

THE AFFECTS OF FORGIVENESS ON THE SYMPTOMS OF
POSTTRAUMATIC
STRESS DISORDER AS A RESULT OF SEXUAL TRAUMA

by

Sandra K. Johnston

A Thesis submitted in Partial Fulfillment of the requirements for The Master of
Counseling Education Degree

Thesis Chair: Dr. David Van Doren

THE UNIVERSITY OF WISCONSIN-WHITEWATER

May 1, 2007

The University of Wisconsin-Whitewater

Thesis Approval

Sandra K. Johnston

Date: _____

Committee Chair: _____

Committee Member: _____

Committee Member: _____

Table of Contents

List of Tables.....	vi
Abstract.....	vii
Introduction.....	1
Purpose.....	1
Justification.....	1
Hypotheses.....	8
Definitions.....	8
Overview.....	10
Background and Review of Literature.....	10
Theory.....	10
Current Research on PTSD.....	11
Current Research on Forgiveness.....	15
Current Research on the Relationship between Forgiveness and PTSD.....	22
Summary.....	24
Conclusion.....	25
Procedure.....	26
Research Design.....	26
Materials.....	26
Sample.....	26
Instruments.....	27
Demographic Survey.....	27

Offense Specific Forgiveness Measure	27
Posttraumatic Stress Disorder Symptoms Self Inventory	28
Specific Procedures Used.....	28
Internal Validity.....	30
Justification of Statistical Techniques or Method of Analysis Used.....	31
Results.....	31
Within Group Data Analysis.....	31
Between Group Data Analysis.....	31
Table 1.....	32
Limitations.....	33
Discussion.....	33
Table 2.....	34
Implications.....	35
References.....	37
Appendix A: Advertisement/Poster.....	49
Appendix B: E-mail script.....	50
Appendix C: Telephone script.....	51
Appendix D: Cover letter.....	54
Appendix E: Crisis Resources.....	56
Appendix F: Informed Consent.....	57
Appendix G: Demographic Survey.....	59
Appendix H: Offense Specific Forgiveness Measure.....	61

Appendix I: Posttraumatic Stress Disorder Symptoms Inventory.....62

Appendix J: Debriefing Statement.....64

List of Tables

Table 1: Intercorrelations Within Groups

Table 2: Raw Demographic Data

Abstract of Thesis

Sandra K. Johnston

Counseling Education

The Affects of Forgiveness on the Symptoms of Posttraumatic Stress Disorder as a
Result of Sexual Trauma

May 1, 2007

Dr. David Van Dorn, Thesis Chair

The University of Wisconsin-Whitewater

The Affects of Forgiveness on the Symptoms of Posttraumatic Stress Disorder as a
Result of Sexual Trauma

This study continues research pertaining to the affects of forgiveness on Posttraumatic Stress Disorder (PTSD) symptoms resulting from sexual trauma. The research question asked whether or not the ability to forgive would reduce, increase, or have no affect upon PTSD symptoms. The hypotheses stated that the ability to forgive a specific traumatic sexual offense would correlate with fewer symptoms of PTSD, while the inability to forgive a specific traumatic sexual offense would correlate with a greater number of PTSD symptoms. Participants consisted of females eighteen and older, who had experienced sexual trauma, and stated that they had either forgiven or not forgiven their perpetrator/s. The first group was named “forgive”, and the second “unforgive”. Instruments included, a Demographic Survey, Offense Specific Forgiveness Measure, and Posttraumatic Stress Disorder Symptoms Self Inventory. Within group data analysis was performed using the Pearson’s Product-Moment Correlation; between group data was analyzed using the t-test for *r*. Within group correlations for both group “forgive” and “unforgive” yielded strong but insignificant results. When raw from both groups were combined, the resulting analysis showed no significant results. Between group data analysis, indicated a significant difference in forgiveness. There was no significant difference between groups for the dependent variable – PTSD. Results were carefully interpreted and were not used to predict or establish causation as they were not large enough to imply any relationship between the variables. The small number of participants as well as

the predominantly white sample limited generalizations. Demographic data indicated that individuals with stated religious affiliation were less forgiving than those with no stated religious affiliation. Those same individuals were also traumatized as adults rather than as children/adolescents. The sample was predominantly white individuals with post-high school level education. The majority of perpetrators were outside of the biological family. Group “forgiveness” scores indicated an inverse relationship between variables, supporting the hypothesis, while group “unforgive” scores did not. Between group scores indicated support for the correlation between stated forgiveness and actual forgiveness, while analysis of PTSD raw scores between groups was not significant. Mental health implications begin with the importance of age at occurrence of trauma, impacting the ability to forgive. It may be beneficial for researchers to study forgiveness across the lifespan, how forgiveness and unforgiveness are learned, cultural influence on learning, and the impact of education level upon forgiveness ability indicating how practitioners can utilize the most effective forgiveness interventions. Second, the spiritual belief of the client influences expressed and actual forgiveness. Forgiveness is a choice which empowers survivors of trauma. Although not every intervention is appropriate for every client, research supports the use of forgiveness intervention as an adjunct to mental health practice. Finally, further research into the impact of forgiveness interventions, their reliability and validity, and the long-term effects will aid clinicians in determining the part forgiveness will play in practice.

The Effects of Forgiveness on the Symptoms of Posttraumatic Stress Disorder as a Result of Sexual Trauma

Introduction

Purpose

The purpose of this study was to assess the possible correlation between forgiveness and the symptoms of Posttraumatic Stress Disorder (PTSD) resulting from sexual trauma. In recent years, the effects of trauma have become a focal point in the American media and in the personal lives of individuals nationally as well as globally. Mental health practitioners have been looking for more effective methods to treat the symptoms related to trauma. “Psychotherapists have worked to help their clients learn to forgive and some have written about the importance of forgiveness. Until recently, however, the scientific literature has not had much to say about the effects of forgiveness” (Luskin, 1999, p. 1). Studying the ability to forgive may aid mental health practitioners in discerning whether or not it can be used as a viable intervention for survivors of trauma within a therapeutic setting.

Justification

Posttraumatic Stress Disorder (PTSD) is now shared by an estimated 5.2 million Americans (American Psychological Association [APA], 2005a). Anxiety disorder caused by PTSD costs an estimated \$46.6 billion to treat each year. It is believed that 8% of men and women in the U.S. will be traumatized sometime during their lives, becoming sufferers of the effects of the disease (American Psychological Association Online, 2005b). PTSD does not just affect the sufferer; many individuals

become secondary PTSD sufferers through contact with (Salamon, 2001; White, 1998) and/or ill treatment by that person as evidenced in higher domestic violence rates among veterans with PTSD compared to those of the general population (Sherman, Sautter, Jackson, Lyons, & Han, 2007).

The majority of trauma against females is sexual (Orsillo, 2006); 15-43% of adolescent girls will experience trauma of which 3-5% will develop the symptoms of PTSD (Hamblen, 2006). In a study by Kilpatrick, et al. (2003) 19% of the adolescent girls participating had a diagnosis of PTSD from experiencing interpersonal violence. Further, the PTSD was comorbid with major depressive episode and substance abuse disorder. In a study of runaway adolescents, Slesnick, Bartle-Haring, and Gangamma (2006) found that not only is substance abuse comorbid with adolescent physical and sexual abuse, but that protective factors such as parental care and family cohesion are extremely low. Deykin and Buka (1997) investigated childhood trauma in relation to the development of substance abuse. They found that females are more likely to experience sexual trauma at roughly age 11, developing a substance use disorder within two years after the event/s. Deykin and Buka also discovered that trauma accumulates. They purport that numerous low risk traumatic events such as receiving news of violence may eventually equate to a single high risk traumatic event such as rape. All traumas are significant, yet repeated traumas increase the possibility of experiencing PTSD. Herman (1992) supported the fact that victims of ongoing or multiple traumas develop more complicated psychological symptoms than survivors who experience a single-episode trauma.

Survivors who have or develop resiliency factors can cope with trauma enough to function in society. Bogar and Hulse-Killacky (2006) found that positive determinant and process factors such as high interpersonal skill, competency, high self-regard, helpful life circumstances, and spirituality allowed victims to heal without participating in a formal intervention program. Lev-Weisel (2000) studied victim perceptions of the traumatic experience and found that survivors with a better quality of life were able to attribute the blame for the trauma to the perpetrator rather than themselves. Leahy, Pretty, and Tenenbaum (2003), supported this finding reporting nonclinically distressed participants were able to perceive the perpetrator as being responsible for the abuse rather than themselves. Gall (2006) found that adult survivors of childhood sexual abuse were less distressed and had less depression when they admitted the abuse, identified the perpetrator, and then used positive spiritually based forgiveness.

Compare those findings with a study by Johnson and Lubin (1997) in which Vietnam veterans evaluated a number of in-patient treatment modalities including: basic treatment (individual therapy, medication, nursing staff, and overnight passes), thematic verbal group therapy, family programs, art therapy, active groups, and milieu events. The veterans who had more severe PTSD symptoms agreed that basic treatment worked best, but had no long-term effects once they left the treatment facility.

Several treatment methods have been employed to relieve the symptoms of trauma with varying degrees of success. According to van der Kolk (1994), it can be

difficult to perform psychotherapy on trauma patients when they react to everything as if it were a physiological emergency. Pharmacological treatment to reduce trauma symptoms included SSRIs (Ralat, 2006), tricyclic antidepressants (Spivak, et al., 2006; van Liempt, Vermetten, Geuze, & Westenberg, 2006), antipsychotics (Hanretta & Malek-Ahmadi 2006; Lambert, 2006), benzodiazepines (Davidson, 2004), and lithium (Forster, Schoenfeld, Marmar, & Lang, 1995).

Brief, person-centered, Traumatic Incident Reduction (TIR), provided to female inmates for the purpose of eliminating the negative effects of a single past trauma (Valentine, 2000) emphasizes the in vivo exposure aspects of cognitive-behavioral therapy. The study results are weak, though, and even the addition of cognitive restructuring to prolonged exposure treatment does not increase its favorability (Foa, et al., 2005).

