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Forgiveness: Is it a resiliency factor for adult Children of Alcoholics?

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FORGIVENESS:

IS IT A RESILIENCY FACTOR FOR ADULT CHILDREN OF ALCOHOLICS?

by

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ABSTRACT

The purpose of the present study was to examine forgiveness as a resiliency factor in a sample of Children of Alcoholics (COAs). In this study, resiliency was defined in terms of level of self-report of depressive symptomatology.

The present study explored the relation between depressive symptomatology and forgiveness in a sample of COAs that had not been exposed to a forgiveness intervention. The present study also attempted to determine if willingness to forgive provides a unique contribution to predicting depressive symptomatology for COAs, over and above other documented resiliency factors, such as self-esteem and intelligence. Furthermore, given previously documented sex differences in rates of depression and tendency to forgive, sex differences were explored in the present study. Results were also compared to those in the non-COA population. A final purpose of the present study was to examine the utility and cohesion of various forgiveness measures

Of 204 participants (99 females, 105 males), 43 participants (21 females, 22 males) met the criteria for COA status. Results indicated that self-forgiveness predicted the greatest proportion of self-reported depressive symptomatology, followed by self-esteem. This relation was reversed for non-COAs. A measure of intelligence and other measures of forgiveness did not offer additional predictive value above and beyond self-forgiveness and self-esteem.

COAs' ratings of forgiveness at three time periods (Past , Present, and Future) increased significantly across each time period. That is, COAs rated themselves as least forgiving in the Past, with consistently increasing levels of forgiveness for the Present

and Future time periods. No sex differences in forgiveness ratings or levels of self-reported depressive symptomatology were observed.

Finally, correlations among measures of forgiveness indicated that there appear to be at least two distinct types of forgiveness (i.e., forgiveness of others and self-forgiveness). Furthermore, the correlation data suggested that different measures should be utilized depending on whether present or future levels of forgiveness are of interest.

Results are discussed in terms of implications for developing intervention models (i.e., the importance of including components of self-forgiveness in treatment) to foster resiliency, and potentially important differences between COA and non-COA samples.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

INTRODUCTION

A large number of children grow up in a home with an alcoholic parent. Alcoholism is a disease that affects virtually all countries, cultures, and ages. It affects both sexes, and transcends socioeconomic status. It is estimated that there are almost 1 million children under the age of 19 living in an alcoholic home in Canada (Canadian Task Force on Preventative Health Care, 1994), while estimates in the United States range from 6.5 million (Woodside, 1988) to 19.9 million (Windle & Tubman, 1999). Regardless of exact numbers, the experience of growing up in an alcoholic home has become so widespread that these children have become recognized as a distinct sub-sample of the population and are identified initially as children of alcoholics (COAs) who then become adult-children of alcoholics (ACOAs) as they grow up. The present study will examine the risks involved in growing up in an alcoholic home, particularly the experience of depressive symptoms, and explore the potential relation between forgiveness and reducing negative outcomes for young-adult COAs.

Because being the child of an alcoholic is a relatively common experience, many books and support groups (for example, Al-anon and Alateen) have been intended for this population. Children of alcoholics have also attracted the attention of both clinicians and researchers, and have been the focus of research studies for the last century (Sher, 1997). Research pertaining to alcoholism and COAs can generally be separated into two approaches, anecdotal and systematic, that differ in the methodological tactics used to understand the issues facing COAs. The case-study, anecdotal approach is often grounded in clinical work and disseminated in the popular media, and the systematic

A great deal of popular knowledge has been driven by anecdotal accounts that are both drawn from and used in clinical treatment settings. For example, Claudia Black, who is a renowned therapist and author, has been writing about COAs since the early 1980's. In her book, *"It Will Never Happen To Me,"* Black (1981) provides a caricature of COAs. She describes COAs as learning a number of lessons such as not talking, not trusting, and stifling feelings. Black suggests that these lessons are translated into four roles that COAs adopt, the responsible child, the adjuster, the placater, and the acting-out child. Black believes that COAs may exhibit traits from any or all roles, but identify strongly with one or two roles. As the child grows, these roles become more rigid, and without intervention may ultimately result in personal difficulties for the COA.

Black's writings represent a compelling body of anecdotal work, which has generated widespread public interest. Apart from demonstrating a great deal of face-validity, however, these broad statements do not offer any degree of specificity in terms of differentiating COAs from other people who may be experiencing psychological distress (Sher, 1997). For example, COAs tend to agree with descriptions such as fear of rejection to the point of panic if someone is angry with them (Woititz, 1983). People who are not COAs, however, also agree with such statements and, therefore, these types of findings offer little utility in discriminating what experiences COAs have that differ from other people exposed to other potential psychological risk factors.

Similar to the compilation of anecdotal clinical findings, systematic research projects have attempted to clarify the characteristics that best describe COAs, and have endeavoured to do so in a more controlled manner than anecdotal reports. A portion of research has examined the risks that are associated with being raised in an alcoholic

family and the chaotic dynamic within the alcoholic family. For example, alcoholic parents tend to be less actively involved with and attentive to their children (Hunt, 1997) and, when they do take note of their children, alcoholic parents tend to respond inappropriately (Lang, Pelham, Atkeson, & Murphy, 1999). When the degree of inappropriate parental responses intensifies, for example physical abuse, risks for the child increase and as it has been suggested that abuse may be more common in families with at least one alcoholic parent, COAs are at increased risk (Havey & Dodd, 1992; Serrins, Edmundson, & Laflin, 1995). Children of alcoholics may also be exposed to additional risk factors as many researchers believe that alcoholism has a genetic component (Ellis, Zucker & Fitzgerald, 1997; McGue, 1997); however, further research is necessary to clarify the nature of genetic factors and their interaction with environmental risk factors (e.g., modelling of ineffectual coping skills; Windle & Tubman, 1999).

Although causal relations are difficult to determine, growing up with an alcoholic parent has been linked to a number of negative outcomes for COAs. It has become widely accepted that COAs are at an increased risk for developing alcoholism (Hussong, 1998; Hill & Muka, 1996; McGue, 1997). It has also been suggested that as a group, COAs are at an increased risk of behavioural undercontrol, which refers to an increased likelihood for COAs to exhibit impulsive externalizing disorders, be more easily distracted, and exhibit some antisocial behaviour (Price & Emshoff, 1997; Windle & Tubman, 1999). Conversely, COAs have also been noted to exhibit higher levels of internalizing disorders, such depression and anxiety (Bush, Ballard, & Fremouw, 1995; Kuperman, Schlosser, Lidral, & Reeih, 1999; Sher, 1997). It has been suggested that COAs exhibit

both externalizing and internalizing difficulties as a result of lack of parental monitoring (especially for males; Griffin, Botvin, Scheier, Diaz, & Miller, 2000) and perceived parental emotional availability (Griffin & Amodeo, 1998). Lack of parental monitoring and emotional availability contributes to increased unpredictability within the home and thereby increases the risk of maltreatment of any children living in that home. These risks are magnified in families with two alcoholic parents (Windle & Tubmman, 1999).

Despite researchers' attempts to evaluate the issues that COAs face in a more systematic fashion than anecdotal approaches, results continue to be mixed. Research suggests that COAs are at a higher risk for depression and possibly anxiety, however, research to date has been unable to agree on what factors may be related to the development of depression (e.g., familial discord, Merikangas, Stevens, & Fenton,1996; Schuckit, 1996 and genetics, Ellis et al., 1997; McGue, 1997), and the relative effect of those factors. Regardless of the source of depressive symptomatology, it is clear that COAs are at an increased risk of developing depression and also alcoholism (which has been argued to be a form of self-medication for depression; Pattison & Kaufman, 1982). Consequently, their experience of depressive symptomatolgoy and factors that may exacerbate or inhibit symptom expression merits further evaluation, and will be the focus of the current investigation. What follows is a discussion of depression, the history of the disorder and theories regarding the development of depression and what we know may be resiliency factors that may be related to healthy outcomes for COAs.

Depression

Depression is a disorder that has been extensively researched, but beyond a few basic facts (e.g., women are twice as likely as men to develop depression; American Psychological Association, APA, 2000) little is understood. The etiology of depression remains under debate and suggested explanations outlining the cause and course of depression are numerous and varied. Developmental theories examine the successful mastery of maturational tasks, as well as the relation between attachment with primary caregivers and depression, and argue that failure to master tasks and insecure attachments in early stages of development may result in depression (Garber & Flynn, 2001; Kaslow, Croft & Hathcher, 1999). Biological theories examine rates of depression within families, as well as neuroendocrine and brain functioning, in order to determine to what extent genetics and biological functions play a role in depression (Pennington, 2002). Environmental/ life-stress models place more emphasis on outward factors as opposed to individual characteristics and theorize that individuals who are exposed to chronic levels of stress are more likely to develop depression (Kaslow et al., 1999). Social learning theories posit that depression occurs when cumulative punishments outweigh cumulative rewards and as a result, individuals no longer seek out potentially rewarding interpersonal interactions (Reynolds, 1994). Finally, there are also cognitive models of depression, such as learned helplessness theory (Seligman, 1975), which evolved into Abramson, Metalksy, & Alloy's (1989) hopelessness theory, which suggest that individuals who believe they have little control over events or outcomes may feel helpless and hopeless about their future, and are more likely to develop depression. Arguably the most

influential cognitive theory of depression is Beck's (1967) theory, which suggests that depression is caused by stable, automatic cognitive distortions in how individuals view themselves, the world, and the future.

Although no one theory is able to fully explain the etiology, course, and development of depression, the common thread throughout most of the literature, is that people who experience depression are exposed to a negative ecology or environment and lack adequate personal control of that environment (e.g., experience unpredictability). The resultant effect is that these individuals are more vulnerable than others to developing depression. Despite the etiology of the disorder remaining under question, there is also a positive theme in depression literature in that most approaches indicate hope for treatment. For example, Beck's cognitive model of depression that was developed in the 1960's, evolved into cognitive behavioural therapy (CBT), which has been demonstrated to be a successful treatment modality for depression (Kaslow & Thompson, 1998). The treatment model is based on the principle that people experiencing symptoms of depression have negative behavioural and emotional reactions to situations, but at the same time fail to recognize the negative cognitions, beliefs, and attitudes that result in the behavioural and emotional reactions. Interventions are aimed at first recognizing the negative cognitions, beliefs, and attitudes, then learning to evaluate them for validity, and finally working to modify them into more realistic interpretations of situations. When effective, this modification of negative cognitions, beliefs, and attitudes results in more positive behavioural and emotional reactions to situations and thereby reduces depressive symptomatology.

As previously mentioned, various studies have noted a link between being raised in an alcoholic home and higher rates of depression (Bush et al., 1995; Jacob & Windle, 2000; Rodney & Mupier, 1999). However, as findings are gathered it has also become clear that not all COAs develop depression and the reason or reasons for this difference merit study. Sher (1997) points out that often the only definitive statement that can be made about COAs is that they are a heterogeneous group. Consequently, it may be beneficial to begin to evaluate differences within the COA population. For example, if two people are exposed to a similar situation and only one develops symptoms associated with depression, the issue of the sources of the resiliency becomes a relevant question (i.e., what are factors related to the resiliency?).

