, this explanation is unlikely because at posttest 2, the original experimental group, which was then without intervention, fell 17.7 points (to 223.8) whereas the control-group-turned experimental group continued to improve to an average of 252.5). The two groups were moving in opposite directions consistent with the patterns of intervention.

Similarities existed between the two interventions. As discussed in the Procedures section, the conflict resolution intervention was altered to include a focus on emotion. This, coupled with the exploration of cognitive reframing of an unjust situation and anger reduction, which were inherent in the conflict resolution intervention, led to an overlap of content in the two treatments. As noted by Wade, Worthington, and Haake (2009) similarities may exist between explicit forgiveness interventions and alternative treatments such that alternative treatments could promote forgiveness. This may explain the nonsignificant findings for the between-group tests in the current study.

This study had strengths and limitations. Strengths included manualized treatments, fidelity checks, random assignment, and the group format. Working from a manual made the procedures more concrete for therapists and clients by providing a reference to which clients could return when necessary. Fidelity checks ensured the treatments were implemented as intended and random assignment helped prevent systematic differences between the two groups. Despite findings that individual forgiveness interventions produce larger effects than group forgiveness interventions (Baskin & Enright, 2004), we believe the group format of the interventions was a strength. As Brown (1988) noted the group format can help ACOA realize the family dysfunction they experienced is common. The group provides social validation of the ACOA pain and anger in ways not possible in individual treatment. Limitations included a small sample size, an almost entirely female sample, the similarity of interventions, and one interviewer conducting both groups. The sample size limits the power of the analysis and the generalizability

of the results. The sample was mostly women, 11 female participants and one male participant. This also limits the generalizability of the study. The effects of a forgiveness intervention with male adult children of alcoholics should be addressed in future research. The similarity between the two groups increases the possibility of a Type II error, whereas having only one intervener increases the possibility that her skills served as a mediator between the independent and dependent variables.

Injustices from the family of origin can lead to lasting emotional scars. Adult children of alcoholics are particularly vulnerable to such emotional difficulty because of the ongoing nature of the injustices that can result from alcohol abuse by a family member. The current study suggests that the emotional compromise can be reversed through forgiveness and attempts to proactively resolve the conflicts in a just way. Forgiveness is not appropriate for all ACOA; individual treatment plans should recognize specific needs of particular clients. Forgiveness may be appropriate for those who have experienced deep interpersonal hurt. For those ACOA who wish to overcome childhood resentments toward hurtful family members, and move toward healing, forgiveness therapy and the fair resolution of conflicts appear to be viable options. These data suggest forgiving a hurtful family member can result in higher levels of psychological functioning and are consistent with the findings of other studies of forgiveness.

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