Stress Inoculation Training (SIT) has proven beneficial in reducing PTSD symptoms. It involves muscle relaxation, breathing control, covert modeling, as well as role playing, thought stopping, and guided self-dialogue (Barlow, 2001). It appears to reduce anxiety and negative moods with long-term (6-month follow-up) effects. It is more beneficial when combined with prolonged exposure (PE) while more research is required to discover its exact impact upon PTSD when used as a single modality (Foa, et al., 1999).

Eye Movement Desensitization and Reprocessing (EMDR) is a controversial method for treating PTSD that deals with the way the brain processes trauma information through visual cues, and has proven itself beneficial with combat

veterans (Russell, 2006). There have been mixed results with non-combat PTSD sufferers; some with only temporary positive results on the one hand (Markis, Marquis, & Sakai, 2004), and positive lasting results on the other (Shapiro, 2002). This may not be a failure of the modality to work in certain trauma cases, but may indicate subtle physiologic differences in how the brain stores different types of trauma (e.g., combat versus non-combat occurrences).

Gestalt therapists have been challenged since the attack on the World Trade Center to participate in empirical studies proving the effectiveness of their work with PTSD (Cohen, 2003). O'Leary and Nieuwstraten (2001) reported that older adults engaging in dialogue within a group therapy setting had memories which helped them resolve unfinished business, particularly individuals who had served in combat. Most of the memories were most positive for the individual. Lieberman and Tobin (as cited in O'Leary & Nieuwstraten, 2001a) found negatively perceived memories threatened a coherent, consistent sense of self.

Ego coherence, or integrity, may be threatened by the picture of self as a killer in wartime and self as a civilian in peacetime. Kears pointed out that combat soldiers who have routinely taken the lives of others are viewed by others as being 'different' on their return. Soldiers will also view themselves as being different, standing apart, or having a forbidden knowledge. Sexual abuse survivors reported feeling relief in the safe environment of Gestalt group therapy, free from silence and self-blame (Reichert, 1994, pg. 176).

Cognitive-behavioral therapy (CBT) and cognitive processing therapy (CPT) are the most widely used modalities in the United States for treating trauma symptoms (Resick & Schnicke, 1992). Both variations have been successful in reducing PTSD symptoms when used by therapists with minimal training as well as experts with much experience. They have been shown to improve PTSD symptom severity, state anxiety, and trauma-related cognitive schemas, yet, have not been shown to affect depression dissociation, anger, or quality of life in some studies (Foa, et al., 2005). Contrary to those findings, Chard (2005) discovered significant improvement in PTSD symptoms as well as depression when comparing the use of CPT over minimal attention. House (2006) confirmed the results incorporating dialectic behavior therapy skills along with CPT. Resick and Griffin (2002) found that CPT was more effective in conjunction with prolonged exposure (PE). McDonough and colleagues (2005) determined CBT had a great impact upon PTSD; unfortunately, the dropout rate for participants was much higher than briefer therapies proving this modality difficult to employ.

Recent explorations into the use of neurological desensitization techniques (Everly & Lating, 2004) such as, meditation (Nidich et al., 2005; Waelde, 2004), tai chi (Li, 2004), and yoga (Besette, 2006), have led to promising results. A scientific movement in the massage profession known as Body Memory Recall (BMR) studies how memories are stored as energy in the cells of the body rather than the brain (Tripodi, 2005).

Methods that involve memory reframing or those that are calming to an

overexcited CNS appear more helpful for reducing symptoms of PTSD, but the bigger picture must include a method for assisting a deeper, more permanent shift to take place within the individual, resolving underlying problems or healing deep-seated resentments. Where the emotions go, the mind and body will follow. How can the findings summarized previously be translated into an effective formal therapeutic intervention that has a lasting effect on the total quality of life for the whole individual?

Farrow et al. (2001) discovered that forgiveness activates certain areas of the brain, potentially allowing researchers insight into which modalities for treating trauma are most successful. More recently, Farrow et al. (2005) attempted to measure “brain response to forgiveness and the resolution of posttraumatic stress disorder” (p. 45). The main finding was “enhanced brain activation following symptom resolution in brain areas that we have previously shown to be involved in social cognition” (p. 51). A small but growing body of research has indicated that forgiveness positively affects individuals emotionally, physically, and psychologically while unforgiveness affects the individual negatively (Enright, 2001; Worthington, 2001). Wade and Worthington (2003) believe that unforgiveness may be a self-sentence to lifelong negative health consequences; whereas, forgiveness leads to a sense of release, a sense of peace, higher self-esteem, and fewer symptoms of PTSD (Noll, 2005). Recent successful studies performed at UW-Madison (Baskin & Enright, 2004) and Stanford University (Luskin, 1999, 2005), indicate that although forgiveness is not an intervention for every disorder, it could become an efficacious component of the

psychotherapy process, helping trauma survivors unravel the complexities of PTSD.

Hypotheses

The research question: does the ability to forgive a specific traumatic sexual offense reduce, increase, or have no effect on the symptoms of PTSD? The hypotheses state that the ability to forgive a specific traumatic sexual offense would correlate with fewer symptoms of PTSD, and that the inability to forgive a specific traumatic sexual offense would correlate with greater symptoms of PTSD.

Definitions

Abnormal: “The state of being markedly irregular, characterized by mental deficiency or disorder” (Woolf, 1980, p. 3). For the purposes of this study, the term “abnormal” will be defined by the DSM-IV disorder characteristics.

Adult: “An individual after the age of majority as specified by law or a fully developed and mature person” (Woolf, 1980, p. 16). For the purposes of this study, individuals 18 and older are considered adults.

Disease: “A condition of the living organism that impairs the performance of a vital function” (Woolf, 1980, p. 324).

Disorder: “An abnormal physical or mental condition” (Woolf, 1980, p. 326).

Forgiveness: To give up resentment against an injustice or freely release an individual from debt. It includes the replacement of unforgiving emotions with positive ones, and may include desire to reconcile. A wish to move on with life may also be present (Noll, 2005). This researcher believes that forgiveness is innate as seen in children who protect their abusers.

Offender: For the purposes of this study, is any individual/s that carries out trauma, especially of a sexual nature, against an unwilling victim.

Perpetrator: For purposes of this study, is one who carries out trauma against another individual.

Posttraumatic Stress Disorder (PTSD): “A lifelong, intrusive condition caused by extreme trauma” (Rothschild, 1998, p. 1). Symptoms include, but are not limited to: nightmares, dissociative flashbacks about the incident, low startle threshold, difficulty sleeping (APA, 2000), thoughts or obsessions about death and dying, difficulty concentrating, loss of desire to do things the individual formerly enjoyed, isolating, avoidance of reminders of the trauma (Foa, Riggs, Dancu, & Rothbaum, 1993), and substance abuse (Kilpatrick et al., 2003). For the purpose of this study it is caused by interpersonal (as opposed to witnessed) sexual trauma.

Sexual trauma: “Any unwanted sexual activity perpetrated by a male or female individual/s within or outside of the biological family. It includes: kissing, touching, forced masturbation, oral sex, anal sex, and forced sexual activity with humans, animals, or objects” (Moritz, 2005, pp. 2-3).

Survivor: One who continues to exist, live, and/or thrive after a trauma.

Trauma: “A sudden or violent occurrence that leaves the individual emotionally and/or psychologically injured or wounded” (APA Online, 2005b). For the purpose of this study, trauma is caused by a human perpetrator.

Unforgiveness: An unwillingness or inability to forgive unresolved hurt. The individual may hold the perpetrator responsible, want revenge, feel hatred or anger, and ruminate about the event. It can be the blameful prolongation of or attachment of resentment to grief (Witvliet, 2005). Unforgiveness may be directed toward others or the self. This researcher believes that unforgiveness is a learned response.

Victim: One who has been injured physically, emotionally, or sexually by the intentional act of another individual.

Overview

The science of psychology deals with the personal equation, which involves a wide variety of variables. Although psychotherapists use forgiveness concepts in their professional practices, the scientific study of forgiveness is just beginning. More empirical data needs to be collected before researchers can make conclusions about the use of forgiveness as a formal therapeutic intervention. This study accumulated data assessing the effects of forgiveness on PTSD symptoms expressed by females who have experienced sexual trauma. It is hoped that this study will inspire future research.

Background and Review of Literature

Theory

The reduction of trauma symptoms has been linked in recent research with forgiveness (Baskin & Enright, 2004; Luskin, 1999 & 2005; Worthington, 2001 & 2005). These findings led to the development of a theory pointing toward

forgiveness intervention as a viable psychotherapy method in working with PTSD.

Current Research on PTSD

Trauma is stored in somatic memory and expressed as changes in the biological stress response (van der Kolk, 1994). “Extreme distress causes a release of endogenous threat response neurohormones, including epinephrine, oxytocin, cortisol, vasopressin, and endogenous opioids” (van der Kolk, 1994, p. 224). Some studies indicate that victims who develop PTSD have increased cortisol and CNS arousal immediately following trauma, producing permanent neuronal changes that have a negative affect on memory, habituation, and stimulus discrimination (Kolb, 1984).

Rossi (2004) has shown that “stress can alter the expression of the acetylcholinesterase gene, generating at least three alternative proteins implicated in the development of PTSD symptoms” (p.13). Those symptoms include flashbacks or nightmares about the event, low startle threshold, panic attacks, numbing, dissociation, feeling overwhelmed by normal situations, isolating, increased alcohol or drug use, extreme anger, and suicidal thoughts (VOW, 2006). The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) adds that there is chronic arousal of the autonomic nervous system: i.e., accelerated heart beat, cold sweating, rapid breathing, heart palpitations, and hypervigilance (APA, 2005b).