Resiliency

Resiliency is a relatively new concept grounded in positive psychology that continues to garner attention and gain acceptance in psychological research. In general terms, resilience refers to the idea that not all people who are exposed to negative events suffer negative consequences, that is, they are able to transcend adversity (Rutter, 2000). Despite general consensus, the understanding of resilience diverges in a number of areas including whether or not it is best described as a state or a trait, the role of personal versus environmental characteristics, and how to best recognize and measure resilience (Werner, 2000). For example, Werner (2000) outlines how some research examined resilience at later stages of development by assessing outcomes for children who experienced high-risk situations (e.g., parental mental illness or substance abuse), while other investigations examined competence during a sustained period of stress (e.g.,

parental divorce), and finally other investigations viewed resiliency as successful recovery from serious childhood trauma (e.g., surviving war). The concept of resilience is further complicated by differing operational definitions. For example, some studies may conclude that resilience is exemplified by a positive outcome, while other studies may conceptualize resilience as a lack of negative outcomes (e.g., no significant developmental delays). Such differences mean that it is difficult to merge various scientific findings.

Like many other areas of research, it appears that a variety of factors (e.g., both personal and environmental) may be involved simultaneously or exert varying effects at different developmental periods. Garmezy, Masten, & Tellegen's (1984) hypothesized mechanisms of operation of protective factors, offers a useful means of conceptualizing how factors could alter outcomes for children. The authors outline three mechanisms: compensation, challenge, and immunization. Compensation refers to factors (either personal or other sources of support) that counteract stress. Challenge refers to the notion that the experience of stress may create an opportunity to enhance competence. Immunity refers to the idea that protective factors may lessen the impact of stress but the factors do not exert a positive effect in the absence of stress.

In relation to parental substance abuse, some examples of protective factors that have been evaluated in research include, "easy" temperament, ability to distance oneself, strong achievement motivation (Werner, 2000), average to above average intelligence (especially communication and problem solving skills; Windle & Tubman, 1999), close bond with a primary caregiver (not necessarily a biological parent), supportive siblings, supportive grandparents or teachers (or at least one nurturing adult figure) and increased

self-esteem (Walker & Lee,1998), the ability to express anger in an appropriate manner (i.e., anger reduction; Hart & McAlerr, 1997), ability to openly discuss problems, and a strong religious orientation (Chandy, Blum, & Resnick, 1996). As outlined by Garmezy et al. (1984), these factors may foster resilience through skill development that occurs because of the uniqueness of a particular situation. For example, living in an alcoholic home provides many opportunities for children to evaluate their beliefs and put their beliefs into action. Research on faith has suggested that fatih might enable children to foster a sense of meaningfulness and hope in their lives that persists into adulthood and allows them to love despite hate and treat fellow human beings with compassion (Werner & Smith, 1992; 2001).

Werner & Smith's (1992; 2001) description of faith mirrors discussions about forgiveness, which is a potential resiliency factor for COAs that has not received much attention, and therefore, will be the focus of resiliency hypotheses in this paper. Developments in forgiveness research are relatively new; therefore, what follows is a description of the relevant literature to date (including issues regarding definition, conceptualization, and measurement of forgiveness), the positive outcomes associated with forgiveness (including the relation between forgiveness and depression), and implications for COAs.

Forgiveness

Forgiveness is a concept that has been studied from a theological perspective for centuries. It has only been during the past two to three decades, however, that forgiveness has been considered by the psychological community. Despite increasing

interest, there remains considerable deliberation about how to best define and conceptualize forgiveness. According to McCullough, Pargament, & Thoresen (2000), a certain level of agreement has been reached regarding what forgiveness is not. Researchers seem to agree with Enright and the Human Development Study Group's (1991) assertion that forgiveness should be differentiated from "pardoning" (which is viewed as a legal term), "condoning" (which implies that an offense may have been justified), "excusing" (which implies that the offender had a valid reason for committing the offense), "forgetting" (which implies that the offendee has no conscious memory of the offense), "denying" (which implies that the offendee has chosen to ignore the injuries incurred by the offender), and finally, "reconciling" (implying a restoration of a relationship). Reconciliation has been associated with forgiveness, but most agree that it is a separate concept as forgiveness can occur without reconciliation and vice versa (McCullough et. al., 2000).

Although most researchers have been able to agree on what forgiveness is not, this does not mean that everyone agrees on what forgiveness actually encompasses. Individuals from various theoretical and religious backgrounds have attempted to define forgiveness. Most definitions seem to have a common central feature in that when people forgive, their responses toward the person who has offended against them (whether those responses be cognitive, verbal, behavioural, or emotional) become more positive and less negative (McCullough et. al., 2000). Examples of movement to the extreme end of the positive spectrum include Hargrave and Sells' (1997) definition of forgiveness as an "effort in restoring love and trustworthiness to relationships so that victims and victimizers can put an end to destructive entitlement" (p.43). Similarly, Enright and his

colleagues (1991; Enright & Coyle, 1998; Enright, Freedman & Rique, 1998) have defined forgiveness as "a willingness to abandon one's right to resentment, negative judgment, and indifferent behavior toward one who unjustly injured us, while fostering the underserved qualities of compassion, generosity, and even love toward him or her" (Enright et. al., 1998, p.46-7). A more moderate approach has been taken by McCullough and his colleagues (2000) who suggest that forgiveness is best defined within a motivational framework as "intraindividual, prosocial change toward a perceived transgressor that is situated within a specific interpersonal context" (p. 9).

Our research team at the University of Windsor has incorporated both the Enright and McCullough definitions of forgiveness to arrive at the following definition: Forgiveness is *an active process of intraindividual, prosocial change in emotions, behaviour and/or cognitions in relation to a perceived transgressor. This process involves relinquishing negative emotions, cognitions, and behaviours towards the perceived transgressor and may encompass adopting positive emotions, cognitions, and behaviours*. This definition captures our belief that forgiveness is a process that occurs within the individual who has been offended against (i.e., victim), and like Enright and colleagues we feel that there is an active component to this process. We chose to adopt McCullough and colleagues' use of the term prosocial because although we agree that the results of forgiving are positive, we are not convinced of Enright's claim that forgiveness necessarily includes fostering positive qualities, such as love, toward the perceived transgressor. Finally, we chose to stress that forgiveness is a process that occurs within the offended individual because we believe that forgiveness toward another can occur in

the absence of any form of continued relationship between the victims and the perceived transgressor.

A lack of consensus regarding how forgiveness is defined hampers cross-study comparisons (Elder, 1998; Enright & Coyle, 1998; Enright, et al., 1998; Enright, Gassin, & Wu, 1992); nonetheless a variety of research has been generated. One of the first psychological approaches to studying forgiveness was undertaken by Enright, Santos, & Al-Mabuk (1989) who used a cognitive-developmental model of forgiveness that approximates Kohlberg's (1976) theory of moral development/stages of justice. The Enright forgiveness model suggests that there are six stages or levels of forgiveness such that each corresponds with a stage outlined by Kohlberg. The stages range from a cognitively immature, rigid notion of reciprocal justice to a more evolved stage where forgiveness is freely given because the forgiver feels a sense of caring for the transgressor (and all humans) and does not allow a transgression to alter that sense of caring (i.e., referred to by Enright et al. as, "forgiveness as love," 1989). Research on Enright et al.'s cognitive developmental model suggests that people do not progress through the stages/levels in a linear fashion. There does, however, appear to be a developmental progression as age is positively correlated with the upper stages/levels in the model (i.e., increased age is positively related to increased likelihood to employ "forgiveness as love rationale;" Enright & the Human Development Study Group, 1994; 1996).

The limited fit of participants' experiences with the cognitive developmental model of forgiveness, stimulated Enright and the Human Development Study group (1991) to also develop a more fluid process model of forgiveness. This model suggests that the process of forgiveness entails four tasks including (1) the uncovering phase, (2)

the decision phase, (3) the work phase, and (4) the outcome/deepening phase. The four main tasks are further divided into 19 steps, all of which may or may not be traversed in the process of forgiveness. In fact, some research has suggested that people place varying importance on the steps, thereby suggesting a somewhat idiosyncratic approach to forgiveness (Miller, 2002). Delineating the factors involved in the process of forgiveness has increased both understanding of forgiveness in general and facilitated the implementation of forgiveness principles in therapeutic and intervention settings (e.g., Al-Mabuk & Downs, 1996; Osterndorf, 2000; Rye & Pargament, 2002).

Just as research approaches have differed depending on whether forgiveness is being evaluated from a developmental perspective or a process model, research has also varied depending on if forgiveness is conceptualized as a state or trait characteristic. Until recently, forgiveness has generally been studied as an act that is an end-state dependent variable (i.e., state characteristic; Berry, Worthington, Parrott, O'Connor, & Wade, 2001). This is accomplished through the use of vignettes or scenarios where participants are asked to read about a transgression and are then asked about their reactions to that transgression (i.e., whether or not they would grant forgiveness in that situation). Through this approach, researchers have been able to increase understanding regarding various factors that may impact on forgiveness, such as, age (Enright et al., 1989; Girard & Mullet, 1997), empathy (Brandsma, 1982; Fitzgibbons, 1986; Hope, 1987), sex (Girard & Mullet, 1997; Cornock, 2002), intentionality (Boon & Sulsky, 1997; Enright and the Human Development Study Group, 1991), nature of transgressor/victim relationship (Kelley, 1998), presence/absence of an apology (Enright, 2001; Girard & Mullet, 1997;

McCullough, Worthington, & Rachal, 1997; Hargrave, 1994), religiosity (Rye et al., 2000), severity of consequences (Girard & Mullet, 1997), and time (Cornock, 2002).

In addition to surveying a variety of factors, research on situational forgiveness has also evaluated forgiveness across a number of domains and types of interpersonal transgressions. For example, forgiveness has been examined in romantic relationships (Rye & Pargament, 2002, McCullough et al., 1998), friendships (Park & Enright, 1997), marriage (DiBlasio, 2000), familial disputes (Paleari, Regalia, & Fincham, 2003; Byng-Hall, 1986), the workplace (Girard & Mullet, 1997), parents of suicide victims (Al-Mabuk & Downs, 1996), abortion (Coyle & Enright, 1997), and incest survivors (Freedman, 1999; Freedman & Enright, 1996). As more has been learned about forgiveness in specific situations, researchers have begun to move beyond situational evaluations and are beginning to explore forgiveness as a disposition, trait, or personality characteristic (Berry et al., 2001; Emmons, 2000; McCullough, Hoyt, & Rachal, 2000).

The shift from situational to dispositional research is exemplified by a discussion of some of the measures that have been developed and utilized in forgiveness research. Researchers began moving away from supplying participants a transgression scenario and instead began relying more on participants' personal experiences. For example, Enright, Rique, and Coyle, (2000) developed the Enright Forgiveness Inventory (EFI) which asks participants to generate an example of a past hurt or transgression and then answer 60 questions about the transgression which are intended to tap affective, behavioural, and cognitive components of forgiveness. However, at a recent forgiveness conference, discussion indicated that several yet unpublished and ongoing projects were discovering

that the questions of the EFI do not group together as proposed and therefore researchers have turned to other measures (K. Belicki, personal communication, January 13, 2003).

McCullough and colleagues (1998) have developed another measure that merges personal experience with a series of standardized questions about that experience based on their motivational conceptualization of forgiveness. This measure is called the Transgression-related Interpersonal Motivations (TRIM) inventory. Like the EFI, the TRIM inventory is situationally based in that it asks participants to think of a past transgression and answer a series of questions about that transgression. Unlike the EFI, however, the questions from the TRIM inventory factor out into three subscales (McCullough & Hoyt, 2002). These three subscales (avoidance, revenge, and benevolence) have been found to account for a significant percentage of participants' forgiveness related responses (McCullough & Hoyt, 2002). Furthermore, the three different types of motivation to forgive also vary across situations which suggests that trying to predict a person's tendency to forgive based on a single, isolated situation could be highly misleading. To rectify this type of measurement error, McCullough and Hoyt (2002) suggest that it would be necessary to evaluate a participant's responses to a variety of different transgressions (e.g., 12-16) in order to measure dispositional forgiveness.

