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The Effectiveness of a Forgiveness Intervention on Mental Health in Bereaved Parents – a Pilot Study

Lucia Záhorcová, Robert Enright, Peter Halama

Abstract

The aim of this pilot study was to test the effectiveness of an educational forgiveness intervention on mental health in grieving parents. 21 grieving parents were randomly assigned to the experimental group (in which the educational forgiveness intervention occurred) and to the control group (in which a psycho-education grief intervention with a humanistic approach took place). Participants in both groups completed 12 individual hourly sessions for three months. The results showed that participants in the experimental group achieved statistically greater improvement in forgiveness towards others, self-forgiveness, and a greater decrease in depression in the post-test and follow-up test; a greater decrease in anxiety and anger in the post-test; as well as higher improvement in the post-traumatic growth in the follow-up test, four months after the end of the intervention. We highlight the potential benefits of using a forgiveness intervention with bereaved parents.

Keywords: bereaved parents; loss of a child; forgiveness; intervention; grief

Introduction

The death of a child is a one of the most devastating and traumatic experiences a parent can endure. Previous research studies showed significant negative consequences of child loss for parents, such as high distress, complicated grief, depression, anxiety, low self-esteem, as well as the loss of life's meaningfulness (e.g. Doka, 2016; Floyd et al., 2013; Murphy et al., 2003; Rogers et al., 2008). Anger and guilt are frequent and problematic emotional reactions after the loss of a child (Anderson, 2010). Bereaved parents may experience anger toward a partner, doctor, a person responsible for the death, a person insensitive to their reactions to the loss, or toward themselves (Anderson, 2010; Martinčeková & Klatt, 2017). While anger is a natural reaction to the loss, it can become maladaptive when it lasts too long, is too intensive, leads to self-blame or social isolation of the person (Doka, 2016). Moreover, unresolved anger in grieving individuals is related to complicated grief (Ronel & Lebel, 2006).

One of the adaptive coping strategies to alleviate anger is forgiveness (Enright & Fitzgibbons, 2015). Forgiveness has been defined as a process, which includes gradual decrease in negative reactions towards an offender and the gradual development of positive emotions, thoughts, and behaviors toward that person. To forgive also means to offer empathy, compassion, and benevolence toward an offender (Enright, 2001; Worthington, 2005). To date, forgiveness intervention studies have shown positive effects on alleviating depression, anxiety, anger, as well as increasing self-esteem and finding meaning in suffering in various populations (e.g. Akhtar & Barlow, 2018; Enright & Fitzgibbons, 2015; Reed & Enright, 2006; Wade et al., 2014). While forgiveness may be important, it often is challenging for grieving individuals (Hourigan, 2016; Oglesby, 2013)

Quantitative studies of forgiveness in the context of bereavement are concerned mainly with the relationship of forgiveness with grief and with adaptive coping with the loss. The results of studies show that higher forgiveness is related to lower grief (Currier et al., 2013; Jacinto, 2010; Martinčeková & Klatt, 2017), depression, anxiety, anger (Záhorcová et al., 2020), as well as adaptive coping, meaning reconstruction, and post-traumatic growth (Currier et al., 2013; Martinčeková & Klatt, 2017; Záhorcová et al., 2020). However, because of the correlational nature of the studies, it is not possible to conclude that forgiveness causes the alleviation of grief or improves mental health and adaptive coping after the loss.

Qualitative studies in this area have tried to understand the process of forgiveness and motives for forgiveness or unforgiveness in bereaved individuals. Ronel and Lebel (2006) studied parents whose child was murdered during war. For most of the parents, forgiveness was unimaginable, even years after the loss, and these parents experienced prolonged grief and pain. The authors assumed that their inability to forgive the perpetrator was mainly related to negative adaptation to the child's loss even years after the loss. Similarly, Qglesby (2013) conducted a qualitative study with parents who have lost their child because of a murder and forgave their perpetrator. At the beginning, forgiveness was unthinkable for them, but later they perceived it as a gift they give to themselves in order to heal and to improve their health. Most of the participants forgave the perpetrator even despite the absence of an apology. Hourigan (2016) studied individuals who lost to murder a person close to them. The participants forgave their perpetrator or would forgive if they had a chance. Individuals described that forgiveness relieved their constant rumination about the perpetrator and the event and led to healing. Similar positive effects such as reduction in anger, hate, and obsessive ruminations about the perpetrator and event were described in bereaved individuals whose close family member was murdered (Barrile, 2015).