It appears that traumatized individuals have trouble identifying and evaluating stimuli as well as mobilizing the appropriate levels of response. They cannot properly integrate memories of the trauma and are seemingly stuck in reliving the

trauma repeatedly, which is mirrored by the physiological misinterpretation.

Rothschild (1998) feels the medical data is accurate; a true biological shift is at the core of the disorder rather than simply emotional issues.

A number of environmental risk factors are also involved in the development of PTSD, such as age. Adolescents who have been victims of trauma are being diagnosed with PTSD more frequently. It is believed that the negative impact on their lives can cause permanent, arrested psychological and motor development unless intervention is made to restore their lost or undeveloped resources (Pynoos, 1993). Older adolescents are more likely to report violence than their younger counterparts (Kilpatrick, et al. 2003), thus leaving accurate data on younger adolescents unavailable or inaccurate. Alarming, the percentage of adolescents diagnosed with PTSD is rising. In a national survey, Kilpatrick et al. (2003) found that interpersonal violence increased the risk of PTSD relative to other potentially traumatic events such as natural disaster, accidents, or incidents such as the attack on the World Trade Center. Notably, the researchers also discovered that depression and increased alcohol/drug abuse are comorbid with PTSD among adolescents. Although studies examining the relationship between adolescents and interpersonal violence are scarce, Kilpatrick et al. (2003) found that, interpersonal violence factors potentiating the greatest increase in PTSD were sexual assault and witnessed violence, putting females at greater risk than their male counterparts.

Military service is another high risk factor in the development of PTSD. The Department of Defense (Street & Stafford, 2002) conducted a sexual victimization

survey among active military personnel which revealed that 6% of females in service have been sexually assaulted, increasing the stress of military service for females. Adding to the sense of victimization is the fact that enlisted females live and work with their perpetrators. This results in a heightened sense of helplessness, powerlessness, and risk for further victimization (Street & Stafford, 2002). As with a civilian population, “the psychological response of the individual depends upon trauma history, appraisal of the event, and the quality of the support system following the event” (Street & Stafford, 2002, p. 67) although an increased number of those victims of sexual trauma develop PTSD symptoms regardless of protective factors.

It had long been thought that veterans of war were the only PTSD sufferers because discovery of the disease took place among that particular population (Johnson & Lubin, 2005). Today, other forms of trauma have been identified as causing the same symptoms that were once labeled “battle fatigue”. Thus, enlisted persons and civilians share the same disorder according to the DSM-IV-TR guidelines for diagnosing PTSD.

Rothschild (1998) believes it is a mistaken assumption that everyone who experiences trauma will develop PTSD. “Actually only a fraction of those facing trauma will develop the disorder” (Rothschild, 1998, p.1). It appears that numerous factors increase the risk of PTSD development such as: whether or not the individual was prepared for or expected the trauma, prior life experience, having a viable support system, having a successful fight-or-flight response, innate personality trait factors, as well as the ability to forgive oneself and/or the perpetrator. Note that they

are all cognitive or environmental factors, and do not take into consideration biological predisposition.

Although research findings conflict about whether or not individuals will develop PTSD, Tedeschi, Park, and Calhoun (1998) believe that the majority of trauma victims find richer, more fulfilling lives, thus avoiding PTSD symptoms. Tedeschi has coined the term “posttraumatic growth” to describe the life-changing effects of trauma. It is the brain child of twenty years of study with individuals who experienced positive changes that came about as a result of the struggle overcoming extreme trauma. It is not an automatic change; the trauma must be severe, such as combat, violent crime, or sudden serious illness. Arnold, Calhoun, Tedeschi, and Cann (2005) further studied 21 psychotherapists suffering from “compassion fatigue or empathic strain” (p. 241). Seventeen participants reported experiencing at least one major traumatic event in their practices; all of them stated that their own struggles with the trauma yielded positive consequences, gains in self-confidence, independence, resilience, emotional expressiveness, sensitivity, compassion, and a deepened spirituality.

Sexually Based Post Traumatic Stress Disorder (SBPTSD) is the newest term used by sexologists to define the emergent symptoms of PTSD in the context of sexual violation (Moritz, 2005). Mullen and Fleming (1998) believe, as do many mental health professionals, that sexual trauma can lead to the development of SBPTSD. Their study shows a clear adult psychopathology manifest in dissociative disorder after childhood sexual abuse. A recent study by Kalten, Krupnick, Stockton,

Hooper, and Green (2005) found that college students who historically had been exposed to sexual trauma or revictimization showed a greater propensity for psychopathology, poor social adjustment, and risky sexual behavior due to the impact on their developmental processes.

Linley and Joseph (2004) confirmed that there can be growth after adversity. Adversarial growth is defined by the researchers as: posttraumatic growth, stress-related growth, perceived benefit, and thriving. Participants in the study displaying positive cognitive appraisal, acceptance, positive reinterpretation, optimism, religious belief, as well as positive affect, were less distressed than their counterparts. As those individuals continued to practice the steps of adversarial growth, they continued to have healthier lives. The outcomes of these resiliency studies bring hope to those who have developed PTSD as well as leading to the viability of a positive approach to therapy, namely forgiveness.

Current Research on Forgiveness

The definition of forgiveness is sometimes misunderstood and often confused with reconciliation. Fitzgibbon, Enright, and O'Brien (2004) define what forgiveness is not: "it does not mean being a doormat, being weak, limiting healthy assertiveness, tolerating and enabling abusive people, trusting or reconciling with those who are abusive, insensitive, or unmotivated to change their unacceptable behavior" (p. 24). Forgiveness is for the offended not the offender according to Anderson (1990). It is a path to freedom for the victim.

When researchers (Berry, Worthington, O'Connor, Parrott, & Wade, 2005)

began studying forgiveness from a morality viewpoint, they found it had a positive impact on the victim in terms of lasting physical health, psychological functioning, created better social adjustment, and had global implications. As important as forgiveness appears to be, researchers question whether it is an innate dispositional trait or depends upon external circumstances, or is contingent upon natural and environmental factors. Brown (2004) studied the innate trait of narcissism in conjunction with the ability to forgive. He found that individuals who were low in dispositional forgiveness were more vengeful than individuals who were high in dispositional forgiveness. The most vengeful individuals were those who were highest in narcissism.

Roberts (1995) created the term “forgivingness” to define the dispositional trait of forgiving. Berry et al. (2005) then adapted that term for dispositional unforgiveness, or “unforgivingness” to differentiate between single acts versus the innate trait. Analysis by Berry et al. (2005) of four different forgiveness studies confirmed the research expectations in each case; “negative affective traits (neuroticism, trait anger, hostility, depression, and fear) correlated with unforgiveness while positive affective traits (agreeableness, empathetic concern, perspective-taking, and extraversion) correlated with the ability to forgive” (p. 213). Further results associated “vengeful rumination” (pg. 213) with perpetuating negative emotions triggered by the event, which in turn perpetuate unforgiveness while inhibiting forgiveness.

Neto and Mullet (2003), adopting Roberts’ (1995) terminology, studied

various personality traits that they believe correlated with the ability to forgive. Their hypothesis stated that “forgivingness” would be positively linked with self-esteem. Study of the relationship between forgivingness and a number of personality dimensions which were judged relevant to forgivingness such as, shyness and embarrassment on the one hand, and self-construal and perceived loneliness on the other hand led to them accepting a null hypothesis. Their examination of forgivingness and interdependence led to the discovery of a positive correlation between the two (Neto & Mullet, 2003).

Some researchers believe that environmental factors play a larger role in the ability to forgive than innate traits. According to Wade and Worthington (2003), “the quality of the relationship before the offense, the severity of the offense, whether the offense had occurred in the past and the victim’s idiosyncratic reactions to being hurt” (p. 343). It seems that a combination of innate traits and external environmental factors affect forgiveness. Rather than being absolute or mutually exclusive, they exist side-by-side on a continuum in various combinations. How can an individual who has a high level of environmental hindrance and a low level of innate trait factors learn to forgive?

Lin, Mack, Enright, Krahn, and Baskin (2004) employed Forgiveness Therapy based on the steps discussed in *Forgiveness is a Choice* (Enright, 2001) to reduce anger in substance abusers living in an in-patient rehabilitation facility. They found that forgiveness intervention successfully improved the ability to forgive, anger, depression, self-esteem, and vulnerability to drug use as seen pre- and post-test

scores. The 4-month follow-up indicated the forgiveness intervention had long lasting effects.

Luskin (2005) performed a forgiveness study with college students who had experienced an interpersonal injury. Post-test scores greatly improved over pre-test scores when a cognitively-based forgiveness intervention was used; specifically, the tendency to forgive increased, the willingness to forgive increased, the degree of hurt decreased, and anger decreased. Positive outcomes of the intervention included a greater degree of focus on the future, development of self-efficacy, as well as spiritual growth. In this case, perceived “posttraumatic growth” (Arnold, Calhoun, Tedeschi, & Cann, 2005, pg. 250) occurred because of the difficulties, making it easier for the participants to deal with future transgressions. An interesting discovery was that growth occurred without a change in attitude toward the offender.

Further, a meta-analysis of nine studies on forgiveness was performed by Baskin and Enright (2004) resulting in positive correlations between long-term forgiveness training and successful forgiving. Process-based interventions worked when decision-based interventions did not; being taught a forgiveness method was more successful than simply trying to make up one’s mind to forgive. Surprisingly, the empirical data even supported forgiveness intervention with traditionally challenging populations such as incest survivors (Baskin & Enright, 2004).

Wade and Worthington (2003) performed a study comparing specific predictors of forgiveness and unforgiveness. They discovered that forgiveness and unforgiveness are not necessarily reciprocally related; rather they are separate entities

on their own continuums. It is possible to reduce unforgiveness without replacing it with forgiveness where forgiveness is not believed to be desirable. Factors such as the severity of the offense, the closeness of the relationship prior to the offense, and the strength of the initial emotional reaction predicted a positive correlation with unforgiveness and a negative correlation with forgiveness. The same result was found for perceived contrition and empathy on the part of the offender toward the victim. Religious commitment and trait forgiveness were also positively correlated with forgiveness. Further, the victim's focused attempt to forgive, imparting a new internal attitude, greatly increased forgiveness.