Other researchers have avoided situational bias by developing dispositional measures of forgiveness that do not depend on situations at all, but rather ask participants to think about what their "typical" response would be. For example, Mauger et al., (1992) have developed a non-situation based measure that evaluates Forgiveness of Others (FOO) and Forgiveness of Self (FOS) by asking participants to respond "true" or "false" to a series of 30 questions (e.g., "I have grudges I have held on to for months or years").

A similar measure, the Heartland Forgiveness Scale (HFS; Yamhure Thompson et al., 2005) consists of 18 items that are general statements or reactions to negative situations (e.g., "Learning from bad things that I've done helps me get over them"). Participants must decide how true that statement is of their typical response style by rating each item on a 7-point Likert-type scale from "almost always false of me" to "almost always true of me." The 18 items on the HFS, further divide into three subscales (1) Self Subscale, (2) Other Subscale, and (3) Situation Subscale. Brown (2003) developed yet another measure called the Tendency to Forgive Scale (TTF) with the intent of capturing individual difference in forgiveness without examining the process of forgiveness (e.g., "I have a tendency to get over it quickly when someone hurts my feelings"). Like the HFS, participants respond to the four items using a seven-point Likert-type scale. Using a similar response format, Brown (2003) developed a six-item measure called the Attitudes Toward Forgiveness Scale (ATF) to assess the extent to which participants view forgiveness as a positive virtue regardless of their actual ability to forgive (e.g., "Forgiveness is a sign of weakness"). With some understanding of how forgiveness has been conceptualized and measured, the findings associated with forgiveness can be evaluated and the implications for COAs explored.

Outcomes Associated with Forgiveness

The bulk of forgiveness literature to date asserts that outcomes related to increased willingness to forgive are positive. These positive outcomes include reduction of negative emotional states, such as, anger (Fitzgibbons, 1998; Hart & McAleer, 1997), bitterness (Diblasio, 2000), anxiety (Enright, 1996; Al-Mabuk, Enright, & Cardis, 1995),

guilt, (Al-Mabuk & Downs, 1996), grief (Coyle & Enright, 1997), fear (Freedman, 1999; Freedman & Enright, 1996), and most importantly for the present study, depression (Brown, 2003; Maltby, Macaskill, & Day, 2001; Osterndorf, 2000), which will be discussed in greater detail in a later portion of this paper.

Besides reduction of negative emotional states, willingness to forgive has also been associated with an increase in positive emotions, such as, hope (Hebl & Enright, 1993; Phillips & Osborne, 1989), as well as improved self-perception (i.e., increased self-esteem Osterndorf, 2000). In addition to improved emotional well-being, willingness to forgive has also been associated with improved physiological health, such as, decreased blood pressure (Huang, 2000) and relief from chronic pain and cardiovascular problems (Pettitt, 1987).

It should be noted that not all researchers agree that outcomes associated with forgiveness are positive. Some researchers view forgiveness as hazardous and suggest that willingness to forgive could place the forgiver in further danger. For example, victims in abusive relationships who are more willing to forgive may be more likely to remain in those abusive relationships thereby exposing themselves to the increased possibility of physical and psychological harm (Katz, Street, and Arias, 1997). This may be, however, an instance when forgiveness is being confused with another concept such as excusing or denial of the severity of the transgression. In the literature, forgiveness that is superficial or less genuine has been labelled *pseudo* or *false* forgiveness, suggesting that the motivation for forgiving is more defensive or manipulative. For example, false forgiveness may occur in order to prevent further conflict so as to provide self-protection, or may occur so one can appear to be the morally superior person

(McCulough et al., 2000). By this definition, false forgiveness is fundamentally different from forgiveness that is pursued for the intrinsic value of movement toward more positive emotions, attitudes, and behaviors, and therefore, the forgiveness described in a potentially violent situation may not actually be forgiveness. It is the more "genuine" form of forgiveness that the author is suggesting may be related to resiliency (i.e., decreased experience of depressive symptomatology) for COAs.

Depression, Forgiveness, and COAs

In the present study, depression is conceptualized using Beck's cognitive triad model that asserts that people who are experiencing depression tend to have negative views about themselves, the world, and the future. These negative views (i.e., cognitions) affect how an individual interprets situations and thereby has an impact on his/her emotional experience and behavioural conduct. As both depression and forgiveness are defined within the cognitive, emotional, and behavioural spheres, it makes logical sense that forgiveness could potentially alter someone's experience of depressive symptomatology. For example, Baumeister, Exline, & Summer (1998) argue that victims of transgressions have one of two choices to make, they can either hold a grudge, thereby sustaining anger and resentment, or they can make the choice to forgive, thereby creating the potential for positive feelings and actions and the possibility for relational recovery. The suggested ramifications of each choice are clear, either move beyond the situation towards a healthy recovery or remain mired in the negative aspects of that situation and risk unpleasant, stressful, and possibly even unhealthy consequences.

Being raised in an alcoholic home provides an environment where the choice of whether or not to forgive may be faced by COAs on a regular basis. As noted in an earlier discussion, alcoholic homes are often characterized by increased incidences of disorganization, lack of parental supervision and attention, and inappropriate parental response to children. Theoretically, COAs who are more able or likely to forgive may be more able to move beyond some of their negative experiences and less likely to experience depressive symptomatology. Although depression and forgiveness has been examined in alcohol abusers (Kendler et al., 2003; Lin, 2002), the author is aware of only one study examining depression and forgiveness in COAs (Osterndorf , 2000). Osterndorf screened 27 participants who had responded to a newspaper advertisement. Participants (ranging in age from 25-49) completed screening measures in order to determine COA status, level of forgiveness, and levels of anxiety and depression. Of the 27 participants, 12 met criteria for being a COA, had a below average level of forgiveness, and higher than average levels of either anxiety or depression. Half of these 12 remaining participants were randomly assigned to an intervention designed to teach interpersonal forgiveness, while the other half of the participants were assigned to an intervention designed to teach conflict resolution/negotiation skills (these participants also eventually completed the forgiveness intervention). Both interventions were deemed to be beneficial in that almost all participants reported lower levels of depression, anxiety, anger, and increased self-esteem after completing the treatment. However, the group that first completed the conflict resolution intervention did not make gains in forgiveness level until after they had completed the forgiveness intervention. Incidentally, anecdotal comments by the participants indicated that the forgiveness intervention

"resonated" with them on a deeper level and was perceived as more effective as compared to the conflict resolution intervention.

Osterndorf's work is interesting because it demonstrates that forgiveness is linked to decreased self-reported depressive symptomatology for COAs. Given that she utilized a very specific sample and methodology, however, a number of questions remain. For example, participants in Osterndorf's study were specifically trained in forgiveness techniques and one of the consequences was a reduction in self-reported depressive symptomatology, however, does that relation hold true for people who have not participated in a forgiveness intervention? Also given, the fact that Osterndorf used outcome measures that are related (e.g., depression and self-esteem) it is necessary to consider what, if any, proportion of the reduction of self-reported depressive symptomatology may be related to self-esteem.

Furthermore, the results are based on a very small sample size that was predominantly White (11 of 12) and female (11 of 12), therefore the relation between forgiveness and depressive symptomatology needs to be examined in a more diverse sample to ensure that results generalize to male and culturally diverse COAs. It is also important to remember that most COAs do not receive treatment (Riddle, Bergin, & Douzenis, 1997) and in Osterndorf's study she recruited people specifically for treatment and the vast majority of the participants (11 of 12) had sought previous counselling or therapy (five of them specifically for COA-related issues). Therefore, in order to examine potential resiliency factors and arrive at more generalized statements about COAs, research needs to be conducted with more representative samples (i.e., non-clinical or previously unidentified samples).

The present study expanded upon Osterndorf's findings by enlisting a large number of male and female participants from a culturally diverse undergraduate university population. Utilizing a university population allowed the researcher to explore a younger subset of COAs who have not necessarily sought treatment, which is a group that is under-represented in the literature (Rodney & Mupier, 1999). As younger participants are less likely to have sought counselling or treatment, it was possible to examine participants' naturally occurring tendency to forgive (i.e., trait forgiveness). Furthermore, sampling from a university population also allowed for comparisons between COAs and non-COAs.

Enlisting larger numbers of male and female participants created the opportunity for sex comparisons. The present study considered sex differences for a number of reasons. First, women are twice as likely as men to develop depression (APA, 2000). Second, research on sex differences in forgiveness is relatively limited and inconclusive (Enright et al, 1989; Girard & Mullet, 1997; Cornock, 2002) and therefore requires further exploration. Finally, Osterndorf's (2000) work was conducted with a primarily female sample and, therefore, sex comparisons could not be undertaken.

The present study utilized several different measures of dispositional forgiveness, which allowed comparisons for purposes of establishing validity and optimal predictability of depressive symptomatology. Given that the sample is undergraduate students and thereby arguably relatively high-functioning COAs, additional resiliency factors, such as intelligence (as measured by the Shipley Institute of Living Scale; Zachary, 2000) and self-esteem (Rosenberg Self-Esteem Scale; RSES; Rosenberg, 1965) were included. Depressive symptomatology was evaluated using a more clinically based

measure (i.e., Beck Depression Inventory; BDI-II; Beck, Steer, & Brown, 1996). A more general measure of affect that has been suggested to better reflect a more long-standing or dispositional depressive style (i.e., Positive Affect and Negative Affect Scales; PANAS; Watson, Clark, & Tellegen, 1988), and a measure of perceived stress (Perceived Stress Scale; PSS; Cohen, Kamarck, & Mermelstein, 1983) were also included.

Continuing to build on Osterndorf's work, the present study also explored temporal relations between forgiveness and depressive symptomatology. Previous research has demonstrated that forgiveness takes time to develop (McCullough, Fincham, & Tsang, 2003; Cornock, 2002) and, therefore, by asking participants to rate their past, current, and predicted levels of forgiveness and depressive symptomatology, we examined how the two constructs may be related over time. The following section will outline the specific hypotheses and questions that the present study addressed.

Hypotheses

The research literature has demonstrated a negative relation between forgiveness and depression, and more specifically, Osterndorf's (2000) work demonstrated that a forgiveness intervention was related to decreased depression endorsements. It remains to be seen, however, if the relation between depression and forgiveness exists in a sample of COAs who have not been exposed to a forgiveness intervention. Therefore, the following hypothesis is proposed based on the Osterndorf findings and the positive characteristics associated with a predisposition to forgive:

Hypothesis 1: Within COAs, forgiveness scores will predict self-reported depressive symptomatology.

Furthermore, research has suggested that levels of forgiveness increase over time (McCullough et al., 2003; Cornock, 2002). The relation between forgiveness and time, however, has not been studied across three time periods (i.e., only two time periods). Consequently, the following hypothesis is proposed based on existing findings related to time:

Hypothesis 2: Participants' forgiveness ratings will increase over the three proposed time frames (Past, Present, Future).

Research Questions

Previous research has suggested that not everyone exposed to a particular situation will develop negative outcomes, that is, some individuals exhibit resiliency. One factor that has been associated with resilience in a number of studies is forgiveness, while another factor has been self-esteem. The literature base examining the relation between forgiveness, self-esteem, and depression is relatively limited to date. Therefore, in an effort to increase our understanding of these relations, the following research questions are proposed:

Research Question 1: Is the relation between depression and forgiveness similar across measures of depressive symptomatology and negative affect?