There are no true experimental studies, which include a randomized control group, in the published literature. We are aware of two quasi-experimental studies that had an experimental group only, one-week forgiveness programs in five grieving mothers (Luskin & Bland, 2000) and 17 grieving individuals with various losses (Luskin & Bland, 2001) showing positive consequences of the forgiveness program for reducing depression, anger, and symptoms of distress. Participants of these programs also experienced higher forgiveness and higher positive expectations for the future. In these two short-term studies, however, we cannot examine the significant effect of the forgiveness intervention compared to alternative treatments, given that these studies did not have a control group.

Taken together, preliminary results of quantitative, qualitative, and experimental studies suggest that forgiveness may have an important role in improving mental health and adjustment to the loss. In this study, we extend the previous literature by testing the effect of an educational forgiveness intervention on mental health compared with a psycho-education grief intervention with bereaved parents. Based on the previous forgiveness intervention studies (Baskin & Enright, 2004; Wade et al., 2014) and frequently reported negative consequences from the loss of a child (Floyd et al., 2013; Murphy et al., 2003; Rahman et al., 2018; Rogers et al., 2008) we decided to measure the effects of a forgiveness intervention on the following variables: forgiveness toward others, normative and complicated grief, self-forgiveness, depression, anxiety, anger; self-esteem, hope, meaning in life, and post-traumatic growth.

Method

Participants

Participants were recruited through national bereavement organizations (Compassionate Friends, Open to Hope foundation). Personnel in these groups shared a research flyer through their websites and contacted their members on their email addresses. Individuals who were

interested in participating in the study contacted us through email or by a phone call. The participation was voluntary and there was no fee for participation in the study. The selection criteria for participation in the study were having lost a child, having experienced a deep hurt from another person related to the loss of a child (e.g. a partner or a family member who did not provide an appropriate support, a loved one who had insensitive remarks, a doctor for perceived insufficient medical care), and a minimum elapsed-time since the loss as one year. A criterion for the child's age was 3 to 30 years because most of the previous interventions for bereaved parents were conducted with parents bereaved by perinatal loss and loss of a child up to 3 years old (Endo et al., 2015) and we expected a deeper relationship of parents with their older children. Also, participants could not take antidepressants during the study period since depression was measured in the post-test and in the follow-up test.

Twenty six participants took part in the pre-test. The sample size was chosen based on previous forgiveness intervention studies (Wade et al., 2014), where sample sizes of 10-14 participants produced strong effects for forgiveness and other dependent variables of mental health. Twenty two individuals who met the criteria were chosen to participate in the study and randomly assigned into the experimental and control group (with the use of www.randomlists.com). One participant dropped out of the study after the third session without stating the reason. The final research sample consisted of 21 bereaved parents ranged in age from 31 to 65 years ($M = 56$; $SD = 8.75$), 20 were women and 1 was a man. All participants were European Americans. Twelve participants were married, eight were divorced and one was single. The mean length of time elapsed since the loss was five years ($SD = 4.68$). The average age of a child at death was 23 years ($SD = 8.49$) and most of the participants had other living children ($n = 16$). Most of the parents ($n = 18$) had experienced a sudden loss (e.g. accident, murder) and in three cases the loss was anticipated (e.g. cancer).

Twenty one participants filled-out the questionnaire in the pre-test and 20 in the follow-up test, four months after the interventions ended.

Procedure

The design of the intervention procedure was based on previous intervention studies (Baskin & Enright, 2004; Wade et al., 2014). After giving informed consent, participants were randomly assigned to either an experimental group with forgiveness intervention (n = 11) or a control group with a psycho-education grief intervention emphasizing a humanistic approach (n = 11). Individuals could choose between participating in an in-person or Skype video call intervention. Due to different geographical locations, all participants preferred the Skype video intervention. Individuals participated in 12 individual sessions which were provided on a regular bases each week for one hour. The sessions were facilitated by a doctoral candidate in psychology, who has obtained trainings in grief counseling and forgiveness intervention, under the supervision of Dr. Robert Enright, who is a founder and an expert in forgiveness interventions. Participants were tested at the beginning of the intervention (pre-test), at the end of the intervention (post-test) and 12 weeks later (follow-up test).