“Cases in which forgiveness is impossible (the perpetrator has died or refuses to apologize), the client cannot or will not forgive, or in which the counselor does not want to recommend forgiveness (e.g. situations in which revictimization may occur) potentially block the healing process and force the victim to live with lifelong negative health consequences” (Wade & Worthington, 2003, p. 350). The researchers discovered that reducing unforgiveness worked as well as attempting to find forgiveness. If the only way to reduce unforgiveness was to forgive, clients and their counselors would be restricted (Wade & Worthington, 2003). Victims who felt they had completely forgiven also reported having less unforgiveness. They were able to help themselves by reframing the offensive circumstances, seeking justice, or receiving restitution.

Enright (2001) distinguishes “reconciliation as the coming together of two parties in mutual respect, whereas forgiveness is one person's moral response to

another's injustice" (pg. 31). Enright developed a four-phase process model of forgiveness intervention. The uncovering phase is a time when the individual becomes aware of the emotional pain and anger that resulted from deep, unjust injury. The decision phase is the phase during which the individual realizes that focusing on the injury causes more unnecessary pain, and wants to release that pain. The work phase consists of creating a new way of thinking about the offender, better understanding of the offender, willingness to empathize with that person, accepting the pain of the injury, being willing to grant mercy to the offender, and not passing the injury or pain on to others. Lastly, the deepening phase results in the victim realizing that he/she is gaining emotional relief from the process of forgiving the offender. This leads to a newfound compassion for the self and its worth. Many individuals may find a new purpose to life as well as the capacity to grant mercy, generosity, and moral love.

Worthington (2001) defines forgiveness as "the emotional replacement of (1) hot emotions of anger or fear following a perceived hurt or offense or (2) unforgiveness that follows ruminating about the transgression, by substituting positive emotions such as unselfish love, empathy, compassion, or even romantic love" (p. 32). Worthington has developed a forgiveness intervention using a pyramid system, REACH, (p. 38). First, the individual must Recall the event. Second he/she must Empathize with the offender and attempt to understand the pressure the individual may have been in at the time of the offense. Third, the victim must offer the Altruistic gift of forgiveness to the offender as well as gratitude for having been

forgiven by others himself/herself. Fourth, the victim must Commit publicly to forgive the perpetrator. Lastly, the victim must Hold on to forgiveness even when that is difficult.

Luskin (2003, pp. 211-212) developed a nine-step intervention to permanent forgiveness. The first step is for the injured person to know exactly how he/she feels about the injury, and be able to articulate those feelings. The second step is for the injured person to make a self commitment to do what it takes to feel better. Luskin believes that forgiveness is for the benefit of the injured party, not for the benefit of the offender. The third step is understanding one's goal; forgiveness may or may not involve reconciliation with the offender. The fourth step is to have a right perspective. In essence, the incident is over, and now one is left with only the memory and the feelings attached to the memory. The fifth step is to be aware of feeling upset, and immediately use self-soothing techniques. Luskin calls his method Positive Emotion Refocusing Technique, PERT, which calms the body's fight-or-flight response. The sixth step is giving up expectations. The seventh step is to find ways to get one's positive goals met rather than replaying the hurtful event. The eighth step is to find personal power in living successfully in spite of having been hurt. The final step is to amend the personal narrative reminding one of the heroic choice to forgive

Luskin (2003) also breaks down the healing process into four stages: experiencing a life event that justifies negative emotions, realizing that the negative emotions do not feel good, remembering how good it feels to forgive while finding

control in choosing to feel hurt for a shorter period of time, and choosing to stop taking offense by learning to think like a forgiving person before it is necessary to do so. From this process, Luskin has designed the HEAL method which stands for Hope, Educate, Affirm, and Long-term, an easy acronym for remembering the components of the guided healing practice.

Witvliet (2005) conducted four studies concerning the choice to forgive, all with similar outcomes. An apology to the victim lowered affective arousal. An apology and restitution lowered unforgiveness while increasing positive prosocial response. Forgiveness sought by the perpetrator increased positive emotional affect in both the victim and the perpetrator. Lastly, “the effects of restorative justice surpassed that of punitive justice or no justice at all” (p. 44). It appears that forgiveness helps victims to cope with trauma, but it is a personal and conditional choice as to what will satisfy the offense.

Although all methods appear different, the same thread runs through them - the victim has a choice. Empowering the one who has been injured is the main goal of forgiveness. Paradoxically, that freedom may lie in granting mercy.

Current Research on the Relationship between Forgiveness and PTSD

A dispositional study done by Witvliet, Phipps, Feldman, and Beckham (2004) asserts that veterans who had difficulty forgiving themselves, others, and/or God suffered higher blood pressure and heart rates, as well as greater levels of anxiety, depression and more intense PTSD symptoms than veterans who were able to forgive. Veterans who had healthy religious associations, who were willing to

work through problems hand-in-hand with God, and who sought spiritual support had fewer PTSD symptoms than researchers expected.

Orcutt, Pickett, and Pope (2005) found that forgiveness was negatively related to trauma exposure, indicating a process of hardening or bitterness associated with repeated traumatization, as in the case of children reared in homes where abuse occurs on a daily basis. The researchers also found that forgiveness, once achieved, reduced PTSD symptoms at a much higher rate than experiential avoidance. Snyder and Heinze (2005) found that PTSD was a strong predictor of hostility, while forgiveness was a strong mediator between PTSD and hostility reduction. Overall forgiveness reduced hostility considerably, but forgiveness of self and situation were more powerful than forgiveness of the perpetrator, which was seen as unnecessary in healing.

Noll (2005) performed a longitudinal forgiveness study with adolescent females who had been sexually abused. Forgiveness in this study meant letting go of the desire for revenge, letting go of anger, a wish to move on with their lives, and a desire for reconciliation with their offender. In fact, forgiveness was so powerful that the girls who were able to forgive were warned not to seek a sustained relationship with the offender for their own safety. She found that girls who were able to forgive had higher self-esteem, less anxiety, better relationships with their mothers, and fewer symptoms of PTSD.

Reed (2004) compared the outcomes of a forgiveness educational intervention to the outcome of alternative treatment for women who had experienced spousal

psychological abuse. The results revealed that the participants in the forgiveness educational intervention were better able to forgive their former abuser, their self-esteem was higher, they found meaning in their suffering, their depression decreased, and the symptoms of PTSD decreased (Reed, 2004). This is hopeful news, putting trauma in a different light. Survivors can find that the emotional rewards compensate for the pain and difficulty of adversity.

What is intriguing about this research is that even people who are not depressed or particularly anxious can obtain the improved emotional and psychological functioning that comes from learning to forgive. This suggests that forgiveness may enable people who are functioning adequately to feel even better. While the research is limited, a picture is emerging that forgiveness may be important not just as a religious practice but as a component of a comprehensive vision of health (Luskin, 1999, p. 1).

Summary

Studies have demonstrated that PTSD is a serious biological disorder with distinctive, lifelong symptoms. Although not all victims of trauma develop the disorder, as the population increases more individuals will experience and report trauma. It is anticipated that the cost of treating PTSD symptoms may increase at a tremendous rate. Forgiveness is emerging as a possible psychotherapy method for treating PTSD.

Conclusion

Forgiveness has historically been associated with religious practices which may have been instrumental in delaying investigation of its therapeutic usefulness by the secular scientific community. It may also have appeared to be a simple solution to a complicated problem. No matter what the reason for its late emergence into secular awareness, the increased number of individuals living with PTSD calls for mental health providers to attempt to find new, better, and perhaps faster methods of treating the disorder.

As a greater number of young people experience and report trauma, research exploring forgiveness interventions during the formative years of life becomes necessary. Increased intervention for children and adolescents may help them cope with arrested development, the possibility of living with the abuse, stress, and/or trauma for a much longer time period than their adult counterparts, having less control over their lives, and in some cases living with long-term, ongoing abuse or living with the abuser/s. Forgiveness intervention in this type of scenario, it must be pointed out, would be solely for the mental health benefit of the victim, and not a cure-all or safety measure.

Although the affects of PTSD may negatively impact the lives of others within the primary patient's environment, positive refashioning can also occur. "As adults mature and learn to forgive, society becomes healthier, morality increases, and interpersonal relationships deepen" (Luskin, 1999, p. 1). The results of the aforementioned studies suggest that the affects of forgiveness intervention are worthy

of further investigation, which led to formation of the research question: does the ability to forgive a specific traumatic sexual offense reduce, increase, or have no effect on the symptoms of PTSD?

Procedure

Research Design

The research design was correlational in nature as there was no manipulation of variables. Instruments consisted of one survey for data gathering purposes as well as possible uses in future research, and two surveys for measuring the quantitative variables (forgiveness and PTSD symptoms).

Materials

The researcher provided testing packets to the participants via the United States Post Office. They included: a cover letter of instruction, an informed consent document, a crisis resource document, the three surveys, and a self-addressed, stamped return envelope. Surveys within each packet were numerically the same (e.g., participant number one received packet number one, the three surveys of which were all numbered consecutively).

Sample

Participants consisted of a convenience sample of 8 female graduate and undergraduate students aged 18 and older, who live in a Midwestern city, attend the same university, and who have experienced sexual trauma. The majority of students who participated were white, between the ages of 18 and 27, studying at the graduate

level, and were not victims of incest. Hispanic, African American, Middle Eastern, and Native American students were not represented, which reflects the population of campus enrollment rather than a research bias. An equal number of individuals reported having or not having a religious affiliation. The age of occurrence was also evenly divided between childhood/adolescence and adulthood.