Research Question 2: Will Past, Present, and Future forgiveness ratings be negatively related to Past, Present, and Future depression ratings?

Research Question 3: Do forgiveness scores predict self-reported depressive

symptomatology over and above other resiliency factors, such as intelligence and self-esteem?

Research Question 4: Is one particular forgiveness questionnaire better able to predict self-reported depressive symptomatology?

Research Question 5a: Are there sex differences in COAs' forgiveness scores?

Research Question 5b: If there are sex differences in forgiveness, is there a similar or different relation between depressive symptomatology and forgiveness for the two groups?

Research Question 6: If, as predicted, there is a relation between forgiveness scores and self-reported depressive symptomatology, is this relation similar for COAs and non-COAs?

METHOD

Participants

Participants were 204 (99 female, 105 male) undergraduate students from the University of Windsor, in Windsor, Ontario, Canada. Participants were randomly drawn from the University of Windsor Psychology Participant Pool, and were contacted by telephone and/or e-mail and were asked if they were interested in participating in a study about resiliency in young adults. Students who agreed to participate received two bonus points towards one of their psychology courses. Participants signed a consent form (see Appendix A), and were also given a letter of information (see Appendix A), a replica of the consent form for their personal records. Upon completion of the questionnaire, participants received written feedback (see Appendix A) that included information about the study, counselling resources, and how to obtain results of the study.

Participants ranged in age from 18-54, with a mean age of 22.9 years (SD = 6.3). Fifty-five percent of the sample identified themselves as White, followed by 14% Asian, 8% Black, 6% Middle Eastern, 4% Indian, 1% First Nations, 3% Other, and 9% of participants did not respond. Forty-eight percent of the sample identified themselves as Christian, 11% identified other various religions (including Hinduism, Islam, Buddhism, and Judaism), while 42% of the participants did not respond. Table 1 displays mean scores and standard deviations on the variables of interest for the overall sample, further separated into mean scores for males and females. Similar demographic information about the COA/non-COA sub-samples will be outlined in the results section.

Measures

Demographic Questionnaire

Participants completed a brief questionnaire (see Appendix A) detailing, age, race/ethnicity, religion, whether or not they have sought therapy in the past, and if they are currently seeing a therapist.

Children of Alcoholics Screening Test (CAST)

The CAST (Jones, 1983; see Appendix A) is a commonly used, self-report measure to identify children of alcoholics. The CAST measures a respondent's attitudes, feelings, perceptions, and experiences related to his/her parents' drinking behaviour by asking him/her to respond "yes" or "no" to a series of 30 statements. The CAST has a split-half reliability coefficient of .98 and a validity coefficient of .78 (Pilat & Jones, 1984; Jones, 1983). CAST scores are generally interpreted as 6 or above indicating that the respondent is a child of an alcoholic. For the present study, only participants who scored 6 or more were considered to be a COA.

In order to learn more about the COAs situation, participants were also asked a number of questions that are not directly addressed by the CAST (see Appendix A). The additional questions were not used in calculating CAST scores.

Forgiveness of Self (FOS) & Forgiveness of Others (FOO)

As part of a group of dispositional measures of forgiveness, participants will complete the FOS & FOO (Mauger et al., 1992; see Appendix A), which have been

designed to measure individual differences in forgiveness. Participants were asked to consider if each of the 30 statements described them by answering "true" or "false." The FOS & FOO have demonstrated excellent two-week stability (r = .94) and reasonable internal consistency (r = .79; Mauger et al., 1992). For the present study, the true/false format was modified into a 7-point Likert-like format (ranging from strongly disagree to strongly agree) in order to maintain consistency across questionnaires. Scores were separated into the two separate scales (i.e., FOS and FOO) for analyses.

Heartland Forgiveness Scale (HFS)

Participants completed the HFS (Yamhure Thompson et al., 2005; see Appendix A), which is an 18-item measure of dispositional forgiveness. It is composed of three subscales including forgiveness of self, others, and situation. Items are endorsed on a 7-point Likert-type scale. Responses are then summed across each scale and an overall forgiveness sum can also be obtained (which was the score utilized for the present study). The HFS correlates positively with other dispositional measures of forgiveness, has internal consistency reliability coefficients ranging from .84-.87 for the overall forgiveness score and .71-.83 for the subscales, and demonstrated three-week test-retest reliability coefficients of .83 for the overall score and .72-.77 for the subscales (Yamhure Thompson & Snyder, 2003).

Tendency to Forgive (TTF) & Attitudes Toward Forgiveness (ATF) Scales

Participants completed the four-item TTF scale (Brown, 2003; see Appendix A) which was developed to measure individual differences in dispositional forgiveness and

the six-item ATF scale (Brown, 2003) which was designed to measure the extent to which participants view forgiveness as a positive virtue regardless of their actual ability to forgive. Participants indicated how much each statement described them by rating it on a 7-point Likert-type scale ranging from "strongly disagree" to "strongly agree." Preliminary data has indicated that the TTF has an internal consistency rating of .82 and is reliable over an eight-week period with a test-retest coefficient of .71, and is positively related to other measures of forgiveness (Brown, 2003). The TTF and ATF are moderately related ($r = .37$). The ATF has an internal consistency rating of .71, however no additional relevant data is currently available.

Beck Depression Inventory – II (BDI-II)

Level of self-reported depressive symptomatology was assessed using the BDI–II (Beck, Steer, & Brown, 1996; see Appendix A), which is a 21-item, self-report instrument outlining cognitive, affective, motivational, and somatic symptoms of depression. On each item, participants selected one statement from a group of four that best described their experience for the preceding two weeks. Each response is weighted on a scale from 0-3, with higher scores representing more severe depressive symptomatology. The BDI-II is one of the most widely accepted instruments for detecting depressive symptomatology. The measure has shown to have high reliability and test-retest correlation, as well as good convergent and discriminant validity (Beck et al., 1996). Furthermore, correlations with demographic factors such as race/ethnicity and age are not significant (Beck et al., 1996).

Positive Affect and Negative Affect Scales (PANAS)

In addition to assessing depressive symptomatology with the BDI-II, the present study also included the PANAS (Watson, Clark, & Tellegen, 1988). The PANAS is a measure that assesses an individual's level of positive affect (PA; defined by the authors as the extent to which a person feels enthusiastic, active, and alert), and negative affect (NA; defined by the authors as a general measure of subjective distress and unpleasurable engagement that includes a variety of aversive mood states, such as anger, contempt, disgust, guilt, fear, and nervousness). Low levels of PA are associated with depression, while high levels of NA are associated with both depression and anxiety. Participants were presented with a list of 20 adjectives (10 for PA, 10 for NA) and were asked to what extent they have felt that way for a specific time period (the PANAS has utilized various time periods such as, the "present moment," the "past week," and "in general," Watson, 1988). These time periods have been compared as separate scales. The most common response format for the PANAS is a five-point Likert-type scale that ranges from, "very slightly or not at all," to "very much," anchored by "moderately."

Across samples (e.g., undergraduate and clinical), the PANAS scales have been shown to be related (-.12 to -.23), but still independent, as well as demonstrating internal reliability coefficients in the acceptably high range (.86 to .96 for PA, and .84 to .87 for NA; Watson et al., 1988). Validity studies have also indicated that the PANAS is related to other well-known measures of depression, including the BDI (PA -.36, and NA .58; Watson et al., 1988), but correlations are low enough to suggest that the two measures are not interchangeable.

As a variety of response formats have been utilized with the PANAS (e.g., four and five-point rating scales and dichotomous "yes," "no," format) with results indicating that the measure maintains a similar factor structure (Watson, 1988), for the present study the response format was modified into a 7-point Likert-type scale in order to maintain as much consistency as possible across measures. Furthermore, the author added six additional terms (referred to as the Dispositional Trait Scale). These terms were not used in calculating the PA and NA scores, but provided further understanding the relation between depressive symptomatology and forgiveness.

Perceived Stress Scale

The Perceived Stress Scale (Cohen et al., 1983) was also included and is the most widely used instrument for the perception of stress. Participants are asked to respond to a series of 10 questions about their feelings and thoughts over the past month in regards to how unpredictable, uncontrollable, and overloaded they have found their lives. Participants respond on a 5-point Likert-type scale about how often they have felt a certain way (i.e., from 0=never to 4=very often). This scale was modified to a 7-point Likert-type scale to remain consistent with other measures. Test-retest reliability for the PSS is .85 after six weeks and the measure correlated highly with the Center for Epidemiologic Studies Depression Scale (CES-D; .52-.76 in various samples; Cohen et al., 1983).

Rosenberg Self-Esteem Scale

The Rosenberg self-esteem scale (Rosenberg, 1965; see Appendix A) is a well-known measure of attitudes towards the self, designed specifically for young adults. It is in widespread use and has been found to be internally consistent and temporally stable (Dobson, Boudly, Keith, & Powers, 1979). In its original format the 10 items were responded to by the respondent choosing how much they agree with each statement on a four-point Likert-type scale ranging from strongly agree to strongly disagree. The format has been modified in the past and continued to be valid and reliable (Kernis, Grannermann, & Barclay, 1989). Therefore, the response format was modified into a 7-point Likert-type scale in order to maintain as much consistency as possible across measures.

Shipley Institute of Living Scale

The Shipley Institute of Living Scale (Zachary, 2000) is designed to assess general intellectual functioning in adults and adolescents. The scale consists of two subtests, a 40-item vocabulary test (i.e., participants chose which of four words means the same or nearly the same as a target word) and a 20-tem test of abstract thinking (i.e., participants were presented with a logical sequence and then asked to fill in numbers or letters that best completed said sequence). Age-corrected scores are totaled and an estimated Full Scale IQ score based on the Wecshler Adult Intelligence Scale-Revised (WAIS-R; Wechsler, 1981) was derived.

Past, Current, and Future Estimates of Forgiveness & Depression Levels

As a preliminary means of exploring the temporal relation between forgiveness and depression, participants were asked to rate their overall tendency to forgive at three different time periods by making a slash on a 100 mm line ranging from 0 (not at all forgiving) to 100 (completely forgiving; see Appendix A). The three time periods were (1) Past -defined as 5 years ago, (2) Present – defined as within the past two weeks, and (3) Future – defined as 5 years from now. Participants were also asked to rate their experience of depressive symptomatolgoy using a similar method, rating from 0 (no depressive symptoms) to 100 (most depressed I've ever been) for the three time periods (see Appendix A).

Procedure

Following approval of the University of Windsor Ethics Review Board, participants were recruited through the Psychology Participant Pool. The Psychology department organizes a list of undergraduate psychology students who qualify for bonus points in pre-approved courses when they participate in research (students also have the option of completing an assignments to earn bonus point as an alternative to participating in research). Students were contacted by phone and/or e-mail, were provided with a brief outline of the study (i.e., were told that the study was interested in examining resiliency factors in young adults), and were also given an opportunity to ask questions about the study.

Data Collection

When participants arrived and identified themselves to the primary investigator, the investigator explained informed consent, confidentiality, and details related to the questionnaires. Participants were encouraged to ask questions and share concerns before signing two consent forms (one is for their own records and one is returned to the researcher; see Appendix B). Participants completed the questionnaire package (including a brief demographic portion) in small groups and generally finished the package within one hour. The order of presentation of the questionnaires was randomized, with the exception of the intelligence measure (which was always first due to the timed nature of the task), the intelligence measure was always followed by the demographic questionnaire, and the measure examining forgiveness, depression, and time was always the final measure (so as to not cue the participant to the nature of the study). The questionnaires did not contain identifying information (e.g., participant's name) and were coded by number in order to maintain confidentiality.