In the experimental group, an educational forgiveness intervention was used. This intervention was based on the manual of Enright (2001), Forgiveness is a choice, which was also used in previous forgiveness intervention studies (Baskin & Enright, 2004; Reed & Enright, 2006; Wade et al., 2014). The sessions were based on the four phases of the forgiveness intervention process: a) uncovering phase, in which the participants work on uncovering anger, shame, guilt, and others emotions related to the hurt, as well as examining their defense mechanisms; b) decision phase, in which forgiveness is defined and its distinction with similar concepts such as reconciliation is made; the participants examine previous strategies to cope with the hurt and their effectiveness; and make a commitment to

work on forgiving; c) work phase, in which participants explore the past of an offender (their personal, family history, life at the time of the event), work on building empathy and compassion; and d) deepening phase, in which the mutual work is concentrated on finding meaning in suffering and considering new meaning in life. Each participant was given a free copy of the manual (Enright, 2001). For each session, an individual was supposed to read a selected chapter from the book and at the following session, the chapter was discussed. All participants were expected to have a journal in which they worked on the tasks from the manual, and these were later discussed at the subsequent session. The examples of the tasks are as following: reflection about the offender's past, about the consequences of the hurt, or about previous coping strategies. Participants also wrote a letter, in which they described the consequences of the hurt for their life, and at the end of the intervention they wrote a letter for the offender about their forgiveness journey.

The participants in the control group received a psycho-educational grief intervention with humanistic approach. The grief psycho-education was chosen in order to match as closely as possible with the basic elements of the forgiveness education format. Moreover, previous grief interventions also used the psycho-educational format (Endo et al., 2015; Raitio et al., 2015). Participants in the control group also were given a free copy of the book, Beyond tears: Living after losing a child (Mitchell et al., 2009). For each week, a chapter of the book was assigned, which was discussed at the subsequent session. The book contains stories of nine mothers who, by mutual sharing, discuss the topics relevant to the loss of a child. The discussed topics were, for example: acute grief after the loss; coping strategies; gratitude, love and laughter after the loss; continuing bonds and meeting with the deceased child; intimacy; coping with the anniversaries, birthdays, and holidays; grief in fathers and siblings, and partner relationship after the loss. The common aspects of the experiences of bereaved parents and normalization of grieving were emphasized. Topics discussed did not

include forgiveness. Participants also worked on tasks which are frequently used in the support for grieving (Neimeyer, 2012) and they were chosen based on the completed grief counseling courses of a doctoral candidate, e.g. writing a letter to the deceased child, writing a diary, creating a memory can in order to help build positive memories; and sharing and discussing the child's photographs and items. Moreover, elements of the humanistic approach were used, focusing on empathic listening, congruence, unconditional appreciation and acceptance (Rogers & Webb, 2013).

This study was approved by the Institutional Review Board at the University of Wisconsin-Madison and all participants signed a written consent form and sent us a scanned copy.

Measures

The survey package included a short demographic survey (sex, age, marital status); questions regarding the death of the child (including the cause of death, length of time since death, age of the child, number of deceased and living children); and ten standardized questionnaires to measure outcome variables.

Forgiveness. To measure forgiveness, we used a short version of the original Enright Forgiveness Inventory (EFI, Subkoviak et al., 1995), EFI-30 (Enright et al., under review). The participants were asked to answer questions regarding a person who hurt them deeply and unfairly in the context of their loss. The EFI-30 has three subscales: affective (e.g., *"I feel unloving toward him/her"*), behavioral (e.g., *"I would show him/her friendship"*), and cognitive (e.g., *"I think he or she is a bad person"*), each consisting of 10 items (half positive and half negative), and rated on a 6-point scale (1 = strongly disagree, 6 = strongly agree). The questionnaire also consists of an independent scale to assess pseudo-forgiveness which is comprised of 5 items (e.g. *"There really was no problem now that I think about it"*) rated on

a 6-point Likert scale. If a participant scores 20 or higher on this pseudo-forgiveness scale, the participant's data was eliminated from the sample because the person may be excusing the behavior, thus not providing a valid assessment of forgiveness. None of our participants met the criteria for pseudo-forgiveness. The internal consistency for the EFI-30 in our study was high, α = 0.98 (pre-test), α = 0.98 (post-test), and α = 0.98 (follow-up test).

Grief. To assess the intensity of normative grief, we used the Core Bereavement Items (CBI; Burnett et al., 1997) which consists of 17 items. The scale measures thoughts (e.g. *"Do you think about "x"?*) and emotional reactions (e.g. *"Do reminders of x cause you to feel loss of enjoyment"?*) after the loss (Holland et al., 2013). Participants rate the items on a 4-point Likert scale (0 = never, 3 continuously/always). The internal consistency for the CBI was α = 0.89 (pre-test), α = 0.93 (post-test), and α = 0.94 (follow-up test).