Participants were provided with the study definition of sexual trauma, and asked to think of a specific sexual trauma that had occurred in their lives. They were then provided with the study definitions of forgiveness and unforgiveness, and asked to decide whether or not they believed that they had forgiven the perpetrator/s of that specific sexual trauma. The first group was referred to as the “forgive” group and the second group as the “unforgive” group.

Instruments

Demographic Survey (Johnston, 200; see Appendix G)

Participants reported their age, date of birth, occupational field, level of education, ethnicity, whether or not there was a religious affiliation, approximate date of the trauma, developmental stage at the time of the occurrence, and whether or not the sexual trauma was within (incest) or outside of the biological family.

Offense Specific Forgiveness Measure (Brown & Phillips, 2003; see Appendix H)

Participants completing this instrument are asked to think of a specific offense for which they may not have forgiven the offender. The term used for these feelings of not having forgiven the offender is “state forgiveness”. Participants

are then asked to rate their agreement with seven statements measuring feelings of forgiveness, anger, empathy toward the offender, avoidance, and revenge. Reverse scoring is required on questions 2, 4, 6, and 7. Permission to use and print the instrument was obtained from author Ryan Brown.

Posttraumatic Stress Disorder Symptoms Self Inventory (Foa, 1993; see Appendix I)

The original Posttraumatic Stress Disorder Symptoms Self Inventory (PSSI) for adults consisted of 49 items capable of assisting interviewers in making a diagnosis of PTSD. The instrument used here is a seventeen question self-survey which was originally the Child PTSD Symptom Scale (CPSS), and has been widely accepted for use with adults from the government and military, to private organizations, and student researchers. It has been adapted to a Likert Scale for this study. Questions were written according to the DSM-IV description of cluster symptoms which identify a diagnosis of PTSD. The psychometric properties of the PSSI show high internal consistency and test-retest reliability for both the total score and the three subscales (Foa, Riggs, Dancu, & Rothbaum, 1993).

Specific Procedures Used

Participants were recruited via posters on the university campus (see Appendix A) placed in approved high traffic areas, as well as by word-of-mouth. The student researcher's temporary e-mail address was made available on the posters to potential participants; most university students own computers, or have access to

them on campus. After initial contact via computer was made (see Appendix B) by a potential participant, the researcher held a phone interview to ascertain individual eligibility (see Appendix C). Prescreening helped determine whether or not the individual met the eligibility criteria which included being of female gender, active student status, being 18 years of age or older, and having a specific offense to forgive due to sexual trauma.

Once eligibility was ascertained (per the stated criteria) and the potential participant made the decision to be a part of the research, she was asked whether or not she believed she had forgiven the perpetrator/s or not; at which point she was, by the very nature of her perceived forgiveness, a member of group “forgive” or group “unforgive”.

Confidentiality and identity protection were a priority. All e-mail was accessed on the researcher’s home computer, and all calls were held in privacy. The student researcher blocked her personal phone number when making any outgoing calls pertaining to the research study. Participants were able to leave confidential phone messages for the student researcher through the on-campus student counseling lab.

Participants were sent test packets, each containing a cover letter of instruction (see Appendix D), a Crisis Resource document (see Appendix E), a document of Informed Consent which had been approved by the Institutional Review Board (see Appendix F), the surveys (see Appendices G, H, and I), and a self-addressed, stamped return envelope. The letter of instruction asked participants to

return signed informed consent and completed surveys to the student researcher no less than seven days after receiving them. Upon completion of the study, the student researcher either e-mailed or phoned each individual for a debriefing (see Appendix D). Results of the study were later sent to participants upon request.

Internal Validity

Attempt to control internal validity began by choosing subjects randomly even though the sample was one of convenience, having been limited to the university campus. All subjects were female, aged 18 years or older, attended the same university, had experienced sexual trauma, and had either forgiven or not forgiven the perpetrator/s of a specific sexual offense. The student researcher provided all materials to the participants thus controlling for instrumentation threat. All participants took the same surveys in an effort to eliminate testing bias, and had contact only with the student researcher.

The range of sexual traumatic events included unwanted and/or forced kissing, touching, oral sex, anal sex, and sex with humans, animals, or objects perpetrated by a male or female within or outside of the biological family. Sexual trauma may have occurred in adolescence or adulthood, or both. Including this broad range of sexual acts and time frames could be seen as a limitation, but narrowing the criteria further would have eliminated many important test subjects. Barlow (2001) states that “it is now widely accepted that the type of trauma is less important than the trauma severity and the individual reactions and vulnerabilities” (p. 60).

Justification of Statistical Techniques or Method of Analysis Used

Data from the Offense Specific Forgiveness Measure and the Posttraumatic Stress Disorder Symptoms Self Inventory were analyzed according to methods appropriate for correlational research. Within group correlational indices were calculated for the quantitative variables using the Pearson Product-Moment Coefficient (Fraenkel, & Wallen, 2006). Data within and between groups was analyzed using the t-test for r .

Results

Within Group Data Analysis

Group “forgive” (see Table 1) yielded a strong comparative relationship ($r = -0.527$, $r^2 = 0.278$; $p > .05$, two-tailed), while the t score was insignificant (-0.878 ; $p < .05$, two-tailed). Group “unforgive” (see Table 1) also produced a strong comparative relationship ($r = 0.496$, $r^2 = 0.246$; $p < .05$, two-tailed), while the t score was not significant (0.902 ; $p < .05$, two-tailed). The combined raw group scores (see Table 2) resulted in no significant difference between group “forgive” ($M = 24.625$, $SD = 6.981$), and group “unforgive” ($M = 56.25$, $SD = 29.89$; $t = -1.566$, $p > .05$, two-tailed).

Between Group Data Analysis

An independent-samples t -test was conducted to compare (1) forgiveness and (2) PTSD symptoms scores between groups “forgive” and “unforgive”. There was a significant difference in forgiveness scores for groups “forgive” ($M = 28.75$, $SD = 6.057$), and “unforgive” ($M = 28.25$, $SD = 8.045$; $t = -4.482$, $p < .05$, two-tailed).

Table 1

Intercorrelations Within Groups (N = 8)

	Mean	SD	r	r ²	t	p
Group Forgive						
Forgiveness	28.75	6.057	-0.53	0.28	-0.88	0.47
PTSD	28.25	8.043				
Group Unforgive						
Forgiveness	20.5	5.172	0.5	0.25	0.9	0.46
PTSD	84.25	12.417				
Combined Groups						
Forgiveness	24.63	6.98	-0.54	0.29	-1.57	0.17
PTSD	56.25	29.89				

There was not a significant difference in PTSD symptoms scores for groups “forgive” ($M = 20.5$, $SD = 5.172$), and “unforgive” ($M = 84.25$, $SD = 12.417$, $t = .902$, $p < .05$, two-tailed).

Limitations

The small number of participants as well as the predominately white sample limited generalizations. In order to maintain anonymity, participants were not required to test as a group threatening internal validity through testing location. Another limitation was the intrapersonal perception of forgiveness. Even though definitions of forgiveness and unforgiveness were provided, personal point of view still affected the answers of each individual. Finally, innate personality traits and protective environmental factors that predict individual ability to forgive were not controlled. The main goal of this study was to focus on forgiveness and how it may correlate with PTSD symptoms.

Discussion

Results were carefully interpreted and were not used to predict or establish causation (Greene, & D’Oliveira, 2001) as they were not large enough to imply any relationship between the variables. Limited test participation may have reduced the strength of the results, yet interesting demographic data was acquired (see Table 2).

Participants who stated they had a religious affiliation had lower stated forgiveness, and scored about the same on the forgiveness survey as participants who stated that they did not have a religious affiliation. Those same individuals, though, had a higher rate of adult traumatization. Among these participants ($N=8$), it appears

Table 2

Raw Demographic Data (N = 8)

Variable	Group Forgive	Group Unforgive	Total
Age			
18 - 27	3	2	5
28 - 37	1	1	2
38 - 47	0	1	1
Education Level			
Undergraduate	0	2	2
Graduate	4	2	6
Ethnicity			
White/European	4	3	7
Asian American	0	1	1
Religious Affiliation			
Yes	1	3	4
No	3	1	4
Developmental Age at Occurrence			
Childhood/Adolescence	3	1	4
Adulthood	1	3	4
Family Occurrence			
Outside	3	4	7
Within (Incest)	1	0	1

that forgiveness may have been easier when sexual trauma was experienced in childhood or adolescence versus. This evidence is based on a small sample and warrants further study into the correlation between the ability to forgive and age.

The majority of perpetrators identified for this study were outside of the biological family rather than within. This researcher wonders how the shame of incest may influence study participation thus skewing test results by underrepresented that victim population. Future research may involve greater ethnic disparity and how forgiveness relates to race and culture. This may further lead to the discovery of how forgiveness or unforgiveness is learned, and the influence of culture or family versus educational institutions.

Group “forgive” data indicated an inverse relationship between the variables supporting the hypothesis, whereas group “unforgive” data analysis indicated a positive correlation between variables which did not support the hypothesis. Although it would be unwise to generalize these results beyond this study, there is an indication that forgiveness has some type of effect upon an individual’s development of PTSD, which warrants further investigation. Significant independent variable difference between groups supports research findings that forgiveness is a conscious, empowering choice. While studied for years, the results are only recently being utilized globally.

Implications

The strongest data compiled was descriptive statistics. First, it appears that age at the time of the trauma may be important. Working with adults who were

traumatized as children may require some uncovering of past events to fully realize forgiveness. Some individuals stated they were too young to remember the trauma, and thus, did not accord the same meaning to it that an adult might. Adults who have been sexually assaulted have a greater understanding of boundaries, appropriate behavior, societal mores, and are more aware of their feelings. Preconceived cognitions, expectations, self-worth, and safety may be influential at the time of a trauma, causing the individual to have an even greater awareness of pain and injustice.