Upon completion of the questionnaires, participants were asked to sign a form indicating which class they would like the bonus marks to be applied to. They received written feedback about the study, as well as information informing them how to obtain feedback of the overall results on a website once the study is completed (please note that individual results were not disseminated; see Appendix B). In addition, as the content of the questionnaires has the potential to raise concerns for some participants, the feedback information also contained the researcher's and primary supervising psychologist's contact information, as well as information regarding how to obtain counselling services

on campus (e.g., Student Counselling Centre & Psych Services Centre) or in the community.

RESULTS

The purpose of the present study was to examine forgiveness as a resiliency factor in a sample of COAs (who will be described in more detail in the next section). In this study, resiliency was defined in terms of level of self-report of depressive symptomatology and negative affect and, therefore, the analyses below describe the relation between forgiveness and depressive symptomatology/negative affect. Following from Osterndorf's (2000) findings that a forgiveness intervention was related to decreased endorsements of depressive symptomatology, the present study explored the relation between depression/negative affect and forgiveness in a sample of COAs that had not been exposed to a forgiveness intervention (i.e., participants were not coached or educated about forgiveness in the present study). An additional purpose of the present study was to attempt to determine if forgiveness provides a unique contribution to predicting depressive symptomatology/negative affect for COAs, over and above other documented resiliency factors, such as self-esteem and intelligence. Furthermore, given previously documented sex differences in rates of depression and tendency to forgive, sex differences were explored in the present study. Results were also compared to those in the non-COA population. Means and standard deviations for the variables of interest for the overall sample can be found in Table 1, while similar information for COA and non-COA samples can be found in Table 2. Please note that unless otherwise stated, correlation results refer to the main sample of interest, that is, the COA sample.

A final purpose of the present study was to examine the utility and cohesion of various forgiveness measures, as a number of forgiveness measures (including a measure

developed by our own research team) have developed as a result of the escalating amount of psychological research on forgiveness.

Demographic Information

Of the total sample of 204 participants, 43 participants (21 females, 22 males), approximately 21% of the sample, met criteria for COA status (i.e., scored six or greater on the Children of Alcoholics Screening Test; CAST; see Appendix C for distribution of CAST scores). The remaining 161 participants (78 females, 83 males), 79% of the sample, did not meet criteria for COA status (i.e., scored less than or equal to five on the CAST). It should be noted that the mean age of COAs (27.3 years) was significantly higher than the mean age of non-COAs (21.7), as indicated by an independent t-test analysis, $t\,(202) = 3.79$, $p = .00$.

COA Sample

Fifty-six percent of the COA sample identified themselves as White, followed by 12% Black, 7% Asian, 7% Indian, 5% First Nations, 2% Middle Eastern, 2% Other, and 9% of participants did not respond. Forty-four percent of COAs participants identified themselves as Christian, 8% Other, and 48% of participants did not respond. Sixty-two percent of COAs reported their marital status as single (never married), 7% as single (divorced, widowed, or separated), and 30% as married, engaged, or living with a partner. Forty-seven percent of COAs reported seeking therapy or counselling in the past, however, only 4% were in on-going therapy or counselling at the time of the study.

Table 1. *Mean Scores and Standard Deviations for Overall Sample (separated by sex; N = 204).*

MEASURE	TOTAL		FEMALE		MALE	
	Mean	(SD)	Mean	(SD)	Mean	SD
Age	22.9	(6.3)	23.7	(6.9)	22.1	(5.5)
IQ	103.1	(7.9)	102.3	(8.4)	103.8	(7.2)
Beck Depression Inventory (BDI-II)	11.1	(8.8)	11.7	(9.5)	10.6	(8.1)
Rosenberg Self-Esteem Scale (RSES)	54.0	(10.5)	54.0	(10.3)	54.0	(10.8)
Past Rating of Forgiveness (0-100)	61.6	(23.8)	60.9	(24.5)	62.3	(23.2)
Present Rating of Forgiveness (0-100)	66.0	(18.1)	64.5	(17.8)	67.5	(18.4)
Future Rating of Forgiveness (0-100)	75.2	(16.4)	74.0	(16.9)	76.3	(16.0)
Past Rating of Depression (0-100)	40.2	(28.8)	47.0	(28.5)	33.8	(27.6)
Present Rating of Depression (0-100)	40.3	(26.3)	43.0	(21.6)	37.7	(27.2)
Future of Depression (0-100)	26.1	(22.4)	26.0	(13.6)	26.2	(23.2)
Perceived Stress Scale (PSS)	36.3	(10.4)	37.0	(9.7)	35.5	(11.0)
Positive Affect Negative Affect Scale (PANAS-Positive)	49.6	(9.7)	50.4	(10.2)	48.8	(9.3)
Positive Affect Negative Affect Scale (PANAS-Negative)	31.1	(10.5)	32.6	(11.5)	29.7	(9.3)
Forgiveness of Others (FOO)	51.0	(13.2)	49.9	(13.6)	52.1	(12.8)
Forgiveness of Self (FOS)	49.4	(15.0)	49.0	(14.8)	49.7	(15.2)
Tendency to Forgive (TTF)	15.3	(5.0)	14.8	(4.8)	15.8	(5.0)
Attitude Toward Forgiveness (ATF)	30.0	(16.2)	30.4	(5.7)	29.6	(5.1)
Heartland Forgiveness Scale (HFS)	89.4	(16.2)	89.5	(17.4)	89.3	(15.0)

Table 2. *Mean Scores and Standard Deviations for Overall COA and non-COA Sample (separated by sex; COAs N = 43, non-COAs N = 161).*

MEAUSRE	COA Mean (SD)	non-COA Mean (SD)	Female COA Mean (SD)	Female non-COA Mean (SD)	Male COA Mean (SD)	Male non-COA Mean (SD)
Age	27.3 (9.3)	21.7 (4.5)	29.6 (10.4)	22.2 (4.6)	25.1 (7.9)	21.3 (4.3)
IQ	103.2 (6.7)	103.1 (8.2)	103.5 (7.2)	102.0 (8.8)	102.9 (6.2)	104.1 (7.5)
BDI-II	11.4 (9.8)	11.0 (8.5)	10.8 (10.8)	12.0 (9.2)	12.0 (8.9)	10.2 (7.8)
RSES	53.2 (9.9)	54.2 (10.7)	55.6 (7.6)	53.5 (10.9)	50.9 (11.3)	54.8 (10.6)
Past Forgiveness	51.4 (27.7)	64.3 (22.0)	53.5 (30.5)	62.8 (22.5)	49.5 (25.4)	65.7 (21.5)
Present Forgiveness	62.6 (19.7)	67.0 (17.6)	61.6 (21.0)	65.2 (17.0)	63.5 (18.8)	68.6 (18.2)
Future Forgiveness	73.5 (20.0)	75.6 (15.4)	69.0 (22.7)	75.3 (15.0)	77.7 (16.6)	75.9 (15.9)
Past Depression	48.5 (30.4)	38.0 (28.0)	51.5 27.1)	45.9 (29.0)	45.8 (33.5)	30.6 (25.1)
Present Depression	44.1 (28.8)	39.3 (25.6)	43.9 27.6)	42.8 (24.7)	44.2 (30.5)	36.0 (26.2)
Future Depression	27.2 (25.5)	25.8 (21.6)	23.1 19.0)	26.8 (22.2)	30.8 (29.9)	24.9 (21.1)
PSS	37.5 (11.6)	35.9 (10.1)	38.0 10.4)	36.8 (9.6)	37.0 (12.8)	35.2 (10.6)
PANAS-Positive	52.0 (9.9)	48.9 (9.5)	54.1 (9.3)	49.4 (10.0)	49.9 (10.2)	48.5 (9.1)
PANAS-Negative	31.6 (11.0)	31.0 (10.4)	32.3 (12.6)	32.7 (11.2)	30.8 (9.4)	29.5 (9.3)
FOO	50.9 (14.8)	51.0 (12.8)	47.4 (17.7)	50.5 (12.4)	54.3 (10.5)	51.5 (13.3)
FOS	50.7 (15.4)	49.0 (14.9)	50.2 (15.2)	48.7 (14.8)	51.2 (16.0)	49.3 (15.0)
TTF	13.8 (4.8)	15.7 (4.9)	15.0 (5.4)	14.8 (4.7)	12.7 (5.4)	16.6 (5.0)
ATF	29.9 (5.4)	30.0 (5.4)	30.9 (5.1)	30.3 (5.9)	29.0 (5.6)	29.8 (5.0)
HFS Total	85.7 (19.2)	90.4 (15.2)	88.1 (23.1)	89.9 (15.7)	83.3 (23.1)	90.9 (14.8)

Of the 43 COAs, 28 reported that their father was an alcoholic, 7 reported that their mother was an alcoholic, 2 reported both parents were alcoholics, and 6 did not list either parent as an alcoholic (but still scored six or higher on the CAST measure, thereby still qualifying as a COA). Only 30% of the COAs still live with the parent(s) who have or had a drinking problem. Length of parental drinking problem was divided into various ranges, with 19% of COAs reporting 0-5 years, 16% reporting 5-10 years, 19% reporting 10-15 years, 14% reporting 15-20 years, 28% reporting 20 years or more, and 4% of COAs did not respond to this question.

Non-COA Sample

Fifty-two percent of the non-COA sample identified themselves as White, 14% Asian, 8% Middle Eastern, 7% Black, 3% Indian, 1% First Nations, 5% Other, and 10% of the participants did not respond. Forty-eight percent of the non-COA sample identified themselves as Christian, 12% Other, and 40% of participants did not respond to the question about religious background. Eighty-six percent of the non-COA sample reported their marital status as single (never married), 6% as single (divorced, widowed, or separated), and 8% as married, engaged, or living with a partner. Eighteen percent of non-COAs had sought therapy or counselling in the past, however, only 3% were in on-going therapy or counselling at the time of the study.

Relation Between Forgiveness and Self-reported Depressive Symptomatology for COAs.

In order to explore the relation between forgiveness[1], self-reported depressive symptomatology, and measures of negative affect, Pearson Product Correlations (see Table 3a) were conducted using the main variables outlined in Table 2. The strength of the relations between variables was then used to help determine which variables would be most appropriate for regression analyses.

Correlation results suggest that in the present study IQ was not significantly related to other proposed resiliency factors (e.g., self-esteem and forgiveness) or dependent variables (self- reported depressive symptomatology and negative affect) and, therefore, IQ was not included in further analyses. Self-esteem, on the other hand, was highly correlated with forgiveness measures, self-reported depressive symptomatology, and measures of negative affect and, therefore, self-esteem was included in all analyses.

Using the correlation matrix outlined in Table 3a, the following two research questions were addressed:

Research Question 1: Is the relation between depression and forgiveness similar across measures of depressive symptomatology and negative affect?

The Beck Depression Inventory-II (BDI-II) correlated strongly with measures of forgiveness (correlations were negative with most forgiveness measures, with the exception of positive correlations with the FOS and FOO which are "unforgiveness" measures). Correlations between other measures of negative affect (i.e., Perceived Stress

[1] Note, that when reviewing correlations involving the forgiveness measures Forgiveness of Self (FOS) and Forgiveness of Others (FOO), it is important to remember that these measures are negatively worded so that higher scores actually reflect lack of forgiveness. This means that the FOS and FOO correlate positively with depression scores.