Self-forgiveness. To assess self-forgiveness, we used The Enright Self-forgiveness Inventory (ESFI) which was based on the original EFI (Subkoviak et al., 1995). The participants were asked to answer questions regarding the hurt they caused in the context of the loss of their child. The scale consists of two subscales, affective (e.g. ,*"I feel unloving toward myself"*) and cognitive (e.g. *"I think I am a good person"*). Each consists of 10 items, half positive and half negative. Items are rated on a 6-point Likert scale (1 = strongly disagree, 6 = strongly agree). Similar to the EFI-30, we included five items for measuring pseudo-self-forgiveness, but none of our participants met the criteria for pseudo-self-forgiveness. The internal consistency for the ESFI in our study was high α = 0.97 (pre-test), α = 0.95 (post-test), and α = 0.95 (follow-up test).

Anger. Anxiety. Depression. For measuring anger, anxiety and depression, we used three short forms (SF) of The Patient-Reported Outcome Measurement Information System (PROMIS) developed by the National Institute of Health. The PROMIS scales are based on Item Response Theory. They are reliable and valid measures suitable for research studies and

clinical trials, given seven-day time frame on these scales is sensitive to change (Pilkonis et al., 2011). Specifically, PROMIS Anger SF 5a measures angry mood (irritability, frustration), negative social cognitions (interpersonal sensitivity, envy, disagreeableness), and efforts to control anger during the last seven days. The scale consists of five items rated on a five-point Likert scale (1 = never, 5 = always), e.g., *"I was irritated more than people knew."* The internal consistency was strong for PROMIS – Anger 5a: α = 0.92 (pre-test), α = 0.92 (post-test), and α = 0.96 (follow-up test). PROMIS Anxiety SF 7a assesses symptoms of anxiety, such as fear (e.g., feelings of panic), anxious misery (e.g., dread), and hyperarousal (e.g., tension). Participant rate seven items (e.g., *"I felt tense"*) on a 5-point Likert scale (1 = never, 5 = always) with respect to the past seven days. Cronbach's alpha for PROMIS Anxiety SF 7a in our sample was: α = 0.94 (pre-test), α = 0.94 (post-test), and α = 0.98 (follow-up test). The PROMIS depression SF 8b consists of 8 items that primarily focus on negative mood and negative views of the self. The scale consists of eight items (e.g., *"I felt that I had nothing to look forward to"*) rated on a 5-point Likert scale (1 = never, 5 = always). Cronbach's alpha for PROMIS Depression SF 8b was: α = 0.88 (pre-test), α = 0.92 (post-test), and α = 0.94 (follow-up test).

Self-esteem. Self-esteem was measured with the Rosenberg Self-esteem Inventory (RSEI; Rosenberg, 1965). Participant assesses 10 items (e.g. *"I feel that I have a number of good qualities"*) on a 5-point Likert scale (1 = absolutely disagree, 5 = absolutely agree). The internal consistency of RSEI was very good, α = 0.86 (pre-test), α = 0.91 (post-test), and α = 0.89 (follow-up test).

Hope. Hope was measured with the Adult Hope Scale (AHS; Snyder et al., 1991). AHS consists of 12 items measured on an 8-point Likert scale (1 = definitely false, 8 = definitely true). The scale has two subscales: agency, which consists of four items assessing goal-directed thinking (e.g. *"I energically pursue my goals"*), and pathways, consisting of four

items which measure planning to meet goals (e.g., *"I can think of many ways to get out of a jam"*). Four items are used as fillers (e.g., *"I worry about my health"*). The reliability of AHS was very good, $\alpha = 0.84$ (pre-test), $\alpha = 0.85$ (post-test), and $\alpha = 0.95$ (follow-up test).

Meaning in Life. To assess life's meaningfulness, we used the subscale, the presence of meaning in life, from The Meaning in Life Questionnaire (MLQ; Steger et al., 2006). The subscale consists of five items (e.g., *"My life has a clear sense of purpose"*). Items are assessed on a 7-point Likert scale (1 = absolutely untrue, 7 = absolutely true). The reliability of MLQ was very good, $\alpha = 0.86$ (pre-test), $\alpha = 0.92$ (post-test), and $\alpha = 0.90$ (follow-up test).