The correlation and t-test results may indicate a clinical relationship between forgiveness and PTSD symptoms. The pattern of forgiveness indicated that consciously perceived forgiveness may be related to fewer trauma symptoms, whereas unconscious forgiveness is unable to reduce trauma symptoms. Certainly, promoting healthy forgiveness will not harm a client. Careful exploration of an individual's true measure of forgiveness may be a breakthrough to freedom from past trauma. Interpersonal forgiveness is a complex human endeavor worthy of increased research.

References

- American Psychological Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.
- American Psychological Association Online. (2005a). Exposure therapy helps PTSD victims overcome trauma's debilitating effects. In *Psychology Matters*. Retrieved October 5, 2005, from <http://www.psychologymatters.org/keane.html>
- American Psychological Association Online. (2005b). The effects of trauma do not have to last a lifetime. In *Psychology Matters*. Retrieved October 5, 2005 from <http://www.psychologymatters.org/ptsd.html>
- Anderson, N. T. (1990). *Steps to Freedom in Christ*. Eugene, Oregon: Harvest House Publishers.
- Arnold, D., Calhoun, L. G., Tedeschi, R., & Cann, A. (2005, Spring). Vicarious posttraumatic growth in psychotherapy. *Journal of Humanistic Psychology*, 45(2), 239-263.
- Barlow, D. H. (Ed.). (2001). *Clinical Handbook of Psychological Disorders*. (3rd ed.). New York: Guilford Press.
- Baskin, T. W., & Enright, R. D. (2004, Winter). Intervention studies on forgiveness: A meta-analysis. *Journal of Counseling & Development*, 82, 79-90.
- Berry, J. W., Worthington, E. L., O'Connor, L. E., Parrott, L., & Wade, N. (2005). Forgivingness, vengeful rumination, and affective traits. *Journal of Personality*, 73(1), 183-225.

- Bessette, A. (2006, May). Solutions for soldiers with PTSD. *Yoga International*, 89.
- Bogar, C. B., & Husle-Killacky, D. (2006, Summer). Resiliency determinants and resiliency processes among female adult survivors of childhood sexual abuse. *Journal of Counseling and Development*, 84(3), 318-327.
- Brown, R. P. (2004). Vengeance is mine: Narcissism, vengeance, and the tendency to forgive. *Journal of Research in Personality*, 38, 576-584.
- Chard, K. M. (2005). An evaluation of cognitive processing therapy for the treatment of posttraumatic stress disorder related to childhood sexual abuse. *Journal of Consulting and Clinical Psychology*, 73(5), 965-971.
- Cohen, A. (2003). Gestalt therapy and post-traumatic stress disorder: The irony and the challenge. *Gestalt Review*, 7(1), 42-55.
- Cohen, J. W. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Davidson, J. (2004). Use of benzodiazepines in social anxiety disorder, generalized anxiety disorder, and posttraumatic stress disorder. *Journal of Clinical Psychiatry*, 65(Suppl5), 29-33.
- Deykin, E. Y., & Buka, S. L. (1997). Prevalence and risk factors for posttraumatic stress disorder among chemically dependent adolescents. *American Journal of Psychiatry*, 154(6), 752-757.
- Enright, R. D. (2001). *Forgiveness is a choice: A step-by-step process for resolving anger and restoring hope*. Washington, DC: American Psychological Association.

- Everly, G. S., & Lating, J. M. (2004). Neurologic desensitization in the treatment of posttraumatic stress. *Personality-guided therapy for posttraumatic stress disorder*. Washington, DC: American Psychological Association.
- Farrow, T. F. D., Zheng, Y., Wilkinson, I. D., Spence, S. A., Deakin, J. F. W., Tarrier, N., Griffiths, P. D., & Woodruff, P. W. R. (2001, August). Investigating the functional anatomy of empathy and forgiveness. *NeuroReport*, *12*(11), 2433-2438.
- Farrow, T. F. D., Hunter, M. D., Wilkinson, I. D., Gouneea, C., Fawbert, D., Smith, R., Lee, K-H. , Mason, S., Spence, S. A., Woodruff, P. W. R. (2005). Quantifiable change in functional brain response to empathic and forgiveness judgments with resolution of posttraumatic stress disorder. *Psychiatry Research: Neuroimaging*, *140*, 45-53.
- Fitzgibbon, R., Enright, R., & O'Brien, T. F. (2004, July). Learning to forgive. *American School Board Journal*, *7*, 24-26.
- Foa, E. B., Dancu, C., Hembree, E., Jaycox, L., Meadow, E. A., & Street, G. P. (1999). A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. *Journal of Consulting and Clinical Psychology*, *67*(2), 194-200.
- Foa, E.B., Riggs, D. S., Dancu, C. V., and Rothbaum B. O. (1993). Reliability and validity of a brief instrument for assessing post-traumatic stress disorder. *Journal of Traumatic Stress*, *6*(4), 459-473.

- Forster, P. L., Schoenfeld, F. B., Marmar, C. R., & Lang A. J. (1995). Lithium for irritability in post-traumatic stress disorder. *Journal of Traumatic Stress, 8*(1), 143-149.
- Fraenkel, J. R., & Wallen, N. E. (Eds.). (2006). Correlational research. *How to design and evaluate research in education* (6th ed.) (pp. 334-368). New York: McGraw-Hill.
- Gall, T. L. (2006, July). Spirituality and coping with life stress among adult survivors of childhood sexual abuse. *Child Abuse and Neglect, 30*(7), 829-844.
- Greene, J., & D'Oliviera, M. (2001). Learning to use statistical tests in psychology (2nd ed.). Philadelphia: Open University Press.
- Hamblen, J. (2006). PTSD in children and adolescents. *United States Department of Veteran Affairs: National Center for PTSD*. Retrieved June 30, 2006 from http://www.ncptsd.va.gov/facts/specific/fs_children.html
- Hanretta, A. T., & Malak-Ahmedi, P. (2006, June). Combined use of ECT with duloxetine and olanzapine: A case report. *Journal of ECT, 22*(2), 139-141.
- Herman., J. L. (1992). *Trauma and recovery*. New York: Basic Books.
- House, A. S. (2006). Increasing the usability of cognitive processing therapy for survivors of child sexual abuse. *Journal of Child Sexual Abuse, 15*(1), 87-103.
- Johnson, D. R., & Lubin, H. (1997). Treatment preferences of Vietnam veterans with posttraumatic stress disorder. *Journal of Traumatic Stress, 10*(3), 391-403.

- Kaltman S., Krupnick J., Stockton P., Hooper L., & Green B. L. (2005). Psychological impact of types of sexual trauma among college women. *Journal of Traumatic Stress, 18*(5), 547-555.
- Kilpatrick, D. G., Ruggiero, K. J., Acierno, R., Saunders, B. E., Resnick, H. S., & Best, C. L. (2003). Violence and risk of PTSD, major depression, substance abuse/dependence, and comorbidity: Results from the national survey of adolescents. *Journal of Consulting and Clinical Psychology, 71*(4), 692-700.
- Kolb, L. (1984). The posttraumatic stress disorders of combat: A subgroup with a conditional and emotional response. *Military Medicine, 149*, 237-243.
- Lambert, M. (May, 2006). Aripiprazole in the management of post-traumatic stress disorder symptoms in returning Global War on Terrorism veterans. *International Clinical Pharmacology, 21*(3), 185-187.
- Leahy T., Pretty, G., & Tenenbaum, G. (2003). Childhood sexual abuse narratives in clinically and nonclinically distressed adult survivors. *Professional Psychology: Research and Practice, 34*(6), 657-665.
- Lev-Weisel, R. (2000). Quality of life in adult survivors of childhood sexual abuse who have undergone therapy. *Journal of Child Sexual Abuse, 9*(1), 1-13.
- Li, F. (2004). Tai chi and self rated quality of sleep and daytime sleepiness in older adults: A randomized controlled trial. *American Geriatric Society, 52*, 892-900.

- Lin, W. F., Mack, D., Enright, R. D., Krahn, D., Baskin, T. W. (2004). Effects of forgiveness therapy on anger, mood, and vulnerability. *Journal of Consulting and Clinical Psychology, 72*(6), 1114-1121.
- Linley, P. A., & Joseph, S. (2004, February). Positive change following trauma and adversity: A review. *Journal of Traumatic Stress, 17*(1), 11-21.
- Luskin, F. (1999, Summer). The art and science of forgiveness. *Stanford Medicine, 16*(4), 1-3.
- Luskin, F. (2003). *Forgive for good*. San Francisco: Harper.
- Luskin, F. (2005). The efficacy of forgiveness intervention in college age adults. *Humboldt Journal of Social Relations, 29*(2), 163-184.
- Marcus, S., Marquis, P., & Sakai, C. (2004). Three- and 6-month follow-up of EMDR treatment of PTSD in an HMO setting. *International Journal of Stress Management, 11*(3), 195-208.
- McDonaugh, A., McHugo, G., Sengupta, A., Demment, C. C., Schnurr, P. P., Friedman, M., Ford, J., Mueser, K., Fournier, D., & Descamps, M. (2005). Randomized trial of cognitive-behavioral therapy for chronic posttraumatic stress disorder in adult female survivors of childhood sexual abuse. *Journal of Consulting and Clinical Psychology, 73*(3), 515-524.
- Moritz, C. (2005). *Sexually based post traumatic stress disorder*. Unpublished doctoral dissertation, American Academy of Clinical Sexologists at Maimonides, Fort Lauderdale, FL.