Table 3a. *Correlations between Main Variables of Interest for COAs Sample (N = 43).*

	IQ	Age	RSES	BDI-II	Past Dep	Pres Dep	Fut Dep	PSS	PANAS Positive	PANAS Negative	Past Forg	Pres Forg	Fut Forg	FOO	FOS	TTF	ATF	HFS
IQ	1.00																	
Age	-.07	1.00																
RSES	.17	.35*	1.00															
BDI-II	.09	.11	-.66**	1.00														
Past Dep.	.22	-.28	.08	.09	1.00													
Pres. Dep.	.28	.07	-.38*	.63**	.19	1.00												
Fut. Dep.	-.22	-.37*	-.40**	.33*	-.11	.38*	1.00											
PSS	-.09	-.35*	-.46**	.57**	-.15	.54**	.19	1.00										
PANAS Positive	-.07	-.15	.57**	-.50**	-.06	-.48**	-.43	-.28	1.00									
PANAS Negative	.15	.22	-.46**	.65**	.14	.56**	.20	.62**	-.41**	1.00								
Past Forg.	-.04	-.08	-.04	.10	.03	.21	.18	.12	-.02	.11	1.00							
Pres. Forg.	-.17	-.02	.16	-.17	-.26	.02	.13	-.13	-.04	-.08	.26	1.00						
Fut. Forg.	-.25	.01	.03	-.15	-.21	.06	.06	.05	-.05	-.07	.04	.70**	1.00					
FOO	.15	.06	-.30	.38*	-.05	.245	.34	.14	-.18	.28	-.08	-.43**	-.34*	1.00				
FOS	.10	-.23	-.56**	.76**	.27	.65**	.33	.56**	-.34	.69**	.20	-.06	-.02	.25	1.00			
TTF	-.04	-.21	.24	-.09	.09	.04	-.16	-.13	-.14	.00	.11	.49**	.30	-.66**	-.11	1.00		
ATF	.09	.10	.36*	-.28	.21	.09	-.07	-.22	.13	-.15	.02	.36*	.49**	-.47**	-.02	.36*	1.00	
HFS	-.24	.29	.49**	-.54**	-.18	-.24	-.15	-.20	.25	-.39*	.15	.39*	.37*	-.49**	-.45**	.30	.29	1.00

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

Table 3b. *Correlations between Main Variables of Interest for COAs Sample (N = 43).*

	IQ	Age	RSES	BDI-II	Past Dep	Pres Dep	Fut Dep	PSS	PANAS Positive	PANAS Negative	Past Forg	Pres Forg	Fut Forg	FOO	FOS	TTF	ATF	HFS
IQ	1																	
Age	-.24**	1																
RSES	.13	.03	1															
BDI-II	-.03	.00	-.70**	1														
Past Dep.	-.13	.10	-.30**	.29**	1													
Pres. Dep.	-.01	.05	-.49**	.62**	.43**	1												
Fut. Dep.	-.10	.01	-.39**	.38**	.34**	.58**	1											
PSS	-.07	.06	-.62**	.60**	.25**	.59**	.39**	1										
PANAS Positive	.08	.07	.56**	-.58**	-.06	-.39**	-.37**	-.41**	1									
PANAS Negative	-.17*	.14	-.60**	.58**	.29**	.52**	.40**	.69**	-.35**	1								
Past Forg.	.01	.02	.07	-.06	-.24**	-.13	-.11	-.12	.04	-.03	1							
Pres. Forg.	-.01	.07	.20**	-.27**	-.10	-.25**	-.20*	-.33**	.26**	-.31**	.54**	1						
Fut. Forg.	.02	.05	.18*	-.20*	-.07	-.23**	-.32**	-.24**	.23**	-.24**	.44**	.69**	1					
FOO	.00	-.26**	-.33**	.32**	.14	.25**	.21**	.33**	-.31**	.29**	-.29**	-.57**	-.47**	1				
FOS	-.18*	-.03	-.67**	.57**	.28**	.43**	.27**	.56**	-.40**	.53**	-.09	-.20*	-.16*	.36**	1			
TTF	.02	.07	.29**	-.30**	-.30**	-.28**	-.25**	-.33**	.30**	-.33**	.29**	.53**	.41**	-.63**	-.36**	1		
ATF	.01	.14	.10	-.8	-.07	.01	-.09	-.13	.19*	-.12	.15	.38**	.35**	-.47**	-.10	.46**	1	
HFS	.23**	.07	.53**	-.46**	-.24**	-.39**	-.33**	-.53**	.49**	-.50**	.18*	.45**	.39**	-.60**	-.54**	.58**	.42**	1

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

Scale, PSS; Positive Affect Negative Affect Scale – Positive, PANAS-Positive; and Positive Affect Negative Affect Scale = Negative, PANAS-Negative) and forgiveness were in the same direction, but were not always significant. For example, both the BDI-II and the PSS correlated negatively with the Heartland Forgiveness Scale (HFS), but only the correlations with the BDI-II was significant. Thus, we can conclude that the negative relation between depression/negative affect and forgiveness was similar (i.e., in the same direction) across measures of depressive symptomatology and negative affect. Furthermore, although there was a similar relation across measures, the correlations between self-reported depressive symptomatology (i.e., the BDI-II) and levels of forgiveness were the highest.

As the correlations between the BDI-II and measures of self-esteem and forgiveness were highly negative (and highly positive for the FOS and FOO) it was decided to use this variable as the dependent variable or criterion for further analyses (as opposed to other related measures such as PSS, PANAS-Positive, and PANAS-Negative, which were dropped from further analyses). Scores on the BDI-II ranged from zero to 39, with 30% of COAs' scores falling within a clinically significant range of depression (which is similar to the non-COA sample which had 27% of participants scoring within the clinically significant range of depression).

To determine whether or not there were sex differences in self-reported depressive symptomatology, an independent t-test analysis was performed (see Table 2 for COAs' mean BDI-II scores separated by sex) which indicated that there was no significant difference, $t(41) = -.41$, $p = .69$. As no sex differences in self-reported

depressive symptomatology were observed, sex was dropped as a predictive or independent variable from subsequent analyses.

Research Question 2: Will Past, Present, and Future forgiveness ratings be negatively related to Past, Present, and Future depression ratings?

Correlations between participants Past (defined as five years ago), Present (defined as within two week of the time participants completed the study), and Future (defined as five years in the future) ratings of depression and forgiveness were not significant (See Table 3a). These correlations were not in the expected direction and, therefore, the negative relation found between most measures of depressive symptomatology and forgiveness was not replicated in the timeline measures.

The following hypothesis and research questions were addressed using step-wise multiple regression analysis:

Hypothesis 1: Within COAs, forgive scores will predict self-reported depressive symptomatology.

Research Question 3: Do forgiveness scores predict self-reported depressive symptomatology over and above other resiliency factors, such as intelligence and self-esteem?

Research Question 4: Is one particular forgiveness questionnaire better able to predict self-reported depressive symptomatology?

Step-wise regression analysis was conducted with the BDI-II as the criterion. Predictor variables included the Rosenberg Self-Esteem Scale (RSES), and five measures of forgiveness; Forgiveness of Self (FOS), Forgiveness of Others (FOO), Tendency to Forgive (TTF), Attitudes Toward Forgiveness (ATF), and Heartland Forgiveness Scale

(HFS). Results indicated that all forgiveness measures except the TTF were significantly correlated to the criterion (See Table 4).

The FOS measure accounted for the greatest amount of variance in predicting BDI-II scores (See Model 1 in Table 5) and was followed by RSES (See Model 2 in Table 5). With both FOS and RSES as predictors, the remaining forgiveness measures did not contribute additional predictive value (see Table 5 for significance scores of excluded variables). These findings support Hypothesis 1 that, forgiveness scores predict a significant amount of variance in self-reported depressive symptomatology.

Research questions 3 and 4 are also addressed, as self-forgiveness accounted for more variance than self-esteem when predicting depressive symptomatology (remember that the intelligence measure was not included as a predictor as it did not correlate significantly with the variables of interest), thereby demonstrating that forgiveness scores predicted a greater proportion of self-reported depressive symptomatology over and above other resiliency factors (i.e., Reseach Question 3). Furthermore, even though most of the forgiveness measures utilized were initially significant predictors, FOS accounted for the greatest amount of variance in self-reported depressive symptomatology.

Table 4. *Correlations for Predictor Variables from Step-wise Regression Analysis with BDI-II as Criterion (N = 43).*

Predictor	BDI-II
RSES	-.66**
FOO	.34**
FOS	.76**
TTF	-.09
ATF	-.28*
HFS	-.54**

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

Table 5. *Summary of Step-wise Regression Analysis for Variables Prediciting COAs' Self-reported Depressive Symptomatology (N = 43).*

Predictors	B	SE B	ß
Model 1			
FOS	.48	.07	.76**
Model 2			
FOS	.36	.07	.56**
RSES	-.35	.11	-.35**
Adjusted R Squared			.64

Note. R^2 = .56 for Model 1, ΔR^2 = .08
*p < .05
**p < .01

Exclude Variables	Beta In	*t*	Sig.
Model 1			
RSES	-.35	-3.12	.00**
FOO	.24	2.01	.05*
TTF	-.01	-.04	.97
ATF	-.26	-2.78	.01**
HFS	-.25	-2.30	.03*
Model 2			
FOO	.15	1.55	.13
TTF	.06	.63	.53
ATF	-.17	-1.72	.09
HFS	-.16	-1.50	.14

*p < .05
**p < .01

In order to explore the seemingly important role of self-forgiveness in predicting self-reported depressive symptomatology, the HFS and FOS scores were removed from the step-wise regression equation, and replaced with the self-forgiveness scale from the HFS. This permitted exploration of whether or not self-forgiveness remained a significant predictor of self-reported depressive symptomatology using an alternate measure of self-forgiveness. Step-wise regression analysis was conducted with the BDI-II as the criterion, and the RSES, FOO, self-forgiveness scale of the HFS, the TTF, and ATF scores as predictor variables. In this case, the RSES was the only significant predictor of self-reported depressive symptomatology (see Table 6). Although the self-forgiveness scale of the HFS approached significance, it was not a significant predictor of self-reported depressive symptomatology, thereby raising questions about whether or not the two measures (i.e., HFS-self and FOS) are in fact assessing the same construct.

The following hypothesis was addressed using a Repeated Measure ANOVA analysis:

Hypothesis 2: Participants' forgiveness ratings will increase over the three proposed time frames (Past, Present, Future).

COAs' forgiveness ratings were compared across the three time periods previously outlined (Past, Present, and Future). The mean scores and corresponding standard deviations for each time period are found in Table 2 (Past Forgiveness = 51.4, Present Forgiveness = 62.6, and
Future Forgiveness = 73.5).

A Repeated Measures ANOVA indicated that the mean forgiveness ratings were significantly different from one another, $F(2, 41) = 18.43$, $p = .00$. Follow-up

Table 6. *Summary of Step-wise Regression Analysis for Variables Predicting COAs' Self-reported Depressive Symptomatology; Excluding FOS (N = 43).*

Predictors	B	SE B	ß
Model 1			
RSES	-.68	.12	-.69**
Adjusted R Squared			.46

Note. R^2 = .48 for Model 1
*$p < .05$
**$p < .01$

Exclude Variables	Beta In	*t*	Sig.
Model 1			
FOO	.18	1.55	.13
TTF	.03	.23	.82
ATF	-.10	-.77	.45
HFS_Self	-.25	-1.85	.07

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

comparisons, incorporating a Bonferroni adjustment for multiple comparisons, indicated that all three meanscores differed significantly from one another, thus supporting the hypothesis that participants' ratings of forgiveness increased over the three time periods. That is, participants rated themselves as least forgiving in the Past, with consistently increasing levels of forgiveness for the Present and Future time periods.