Post-traumatic Growth. To assess post-traumatic growth, the The Stress-Related Growth Scale-short form (SRGSsf; Cohen et al., 1998) was used. SRGSsf consists of 15 items (e.g. *"I learned to communicate more honestly with others."*) and was adapted from the original 50-item SRGS (Park, Cohen, Murch, 1996). The items are rated on a 3-point Likert scale (0 = not at all, 1 = somewhat, 3 = a great deal). The SRGSsf showed a good reliability, $\alpha = 0.90$ (pre-test), $\alpha = 0.90$ (post-test), and $\alpha = 0.86$ (follow-up test).

Data analyses

To test our hypotheses, we used analysis of covariance, ANCOVA, because of its advantages for our research design. First, ANCOVA can adjust the post-test and follow-up scores based on the pre-test score ("estimates" score). This is especially important for randomized studies with small samples, in which differences may occur even despite the randomization and ANCOVA helps to eliminate these differences (Rausch et al., 2003). Second, ANCOVA examines responses of all participants in a group. Third, ANCOVA can work with non-normal distributions in which it is possible to apply bootstrapping (Field, 2009). Therefore, ANCOVA is a robust statistical method for data analysis in experiments (Rausch et al., 2003), especially with small sample sizes.

For testing our main research goal we used ANCOVA with each pre-test variable as a covariant, post-test score or follow-up score as a dependent variable and the fixed factor of group. Given that multiple tests were conducted, the *p* value was edited with the Bonferroni correction. We performed the bootstrapping procedure with 1,000 samples which makes it possible to analyze the data even with a non-normal distribution and it increases the reliability of the model (Field, 2009). These results are presented in Table 1.

Table 1 ANCOVA for all the dependent variables in the post-test and follow-up test

	From pre-test to post-test			**From pre-test to follow-up test**		
Variable	***F*(1, 18)**	***p***	***η2***	***F*(1, 17)**	***p***	***η2***
Forgiveness	4.81	**0.042***	0.21	4.90	**0.041***	0.24
Depression	8.61	**0.009****	0.32	7.87	**0.012***	0.32
Anxiety	6.77	**0.018***	0.27	3.59	0.075	0.17
Anger	10.68	**0.014***	0.37	1.86	0.191	0.10
Normative grief	0.03	0.855	0.00	0.08	0.788	0.00
Self-esteem	1.87	0.188	0.09	3.99	0.062	0.19
Hope	1.75	0.203	0.09	1.06	0.319	0.06
Self-forgiveness	8.69	**0.009****	0.33	6.52	**0.021***	0.28
Meaning in life	4.20	0.055	0.19	0.00	0.984	0.00
Post-traumatic growth	0.66	0.428	0.04	5.36	**0.033***	0.24

Note. Two-side significance test, *$p \leq 0.05$; **$p \leq 0.01$; $\eta 2$ = partial eta squared

Besides the statistical analysis, we also measured clinical significance of the intervention with the Reliable Change Index (RCI; Jacobson & Truax, 1991). The RCI is measured as the difference between pre-test and post-test (follow-up test) scores divided by the standard error of the difference between the two scores. When this coefficient is higher than 1.96, it is unlikely that the post-test (follow-up test) score is caused by measurement error and the change is considered reliable. Besides this criterion, we also used the method described by Samstag et al. (1998) which classifies "improvement" in cases when the RCI score is lower than 1.96 and higher than 0.5. These results are presented in Table 2.

Table 2 Number of participants fulfilling the RCI criteria and improvement criteria

From pre-test to post-test

	Experimental group (n = 11)		**Control group (n = 10)**	
Variable	RCI > 1.96 *n*	1,96 ≥ RCI ≥ 0.50 *n*	RCI > 1.96 *n*	1.96 ≥ RCI ≥ 0.50 *n*
Forgiveness	7	1	2	**4**
Depression	10	1	5	**4**
Anxiety	8	3	4	4
Anger	8	2	3	2
Normative grief	4	6	3	4
Self-esteem	5	6	4	2
Hope	0	7	4	5
Self-forgiveness	5	1	3	1

Meaning in life	1	8	1	3
Post-traumatic growth	1	8	4	4
Overall frequency	51 (42 %)	48 (40 %)	36 (33 %)	37 (34 %)

From pre-test to follow-up test

	Experimental group (n = 11)		**Control group (n = 9)**	
	RCI > 1.96	1,96 ≥ RCI ≥ 0.50	RCI > 1.96	1.96 ≥ RCI ≥ 0.50
	n	*n*	*n*	*n*
Forgiveness	5	3	0	4
Depression	9	0	3	1
Anxiety	5	4	4	1
Anger	7	2	2	2
Normative grief	2	2	2	3
Self-esteem	8	3	3	1
Hope	6	2	4	1
Self-forgiveness	6	0	3	0
Meaning in life	1	9	4	4
Post-traumatic growth	3	2	1	6
Overall frequency	53 (44 %)	34 (28 %)	29 (29 %)	28 (28 %)

Note. Two-side significance test, *$p \leq 0.05$; **$p \leq 0.01$; $\eta 2$ = partial eta squared

Results

From the collected data in the experimental and control groups we calculated means and standard deviations, which are presented in Table 3 and Table 4.