- Mullen, P. & Fleming, J. (1998, Autumn). Long-term effects of child sexual abuse. In *Issues in Child Abuse Prevention, 9*.
- Neto, F., & Mullet, E. (2003). Personality, self-esteem, and self-construal as correlates of forgivingness. *European Journal of Personality, 18*, 15-30.
- Nidich, S. I., Schneider, R. H., Nidich, R. J., Foster, G., Sharma, H., Salerno, J., et al. (2005). Effect of Transcendental Meditation program on intellectual development in community dwelling older adults. *Journal of Social Behavior and Personality, 17*, 217-226.
- Nishith, P., Resick, P. A., & Griffin, M. G. (2002). Pattern of change in prolonged exposure and cognitive-processing therapy for female rape victims with posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 70*(4), 880-886.
- Noll, J. G., (2005). Forgiveness in people experiencing trauma. In E. L. Worthington, Jr. (Ed.), *Handbook of Forgiveness* (pp. 363-376). New York: Brunner-Routledge.
- Orcutt, H. K., Pickett, S., & Pope, E. B. (2005). Experiential avoidance and forgiveness as mediators in the relation between traumatic interpersonal events and posttraumatic stress disorder symptoms. *Journal of Social and Clinical Psychology, 24*(7), 1003-1029.
- O'Leary, E. & Nieuwstraten, I. M. (2001a). The exploration of memories in Gestalt reminiscence therapy. *Counseling Psychology Quarterly, 14*(2), 165-180.

- O'Leary, E. & Nieuwstraten, I. M. (2001b). Unfinished business in Gestalt reminiscence therapy: A discourse analytic study. *Counseling Psychology Quarterly*, 12(4), 395-412.
- O'Leary, E., Sheedy, G., O'Sullivan, K., & Thorensen, C. (2003). Cork older adult intervention project: Outcome of a Gestalt therapy group with older adults. *Counseling Psychology Quarterly*, 16(2), 131-143.
- Orsillo, S. (2006). Sexual assault against females. *United States Department of Veteran Affairs: National Center for PTSD*. Retrieved July 28, 2006 from http://www.nccptsd.va.gov/facts/specific/fs_female_sex_assault.html
- Owens, G. P., Pike, J. L., & Chard, K. M. (2001, Summer). Treatment effects of cognitive processing therapy on cognitive distortions of female child sexual abuse survivors. *Behavior Therapy*, 32(3), 413-425.
- Pallant, J. (2001). *SPSS Survival Manual*. Berkshire, UK: Open University Press.
- Pynoos, R. (1993). Traumatic stress and developmental psychopathology in children and adolescents. In *American Psychiatric Press Review of Psychiatry*, 12 (Oldham, J. M., Riba, M. B., & Tasman, A., Eds.) Arlington, VA: American Psychiatric Publishing.
- Ralat, J. (2006, March). Retrospective study highlights benefits of SSRI's in PTSD. *CNS Spectrums*, 11(3), 166.
- Reed, G. L. (2004). A forgiveness intervention with post-relationship psychologically abused women. *Dissertation Abstracts International*, 65(4-A), 1253.

- Reichert, E. (1994). Expressive group therapy with adult survivors of sexual abuse. *Family Therapy, 21*(2), 99-105.
- Resick, P. A., & Schnicke, M. K. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology, 60*(5), 748-756.
- Roberts, R. C. (1995). Forgiveness. *American Philosophical Quarterly, 32*, 289-306.
- Rossi, E. L. (2004). Stress-induced alternative gene splicing in mind-body medicine. *Advances in Mind-Body Medicine, 20*(2), 12-19. Retrieved October 6, 2005, from EBSCOhost database.
- Rothschild, B. (1998, February). Post-Traumatic Stress Disorder: Identification and diagnosis. *The Swiss Journal of Social Work, 3*.
- Russell, M. C. (2006, January). Treating combat-related stress disorders: A multiple case study utilizing eye movement desensitization and reprocessing (EMDR) with battlefield casualties from the Iraqi war. *Military Psychology, 18*(1), 1-18.
- Salamon, M. J. (2001). Holocaust survivors and secondary PTSD. *Clinical Gerontologist, 24*(3-4), 183-185.
- Shapiro, F., & Maxfield, L. (2002, August). Eye movement desensitization and reprocessing (EMDR): Information processing in the treatment of trauma. *Journal of Clinical Psychology, 58*(8), 933-946.

- Sherman, M. D., Sautter, F., Jackson, M. H., Lyons, J. A., Han, X. (2007). Domestic violence in veterans with posttraumatic stress disorder who seek couples therapy. *Journal of Marital & Family Therapy*, 32(4), 479-490.
- Slesnick, N., Bartle-Haring, S., & Gangamma, R. (2006, July). Predictors of substance use and family therapy outcome among physically and sexually abused runaway adolescents. *Journal of Marital & Family Therapy*, 32(3), 261-281.
- Snyder, C. R., & Heinze, L. S. (2005). Forgiveness as a mediator of the relationship between PTSD and hostility in survivors of childhood abuse. *Cognition and Emotion*, 19(3), 413-431.
- Spivak, B., Strous, R., Shaked, G., Shabash, E., Kotler, M., & Weizman, A. (April, 2006). Reboxetine versus fluvoxamine in the treatment of motor vehicle accident-related posttraumatic stress disorder: A double-blind, fixed dosaged, controlled trial. *Journal of Clinical Pharmacology*, 26(2), 152-156.
- Street, A., & Stafford, J. (2002). Military sexual trauma: Issues in caring for veterans. In *Iraq war clinicians guide* (pp. 66-69). Washington, DC: Department of Veteran Affairs, National Center for PTSD.
- Tedeschi, R. G., Park, C. L., & Calhoun, L. G. (1998). Post traumatic growth: Conceptual issues. In R. G. Tedeschi, C. L. Park, & L. G. Calhoun (Eds.), *Posttraumatic growth: positive changes in the aftermath of crisis* (pp.1-22). Mahwah, NJ: Lawrence Erlbaum.

- Tripodi, J. (2005). *Body memory recall treatment center*. Retrieved August 1, 2006, from <http://www.bodymemory.com>
- Valentin, P. V. (2000). Traumatic incident reduction I: traumatized women inmates: particulars of practice and research. *Journal of Offender Rehabilitation, 31*,(3-4), 1-15.
- van der Kolk, B. (1994). The body keeps the score: Memory and the evolving psychobiology of post traumatic stress. *Harvard Review of Psychiatry 1*(5), 253-265.
- van Liempt, S., Vermetten, E., Geuze, E. (2006). Pharmacotherapy for disordered sleep in post-traumatic stress disorder: A systematic review. *International Clinical Pharmacology, 21*(4), 193-202.
- VOW Foundation. (2006). *Post traumatic stress disorder (PTSD)*. Retrieved October 5, 2005 from <http://www.thevowfoundation.org/pages/585512/>
- Wade, N. G., & Worthington, E. L. (2003, Summer). Overcoming interpersonal offenses: Is forgiveness the only way to deal with unforgiveness? *Journal of Counseling & Development, 81*, 343-353.
- Waelde, L. C. (2004). Dissociation and meditation. *Journal of Trauma & Dissociation, 5*(2), 147-162.
- White, G. D. (1998). Trauma treatment training for Bosnian and Croatian mental health workers. *American Journal of Orthopsychiatry, 68*(1), 58-62.

- Witvliet, C. V. O., Phipps, K. A., Feldman, M. E., Beckham, J. C. (2004, June). Post traumatic mental and physical health correlates of forgiveness and religious coping in military veterans. *Journal of Traumatic Stress, 17*(3), 269-273.
- Witvliet, C. (2005, January). *Forgiveness and psychophysiology: Four experiments emphasizing emotion*. Paper presented at the 6th annual meeting of the Society for Personality and Social Psychology, New Orleans, LA.
- Woolf, H. B. (Ed.). (1980). *Webster's new collegiate dictionary*. Springfield, MA: Merriam-Webster.
- Worthington, E. L. (2001). *Five steps to forgiveness: The art and science of forgiving*. New York: Crown Publishers.

Seeking students to participate in a
Research study

Criteria include but may not be limited to:

- * female gender
- * 18 years of age or older
- *active student status at UW-Whitewater
- *experience of sexual trauma dating six months ago or before that time

All correspondence is confidential. Initial interviews will determine the eligibility of possible participants. Participation in this study is voluntary. Send a general e-mail of interest, your first name only, a phone number you can be reached at, and the best time to contact you to the address below. Unless otherwise indicated, a voice message may be left at the number you give. Please note that counseling is available to all victims of sexual trauma through UW-Whitewater Health and Counseling Services: 262-472-1305.

Contact: studyinquiry@hotmail.com

studyinquiry@hotmail.com	studyinquiry@hotmail.com	studyinquiry@hotmail.com	studyinquiry@hotmail.com	studyinquiry@hotmail.com	studyinquiry@hotmail.com	studyinquiry@hotmail.com	studyinquiry@hotmail.com	studyinquiry@hotmail.com	studyinquiry@hotmail.com	studyinquiry@hotmail.com	studyinquiry@hotmail.com	studyinquiry@hotmail.com	studyinquiry@hotmail.com
--	--	--	--	--	--	--	--	--	--	--	--	--	--

Appendix B

E-mail Script

Thank you for inquiring about the research study. The purpose of the study is to investigate a possible relationship between forgiveness or unforgiveness and the symptoms of stress resulting from sexual trauma. I would like the opportunity to speak with you via telephone concerning your possible participation. We will have a conversation during which I will briefly interview you, and you may interview me, asking any questions you like. I will answer you honestly, but may refrain from directly answering any questions I feel would bias your participation in the study. You may contact me at this e-mail address with your phone number and the best time to contact you. Please note that I may leave a voice message at your contact number unless you indicate otherwise. You may also leave a message with student counseling lab at UW-Whitewater. The number is: 262-472-2842. Do not give your name or any identifying information. Simply tell the person who answers that you would like to contact the student researcher, give your phone number, and the best time to contact you. I will return your call as soon as possible.

Appendix C

Telephone Script

Thank you for your call. As indicated on the poster at UW-Whitewater, this study requires female participants aged eighteen or older, attending UW-Whitewater, who have experienced sexual trauma at least six months ago or before that time. Do you believe that you meet those criteria?