The following research questions were explored by utilizing a General Linear Model Multivariate analysis:

Research Question 5a: Are there sex differences in COAs forgiveness scores?

Research Question 5b: If there are sex differences in forgiveness scores, is there a similar or different relation between depressive symptomatology and forgiveness for the two groups?

In this analysis, sex was entered as a factor so as to compare female COAs and male COAs scores across the five dependent measures (FOO, FOS, TTF, ATF, and HFS). The simple contrast indicated that means of each dependent variable (see Table 2) were not significantly different for any forgiveness measure (see Table 7). This means that female and male COAs responded in a similar fashion across all forgiveness measures, and we can thereby conclude that in the present study there were no sex differences in COAs' tendency to forgive.

Relation between Forgiveness and Self-reported Depressive Symptomatology for non-COAs.

The same step-wise regression analysis that was utilized to explore Hypothesis 1 was employed to explore the relation of forgiveness and self-reported depressive symptomatology for non-COAs.

Table 7. *Multivariate Analysis Comparing Female COAs' and Male COAs' Scores on Five Measures of Forgiveness (N = 43).*

Contrast Female vs. Male	df	F	p
Measure			
FOO	1	5.44	.12
FOS	1	.23	.64
TTF	1	1.73	.20
ATF	1	.81	.37
HFS	1	.49	.49

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

Research Question 6: If, as predicted, there is a relation between forgiveness scores and self-reported depressive symptomatology, is this relation similar for COAs and non-COAs?

This final research question was addressed so as to be able to compare COAs' responses to non-COAs. As such, scores on the BDI-II were the criterion, with self-esteem (i.e., RSES) and the five forgiveness measures (i.e., FOO, FOS, ATF, TTF, and HFS) entered as predictor variables. Similar to results in the COA sample, RSES and FOS were both the most significant predictors of self-reported depressive symptomatology (see Table 8). For non-COAs, however, RSES predicted the most amount of variance, followed by FOS, which was opposite from the COA sample. Furthermore, these two variables accounted for slightly less variance in predicting self-reported depressive symptomatology for non-COAs as compared to COAs (see Tables 8 and 5 respectively).

It is also important to note that the excluded forgiveness measures in each model accounted for less variance for non-COAs as compared to COAs (see Tables 8 and 5). This suggests that although the relation between forgiveness, self-reported depressive symptomatology, and self-esteem is generally similar for *COAs* and non-COAs, there are also potentially meaningful differences.

In order to explore potential differences between COAs and non-COAs, beyond the above sample specific comparison, additional analyses were completed. Firstly, a comparison in ratings on the PANAS (including two of the additional words added) was conducted to see if COAs and non-COAs differed in their responses to various words that are associated with forgiveness and self-esteem.

Table 8. *Summary of Step-wise Regression Analysis for Variables Predicting non-COAs' Self-reported Depressive Symptomatology (N = 43).*

Predictors	B	SE B	ß
Model 1			
RSES	-.55	.05	.70**
Model 2			
RSES	-.45	.06	-.57**
FOS	.11	.04	.19*
Adjusted R Squared			.64

Note. R^2 = .48 for Model 1, ΔR^2 = .02
*p < .05
**p < .01

Exclude Variables	Beta In	*t*	Sig.
Model 1			
FOO	.10	1.64	.10
FOS	.19	2.45	.01**
TTF	-.11	-1.84	.07
ATF	-.01	-.17	.87
HFS	-.12	-1.81	.07
Model 2			
FOO	.07	1.21	.23
TTF	-.08	1.32	.19
ATF	-.00	-.07	.95
HFS	-.08	-1.17	.24

*p < .05
**p < .01

Scores for the words guilty, proud, ashamed, worthless, and forgiving were compared using Independent t-test analysis. No significant differences were found, which means that on the PANAS, COAs and non-COAs responded in a similar fashion and feel similarly guilty $t(1, 200) = 1.05$, $p = .30$; proud $t(1, 201) = .34$, $p = .73$; ashamed $t(1, 202) = .57$, $p = .57$; worthless $t(1, 202) = -.01$, $p = .99$; and forgiving $t(1, 202) = -.49$, $p = .62$.

Furthermore, visual examination of mean scores separated by Sex and COA-status, suggested a possible Sex x COA-status interaction for two key variables in the study, scores on the BDI-II and the RSES (see Table 2). To test this, a Multivariate General Linear Model analysis was completed with Sex and COA-status as fixed factors and the BDI-II and RSES scores as dependent variables. Results demonstrated a possible interactional trend, however, this interaction was not significant for either dependent variable; Sex x COA-status for BDI-II, $F(1, 200) = 1.0$, $p = 0.32$; and Sex x COA-status for the RSES, $F(1, 200) = 2.69$, $p = .10$. This means that there were no significant differences between participants' scores on the BDI-II or the RSES, regardless of their sex or COA-status.

Visual examination of mean scores also indicated possible COA and non-COA differences on the Forgiveness and Depression Timelines (i.e., Past, Present, and Future ratings; see Table 2). To explore this possibility, two Repeated Measures ANOVAs were conducted, one for the Forgiveness Timelines and one for the Depression Timelines.

Results for the Forgiveness Timelines revealed a significant main effect of Forgiveness, $F(2, 199) = 45.40$, $p = .00$, which was further qualified by a significant Forgiveness x COA-status interaction, $F(2, 199) = 5.39$, $p = .01$. This means that over the three time periods (Past, Present, and Future), COAs and non-COAs forgiveness ratings differ. Follow-up comparisons, incorporating a Bonferroni adjustment for

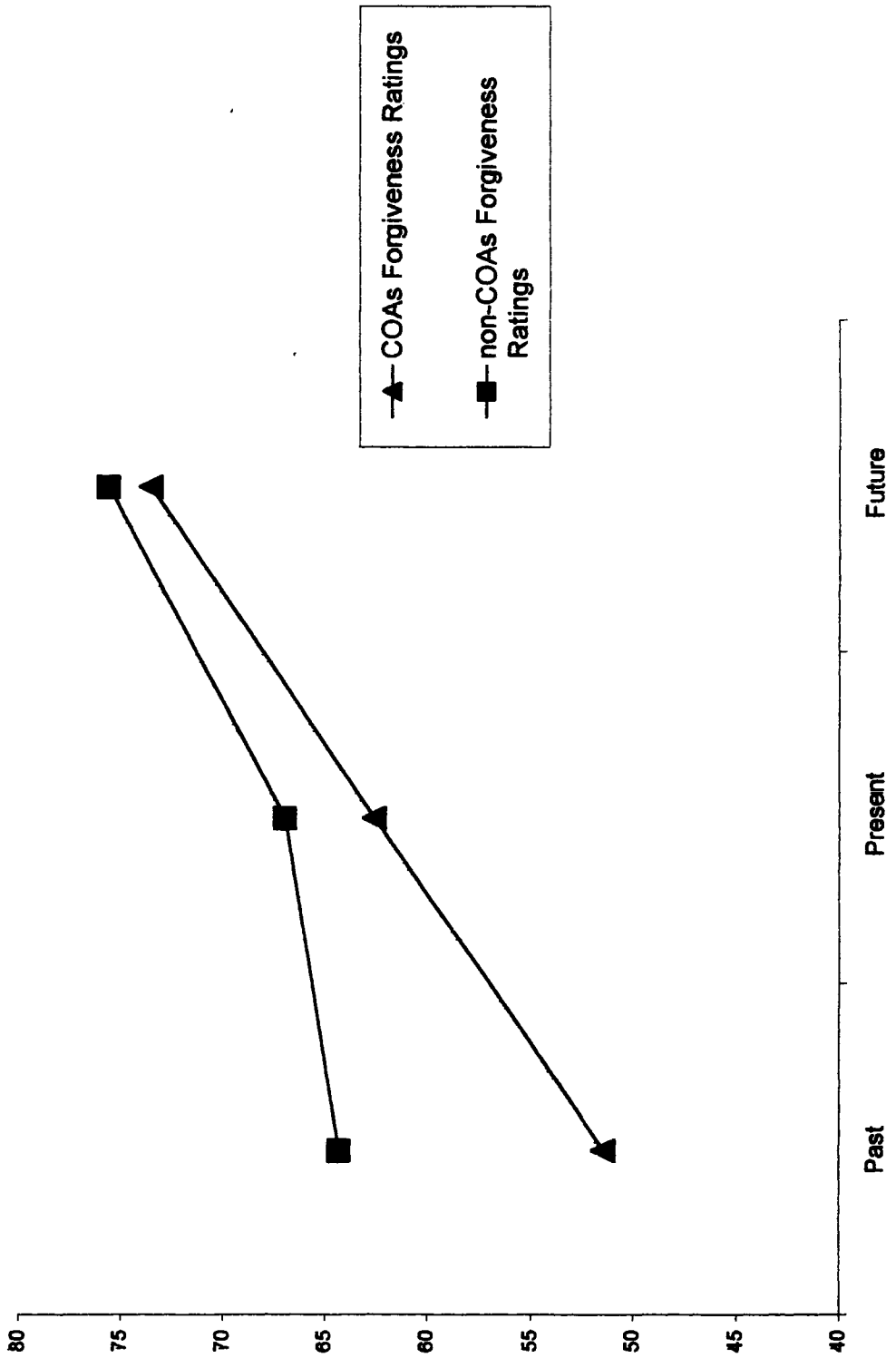
multiple comparisons, indicated that while COAs forgiveness ratings increased significantly across the three time periods (as previously outlined in the support for Hypothesis 2), non-COAs forgiveness ratings were not significantly different from Past to Present, while the Future forgiveness were significantly higher. This means that COAs forgiveness ratings increased over the three time periods in a linear fashion, while non-COAs forgiveness ratings only increased from the Present to the Future time period.

The within group differences in ratings further suggested the possibility that COAs forgiveness ratings may have differed significantly from non-COAs forgiveness ratings at the same time periods (e.g., COAs Past forgiveness ratings may have been less than non-COAs Past forgiveness ratings). A Oneway ANOVA confirmed that COAs Past forgiveness ratings were significantly lower than non-COAs Past forgiveness ratings, $F(1, 200) = 10.20$, $p = .00$. There were, however, no significant differences between COAs and non-COAs Present and Future forgiveness ratings (see Figure 1).

Results of the Repeated Measures ANOVA for the Depression Timelines indicated a main effect of Depression, $F(9, 199) = 26.61$, $p = .00$, but no significant interaction between Depression and COA-status. This means that COAs and non-COAs depression ratings changed in a similar fashion across the three time periods (Past, Present, and Future). Follow-up comparisons using a Bonferroni correction for multiple comparisons, indicated that COAs and non-COAs depression ratings were not significantly different from the Past to the Present, but increased significantly from the Present to Future timelines.

A Oneway ANOVA analysis directly compared COAs and non-COAs ratings at each time period. Similar to the forgiveness ratings, the only significant finding was

Figure 1. *COAs and non-COAs Past, Present, and Future Forgiveness Ratings*



found in the Past depression ratings, with COAs depression ratings being significantly higher as compared to non-COAs, $F(1, 201) = 4.53$, $p = .04$. This means that COAs rated themselves as significantly more depressed in the past as compared to non-COA participants (see Figure 2).