Table 3 Descriptive analysis of dependent variables in the experimental group

Experimental group	**Pre-test (n=11)**		**Post-test (n=11)**		**Follow-up test (n=11)**	
	M	***SD***	***M***	***SD***	***M***	***SD***
Forgiveness	71.73	3.71	106.00	48.16	102.27	45.68
Depression	22.27	6.36	13.18	5.60	15.64	5.22
Anxiety	19.45	7.66	13.00	5.87	14.18	8.86
Anger	13.09	4.53	8.45	3.56	10.27	5.31
Normative grief	47.55	9.10	42.36	10.11	44.27	10.34
Self-esteem	29.82	5.76	35.09	5.47	35.27	4.17
Hope	43.82	8.99	47.82	7.95	52.45	7.69
Self-forgiveness	96.55	21.01	112.91	5.99	113.27	5.33
Meaning in life	24.82	5.36	27.91	5.03	28.64	4.34
Post-traumatic growth	21.36	7.74	25.91	5.61	26.00	3.87

Table 4 Descriptive analysis of dependent variables in the control group

Control group	**Pre-test (n=10)**		**Post-test (n=10)**		**Follow-up test (n=9)**	
	M	***SD***	***M***	***SD***	***M***	***SD***
Forgiveness	99.56	47.51	106.33	47.88	97.44	47.84
Depression	26.44	4.52	21.00	4.92	25.00	6.84
Anxiety	19.78	5.95	17.67	5.34	20.33	6.42
Anger	14.56	5.64	12.33	3.81	14.11	5.86
Normative grief	49.89	5.88	46.44	7.04	47.44	9.17
Self-esteem	27.89	4.60	30.67	4.56	30.89	5.30
Hope	42.11	9.65	48.33	6.56	47.56	11.92
Self-forgiveness	102.67	12.29	93.33	17.07	97.78	18.08
Meaning in life	16.11	6.33	16.78	6.30	21.56	7.27
Post-traumatic growth	18.44	5.90	21.44	6.95	21.00	4.85

Differences between the experimental and the control group

As can be seen in Table 1, the experimental group achieved a significantly greater improvement in forgiving the other in comparison with the control group after controlling for the pre-test forgiveness score, $F(1, 18) = 4.81$, $p = 0.042$ in the post-test, as well as in the follow-up test, $F(1, 17) = 4.90$, $p = 0.041$. The effect size was medium for post-test, $\eta 2 = 0.21$ and for the follow-up test, $\eta 2 = 0.24$.

There was a significant effect of forgiveness intervention on decrease in depression after controlling for pre-test depression score, $F(1, 18) = 8.61$, $p = 0.009$ in the post-test; and in the follow-up test, $F(1, 17) = 7.87$, $p = 0.012$. 32% of variance in post-test depression score can be attributed to the forgiveness intervention both in the post-test and in the follow-up test, which means a high effect size.

The experimental group achieved a significantly greater improvement in anxiety in comparison with the control group in the post-test after controlling for the pre-test anxiety score, $F(1, 18) = 6.77$, $p = 0.018$, with a high effect size, $\eta 2 = 0.27$. The effect of the forgiveness intervention was not significant for a decrease of anxiety in the follow-up test, $F(1, 17) = 3.59$, $p = 0.075$, however, there was a medium effect size, $\eta 2 = 0.17$.

The experimental group achieved a significantly greater improvement in anger in comparison with the control group in the post-test after controlling for the pre-test anger score, $F(1, 18) = 10.68$, $p = 0.014$, with a high effect size, $\eta 2 = 0.37$. In the follow-up test, the effect was not significant ($p = 0.191$), but there was a medium effect size, $\eta 2 = 0.10$.

The experimental group achieved a significantly greater improvement in self-forgiveness in comparison with the control group after controlling for the pre-test self-forgiveness score, $F(1, 18) = 8.69$, $p = 0.009$ in the post-test, as well as in the follow-up test, $F(1, 17) = 6.52$, $p = 0.021$. The effect size was high for post-test, $\eta 2 = 0.33$ and for the follow-up test, $\eta 2 = 0.28$.