One aspect of this study requires you to identify a specific sexual trauma that has occurred in your life, then answer a number of general questions about that experience. There is a risk that participation in this study may restimulate trauma. If participation causes you distress or triggers memories that you do not want, you may discontinue participation right now or at any point in the study. Whether or not you participate in this study, free counseling is available to victims of sexual trauma through UW-Whitewater Health and Counseling Services. They can be reached at 262-472-1305. The UW-Whitewater 24-Hour Sexual Assault Response Team Hotline number is 262-472-1060. If you feel confident that you would not be unduly upset by the trauma memory we can continue.

It is the purpose of this study to investigate a possible relationship between forgiveness or unforgiveness and the symptoms of stress resulting from sexual trauma. The definition of sexual trauma that will be used in this study is as follows: any unwanted sexual activity perpetrated by a male or female individual/s within or outside of the biological family, including kissing, touching, forced masturbation, oral

sex, anal sex, and forced sexual activity with humans, animals, or objects. Without going into any detail or identifying any individual/s, can you answer “yes” to having experienced sexual trauma?

Another aspect of this study pertains to forgiveness and unforgiveness. The definition of forgiveness used for the purposes of this study is as follows: to give up resentment against an injustice or freely release an individual/s from debt, replacement of unforgiving emotions with positive ones, and/or a wish to move on with life. The definition of unforgiveness used for the purposes of this study is as follows: an unwillingness or inability to forgive unresolved hurt, holding the perpetrator/s responsible, wanting revenge, feeling hatred or anger, ruminating about the event, prolonged blame, or continued grief. When you think about the specific sexual trauma that you have identified, do you feel that you have forgiven the perpetrator/s?

You will be asked to read a cover letter, read and sign an Informed Consent document, and fill out surveys pertaining to general demographics, forgiveness/unforgiveness, and trauma. Is this study something that you would like to be involved in? Please take some time to think about your answer to that question. What would be the best choice for you at this time? All participation is completely voluntary. Should you decide not to participate, I will understand. Any time during the study you may withdraw your participation. Please think carefully about your answer. Should you decide to participate I will ask you to read and sign an informed consent document. I suggest that the two of us think about this decision overnight.

May I contact you via e-mail or phone tomorrow? At that time we can discuss our decisions.

Cover Letter

I am voluntarily participating in a research study that is being performed by Sandra Johnston, a graduate student in the Counseling Education program at UW-Whitewater, Whitewater, Wisconsin. The student researcher has discussed the potential risks of participating in the study with me. I have been given the opportunity to ask questions, have received satisfying answers, and give my consent to be a participant. I have already given my verbal informed consent and/or will sign the enclosed Informed Consent document before participating in this study. I understand that completing the surveys indicates that I am at least eighteen years of age and give my informed consent to participate in this study. I will complete the surveys and return them along with the signed consent form to the student researcher within seven days of receiving them.

Any questions about the study or surveys may be addressed to:

Sandra Johnston

studyinquiry@hotmail.com

262-472-2842 (student counseling lab)

Any questions I have regarding my rights as a research subject or my treatment may be addressed to:

Denise Ehlen, IRB Administrator

Research and Sponsored Programs

University of Wisconsin-Whitewater

800 West Main Street

2023 Roseman

Whitewater, WI 53190

Telephone: 262-472-5212

E-Mail: ehlend@uww.edu

24-Hour Crisis Resources

Dane County Domestic Abuse Intervention: 608-251-4445

Dane County Rape Crisis Center: 608-251-7273

Milwaukee County:

The Counseling Center of Milwaukee: 414-271-9523

Sexual Assault Treatment Center: 414-219-5555

The Healing Center: 414-671-4325

Racine Sexual Assault Services: 262-637-7233

Rock County (Beloit) Sexual Assault Recover Program (Crisis): 866-666-4576

Walworth County Association for Prevention of Family Violence: 262-723-4653

UW-Whitewater:

Sexual Assault Response Team 24-Hour Phone Line: 262-472-1060

24-Hour Crisis Help Line: 262-741-3200

24-Hour Campus & Whitewater Police Services: 262-473-0555

24-Hour Emergency Help: 911

Other Crisis Resources (Not 24-Hour)

University Counseling Services: 262-472-1305

Wisconsin Victim Resource Center: 1-800-446-6564 or 608-264-9497

Informed Consent Form

I am voluntarily participating in a research study that is being performed by Sandra Johnston, a graduate student in the Counseling Education program at UW-Whitewater, Whitewater, Wisconsin. The student researcher has discussed the potential benefits and possible risks of participating in the study, as described below. I have been given the opportunity to ask questions, have received satisfying answers, and give my consent to be a participant.

*I am a female.

*I am at least eighteen years of age.

*I have experienced sexual trauma at least six months ago or before that time.

*I understand that my identity will be protected from unauthorized access.

*I understand that I may seek counseling services pertaining to my experiences through UW-Whitewater Health and Counseling Services at 262-472-1305.

*I am willing to answer the three surveys in this study honestly and to best of my ability.

*I will direct any questions I have about the surveys or the study to the student researcher.

*I will return those surveys to the student researcher within one week of receiving them.

*I am free to revoke my consent to participate in the study at any time.

*I understand that I will be asked to think of a specific offense from my past and realize that the memory may cause me to feel negative emotions.

*I understand that the student researcher does not want to know about the specific event, any details about what happened, or the identities of other individuals

involved.

*I understand that the student researcher is not a licensed professional counselor and will not diagnose, prescribe, or treat specific conditions.

*I understand that I may seek professional counseling services apart from this study.

*I understand that participation in this study may provoke future research and greater help for individuals who are trauma survivors.

*I understand that I will not be personally identified, and that all correspondence or contact with the student researcher is confidential to the extent provided by law.

*I understand that my survey answers are anonymous, and that my name will not be used in any reports or presentations derived for this study.

*I understand that I may contact IRB administration if I have any questions that cannot be answered by the student researcher.

*I understand that significant results of the study will be sent to me upon request.

Signature of informed consent

Date signed

Demographics Survey: (Johnston, S.)

1. What is your current age?

- | | |
|---------------|--------------------|
| _____ 12 - 17 | _____ 38-47 |
| _____ 18 - 27 | _____ 48-57 |
| _____ 28-37 | _____ 58 and older |

2. What is your birth date? _____

3. What is your occupational field?

- | | |
|---------------------------|-----------------------------|
| _____ Healthcare | _____ Business/Management |
| _____ Technical | _____ Administrative |
| _____ Science/Engineering | _____ Sales |
| _____ Service | _____ Computer Professional |
| _____ Child Care | _____ Human/Social Services |
| _____ Graduate Student | _____ Undergraduate Student |

4. What is your ethnic background?

- | | |
|------------------------|------------------------------------|
| _____ White/European | _____ Mediterranean/Middle Eastern |
| _____ Hispanic | _____ Native American/Inuit |
| _____ African American | _____ Other Please specify below |
| _____ Asian American | _____ |

5. Do you have a religious affiliation?

- | | |
|-----------|----------|
| _____ Yes | _____ No |
|-----------|----------|

6. What was the exact or approximate date of the trauma?

7. At the time were you an _____ Adolescent _____ Adult

60

8. What was trauma: _____ Incest _____ Rape (non-family)

Offense-Specific Forgiveness Measure (Brown, R., & Phillips, A.)

Directions: Think of a specific sexual trauma you have experienced, and a person you could forgive from the incident. Use the following scale to rate your agreement/disagreement with each statement below.

	Strongly disagree		Agree Somewhat		Strongly agree
	1	2	3	4	5
1. I have forgiven this person.	1	2	3	4	5 6 7
2. I feel angry toward this person.	1	2	3	4	5 6 7
3. Even though his/her actions hurt me, I do not feel ill-will toward him/her.	1	2	3	4	5 6 7
4. I dislike this person.	1	2	3	4	5 6 7
5. I feel warmly toward this person.	1	2	3	4	5 6 7
6. I hope this person gets what's coming to them for what they did to me.	1	2	3	4	5 6 7
7. If I saw this person again, I would try to avoid interacting with him/her.	1	2	3	4	5 6 7

Posttraumatic Stress Disorder Symptoms Self Inventory

Directions: Rate the symptoms you have experienced in the last month and how much they have affected you, by writing the corresponding number from the scale below.

Not at all	Hardly at all	Moderately	Quite a bit	Extremely					
1	2	3	4	5	6	7	8	9	10

- 1) Intrusive, recurrent memories, thoughts, or images of the traumatic event/s _____
- 2) Disturbing dreams of the traumatic event/s (or similar event/s) _____
- 3) A sense of reliving the experience (or flashbacks) _____
- 4) Intense psychological distress at reminders of the traumatic event/s _____
- 5) Physical reaction/distress at reminders of the traumatic event/s _____
- 6) Avoiding thoughts, feelings, or conversations about the traumatic event/s _____
- 7) Avoiding people, places, and/or activities that are reminders of the event/s _____
- 8) Inability remembering some important aspects of the traumatic event/s _____
- 9) Markedly diminished interest or participation in activities you used to enjoy _____
- 10) Feeling distant or cut off from others _____
- 11) Feeling emotionally numb or being unable to feel love for those close to you _____
- 12) Sense that your future will somehow be cut short _____
- 13) Difficulty in falling or staying asleep _____
- 14) Irritability or outbursts of anger _____
- 15) Difficulty concentrating _____
- 16) Hypervigilance (over watchful, protective, worried) _____

17) Exaggerated startle response (feeling jumpy) _____

Thank you for participating in the study. I applaud your courage, and hope that the results will be part of the body of knowledge that helps survivors of sexual trauma. The purpose of my study was to look for a correlation between the ability to forgive and how that may or may not affect the symptoms of posttraumatic stress disorder, although it was not my intent to diagnose you with any condition or disorder. If researchers discover a positive link between forgiveness and fewer symptoms of posttraumatic stress, they may investigate a more formal therapy for helping individuals who survive trauma, such as you. I will share the results of the data analysis upon your request.