The experimental group achieved a significantly greater improvement in post-traumatic growth in the follow-up test in comparison with the control group after controlling for the pre-test post-traumatic growth score, $F(1, 17) = 5.36$, $p = 0.033$, with a medium effect size, $\eta 2 = 0.24$. The effect of the forgiveness intervention was not significant on the increase of post-traumatic growth in the post-test, $F(1, 18) = 0.66$, $p = 0,428$.

As can be seen in Table 1, there were no significant group differences in normative grief, self-esteem, hope, and meaning in life. Therefore, we were interested to see if there were any differences in pre-test and post-test and pre-test and follow-up test scores in these variables within each group. Repeated measures ANOVA was used for this purpose.

Regarding normative grief, there was a significant decline in grief from pre-test to post-test in experimental group, $F(1, 10) = 27.441$, $p < 0.001$, as well as for the control group, $F(1, 10) = 7.866$, $p = 0.021$. Significant decline from pre-test to follow-up test was only in the experimental group, $F(1, 10) = 5.255$, $p = 0.045$; it was not significant in the control group, $F(1, 8) = 1.821$, $p = 0.214$.

In the experimental group, there was a significant increase in self-esteem from pre-test to post-test, $F(1, 10) = 44.853$, $p < 0.001$ and from pre-test to follow-up test, $F(1, 10) = 50.562$, $p < 0.001$. In the control group, there was a significant increase in self-esteem from pre-test to post-test, $F(1, 9) = 7.554$, $p = 0.023$, however, this was not significant from pre-test to follow-up test, $F(1, 8) = 3.028$, $p = 0.120$.

There was a significant increase in hope from the pre-test to post-test in the experimental group $F(1, 10) = 24.444$, $p = 0.001$, as well as in the control group, $F(1, 9) = 15.463$, $p = 0.003$. Similarly, a significant increase in hope was present from the pre-test to follow-up test in the experimental group $F(1, 10) = 7.057$, $p = 0.024$, as well as in the control group, $F(1, 8) = 6.542$, $p = 0.034$.

Regarding meaning in life, there was a significant increase in the experimental group from pre-test to post-test, $F(1, 10) = 19.863$, $p = 0.001$, as well as from pre-test to follow-up test, $F(1, 10) = 23.029$, $p = 0.001$. In the control group, there was no significant increase in meaning in life from pre-test to post-test, $F(1, 9) = 0.489$, $p = 0.502$, however, it was significant from pre-test to follow-up test, $F(1, 8) = 13.839$, $p = 0.006$.

Reliable change index

From Table 2, it can be concluded that overall frequency of reliable change (for all variables) was higher for the participants in the experimental group (42% from pre-test to post-test; 44% from pre-test to follow-up test) compared to the participants in the control group (33% from pre-test to post-test; 29% from pre-test to follow-up test). Similarly, overall frequency of improvement (for all variables) was higher for the participants in the experimental group (48% from pre-test to post-test; 34% from pre-test to follow-up test) compared to the participants in the control group (37% from pre-test to post-test; 28% from pre-test to follow-up test). The highest frequency of reliable change was achieved in depression in the experimental group, for 10 participants (91%) from pre-test to post-test and for 9 participants (82%) from pre-test to post-follow up test. Following was anxiety in the experimental group, for 8 participants (73%) from pre-test to post-test and for 7 participants (64%) from pre-test to post-follow up test.

Discussion

The results of our study show support for the forgiveness intervention. Participants in the experimental group achieved statistically higher improvement than participants in the control group in depression, anxiety, anger, forgiveness towards others, self-forgiveness and post-traumatic growth from pretest to post-test. Differences between the groups continued from pretest to follow-up in forgiveness, depression, self-forgiveness, and post-traumatic growth. Previous forgiveness intervention studies showed similar positive effects in various clinical populations, such as incest survivors (Freedman & Enright, 1996) or women after spousal emotional abuse (Reed & Enright, 2006), and especially in the means of decrease in depression, anger, and increase in forgiveness, hope, and self-esteem (see also Akhtar & Barlow, 2018; Wade et al., 2014). Although our study was the first forgiveness intervention

with grieving parents in which the control group was used, the results suggest a psychological advantage for the forgiveness intervention for the improvement of mental health after the loss of a child. The results of our study suggest that the ability to forgive another person (e.g. a spouse for not providing enough support, a loved one who had insensitive remarks, or even a murderer of their child) can positively influence mental health of a bereaved parent. However, it needs to be said, that even when participants experienced higher forgiveness after their participation in the intervention, it does not mean that they have completely forgiven, showing that forgiveness is a journey, oftentimes a difficult and long one. Moreover, parents, who participated in the forgiveness intervention described helpful factors for their forgiveness. As the most important factor for their forgiving, it was to value the memory of their child and to live the legacy of their child. Also, they chose forgiveness in order to feel better emotionally and physically. These reasons were similar to those participants in previous studies who forgave the murderer of their child (e.g. Hourigan, 2016; Oglesby, 2013).

The one variable, from the clinical perspective, that had minimal impact on the participants in either group was normative grief, which stayed well above the measure's mid-point across all testing times for both groups. There are several possible explanations for this result. First, it is possible that forgiveness intervention is more effective for the improvement of mental health but it is not so effective for decrease of grief. This makes sense to us because the reality of the deceased child remains. Grief measures are more concentrated on grieving the lost relationship with a child, thinking about and remembering the lost child, which are natural after the loss. Therefore, decrease in grief can be very difficult for a parent and actually can even lead to feelings of guilt. Also, some participants from the forgiveness intervention group told us, at the end of the intervention, that their decrease of anger has allowed them to grieve and remember their child more. In these cases, we believe, having a

higher “permission to grieve” may not be maladaptive. Moreover, we were able to see that participants from both groups experienced decrease in their grief, and therefore psycho-educational grief intervention might have been equally helpful for decreasing grief. Again it needs to be noted: the sustained grief did not inhibit considerable growth in important psychological variables, which improved as participants learned to forgive.

We are aware of the limitations of our study. The first limitation is related to the small number of participants. Although this is in line with previous forgiveness interventions (Akhtar & Barlow, 2018), the usage of a larger sample size could lead to different and more representative results. This could especially be the case for some variables where we did not find any significant improvements, but there was a medium effect size (e.g. the effect of forgiveness intervention on decreases in anxiety or anger at the follow-up test). Secondly, the research sample was heterogenous in terms of type of loss, time since loss, and gender. The forgiveness process likely was different for individuals who worked on forgiving a partner compared with those who worked on forgiving a murderer. Third, given that previous grief interventions were the most effective when the pre-test scores of complicated grief were the highest (Waller et al., 2016), future forgiveness interventions for bereaved individuals may consider setting a criterion for the pre-test scores of key variables (e.g. low forgiveness, high complicated grief) in order for participants to be selected for the study.

Despite the above-mentioned limitations, there also are certain strengths of the current study. The advantages of this study were the usage of individual sessions; randomization of participants; the usage of a stronger method of statistical analysis compared to previous forgiveness studies; as well as having the condition for participation as the absence of taking antidepressants, which have been frequently reported limitations in the earlier intervention studies (Waller et al., 2016). Another strength of the study is working with parents after the loss of a child above three years old and the usage of an active control group, since the most

of the previous studies were focused on the loss of a younger child and used only a wait-list control group (Endo et al., 2015; Waller et al., 2016).

Our study has several implications for praxis. Bereaved parents, who have been hurt by another person in the context of their loss, can benefit from learning to forgive this person, in order to potentially decrease their anger, symptoms of depression, anxiety, reach more peace of mind, have more capacity for grieving, and also potentially find some benefits and meaning in their experience, in terms of post-traumatic growth. Forgiveness therapy (Enright, 2001) for bereaved individuals can be used either separately or ideally with another approach, for example with complicated grief therapy (Wetherell, 2012) or with gestalt therapy, which can work with forgiveness in the empathy chair technique (Greenberg et al., 2008). Since self-forgiveness may be an equally important aspect for grieving parents as is forgiving others (Jacinto, 2010; Záhorcová et al., 2020), future intervention studies would do well to aim at testing the self-forgiveness intervention in bereaved parents.

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ORCID iDs

Lucia Záhorcová https://orcid.org/0000-0002-9252-8608

Peter Halama https://orcid.org/0000-0002-6938-4845

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Author Biographies

Lucia Záhorcová is a postdoctoral fellow in the Department of Psychology, University in Trnava. Her research interests focus on the psychology of forgiveness, grief and bereavement, and positive psychology.

Robert Enright is a professor in the Department of Educational Psychology, University of Wisconsin–Madison, USA, and a board member of the International Forgiveness Institute, Inc., Madison, Wisconsin, USA. He has pioneered the social scientific study of forgiveness since 1985.

Peter Halama is a professor in the Department of Psychology, University in Trnava. His research interests include meaning-making, coping, and personality.