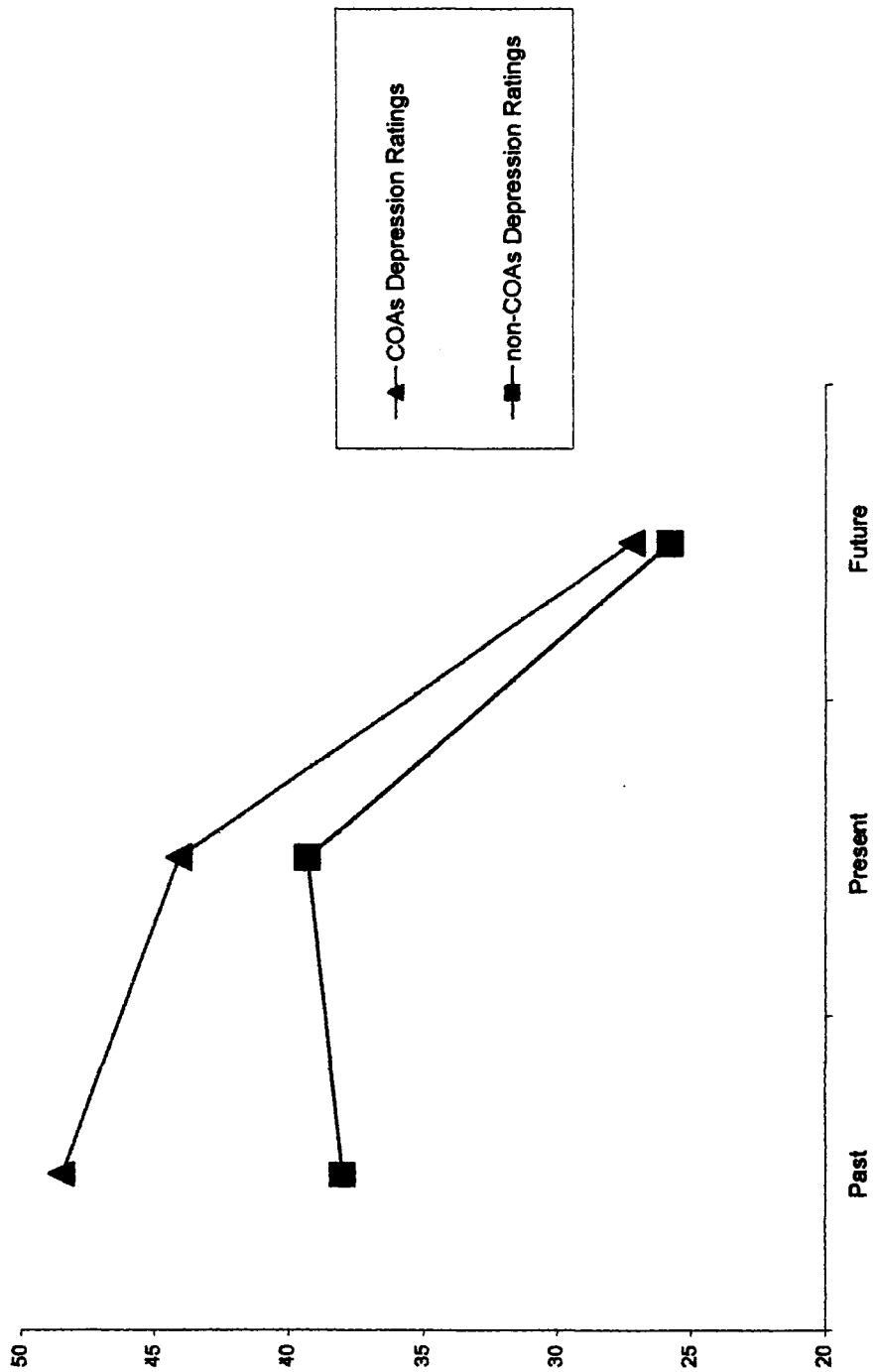
Forgiveness Measures

A final purpose of the present study was to examine the utility and cohesion of various forgiveness measures, as a number forgiveness measures (including a measure developed by our own research team) have developed as a result of the escalating amount of psychological research on forgiveness. By reviewing the Pearson Product Correlations in Table 3a, a number of conclusions can be drawn.

First of all, the Forgiveness of Self (FOS) and Forgiveness of Others (FOO) correlate negatively with other measures of forgiveness, which supports the description of these two scales as measures of lack of forgiveness or "unforgiveness." The FOO scale correlates significantly with most other measures of forgiveness, except the FOS. This suggests that most forgiveness scales are geared toward measuring outward or other-focused expressions of forgiveness, and that the FOO and FOS are definitely tapping into separate constructs (i.e., forgiveness of others and forgiveness of self are different forms of forgiveness). The existence of two different forms of forgiveness is further supported by the fact that the FOS only correlates significantly with the Heartland Forgiveness Scale (HFS), which has a subscale of self-forgiveness.

When reviewing the correlation between the timeline measure of forgiveness (i.e., participants' Past, Present, and Future Forgiveness ratings) and the other measures of

Figure 2. *COAs and non-COAs Past, Present, and Future Depression Ratings*



forgiveness, it is interesting to note that Past forgiveness ratings did not correlate significantly with any measures of forgiveness. Present Forgiveness ratings, however, correlated significantly with most other measures of depression, which suggests that people are most likely to conceptualize forgiveness in a present-time context. It is also interesting to note that FOS was the only forgiveness measure that did not correlate significantly with the Present Forgiveness rating, which suggests that when completing the timelines, participants were conceptualizing forgiveness as an outward, other-focused task. The strongest correlation with the Future Forgiveness timeline was with the Attitudes Toward Forgiveness (ATF) measure. It is also interesting to note that the Tendency to Forgive (TTF) scale did not correlate significantly with Future Forgiveness ratings, which suggests that if trying to evaluate future levels of forgiveness, it is better to consider participants' attitudes and beliefs about forgiveness, as opposed to their current likelihood of forgiving.

The HFS correlated significantly with most measures of forgiveness, except for the ATF and TTF. This may be related in part to the fact that neither the ATF nor the TTF are related to self-forgiveness (as evidenced by lack of significant correlations with the FOS), and the somewhat more vague nature of the questions in the ATF and TTF as compared to the HFS.

DISCUSSION

The present study examined forgiveness as a resiliency factor in a sample of children of alcoholics (COAs) and a similar sample of non-COAs. Resiliency was operationally defined in terms of level of self-reported depressive symptomatology, as measured by the Beck Depression Inventory-II (BDI-II; Beck et al., 1996). A study conducted by Osterndorf (2000), found that COAs who participated in a forgiveness intervention had significantly lower levels of self-reported depressive and anxiety related symptomatology as compared to COAs who participated in a conflict-resolution intervention. The present study expanded on this finding by examining whether or not the relation between forgiveness and depressive symptomatology exists in the absence of participation in specific forgiveness training. The present study also sought to explore generalizability of this finding by recruiting a more diverse sample (e.g., inclusion of both males and females and greater ethnic diversity) and by utilizing a number of forgiveness measures (including the Forgiveness of Self – FOS and Forgiveness of Others – FOO, Mauger et al., 1992; Heartland Forgiveness Scale - HFS, Yamhure Thompson et al., 2005; and the Tendency to Forgive- TTF and Attitudes Toward Forgiveness – ATF, Brown, 2003).

Relation Between Forgiveness and Depression for COAs

The major finding in the present study is that levels of forgiveness, and more importantly self-forgiveness, predict self-reported depressive symptomatology with higher levels of forgiveness predicting lower levels of self-reported depressive symptomatology. This finding supports existing literature that forgiveness is inversely

related to negative emotional states such as depression (Brown, 2003; Maltby et al., 2001; and Osterndorf, 2000) and, therefore, conceptualization of forgiveness, specifically self-forgiveness, as a resiliency factor appears to be valid and warranted.

Self-Forgiveness

The fact that self-forgiveness emerged as the most significant predictor of self-reported depressive symptomatology was not expected as Osterndorf's (2000) work focused on other-focused forgiveness. As such, the present study followed suit, conceptualizing forgiveness in the more traditional other-focused manner with the idea that it may be a potentially important factor in COAs' interpersonal relationships. For example, COAs may have a number of opportunities for other-related forgiveness given the generally chaotic family environment within which they are raised (Griffin et al., 2000; Griffin & Amodeo, 1998). Forgiveness opportunities may include a variety of situations such as coping with broken parental promises, COAs being embarrassed by their parents' drinking behaviour, and instances of verbal, physical, or sexual abuse.

The definition of forgiveness utilized in the present study reflects the typical other-focus found in the majority of forgiveness research. Forgiveness in the present study was defined as *an active process of intraindividual, prosocial change in emotions, behaviour and/or cognitions in relation to a perceived transgressor. This process involves relinquishing negative emotions, cognitions, and behaviours towards the perceived transgressor and may encompass adopting positive emotions, cognitions, and behaviours*. Although the definition was clearly other-forgiveness oriented (e.g., the description following this definition stated that the forgiver was often the "victim"), it is

amenable to the inclusion of self-forgiveness. The definition remains viable as long as it is made clear that the "perceived transgressor" may include oneself and recognition of the fact that "transgressor" does not necessarily imply that a negative act was intentionally perpetrated. For example, forgiveness may be a viable choice in the face of negative actions or non-actions that result in negative outcomes (i.e., forgiving yourself or someone else for not following through on a promise to help another individual).

The amended definition should therefore read: *Forgiveness is an active process of intraindividual, prosocial change in emotions, behaviour and/or cognitions in relation to a perceived transgressor* ***(which may include oneself)****. This process involves relinquishing negative emotions, cognitions, and behaviours towards the perceived transgressor/****oneself following negative actions perpetrated by that individual or non-action that resulted in negative outcomes.*** *Forgiveness may also encompass adopting positive emotions, cognitions, and behaviours.* The slight modification to the definition makes it consistent with both self– and other-forgiveness.

In terms of defining self- and other-forgiveness, Mauger and colleagues (1992) suggest that self-forgiveness reflects an intropunitive style, in contrast to other-forgiveness being indicative of an extrapunitive style. A person who views him or herself as damaged, not worthy of acceptance, and who has a tendency to internalize blame characterizes the intropunitive style and struggles to forgive him or herself. Conversely, the extrapunitive style is characterized by a person who seeks revenge, is more likely to hold grudges, and tends to blame others for transgressions, thereby being unlikely to forgive others. Therefore, self-forgiveness is associated more with qualities

related to guilt, shame, and failure while other-forgiveness generally includes the relinquishing of grudge-like intentions toward others.

Comparing Self- and Other-Forgiveness

Recent literature has supported the existence of two distinct forms of forgiveness (Leach & Lark, 2004; Ross, Kendall, Matters, Wrobel, & Rye, 2004). This vein of research began by exploring the personality characteristics associated with forgiveness utilizing the Five Factor model of personality (FFM), also referred to as the "Big Five," (Neuroticism-Emotional Stability, Extraversion-Introversion, Openness-Closedness to Experience, Agreeableness-Antagonism, and Conscientiousness-Indirectness; Costa & McCrae, 1992). A positive relation between forgiveness and Agreeableness (generally characterized as trust, love, compassion, and empathy) was fairly well established (see McCullough et al., 1997; Ashton, Paunonen, Helmes, & Jackson, 1998; Berry et al., 2001; and John, 1990). A negative relation between forgiveness and Neuroticism (generally characterized as anxiety, depression, self-consciousness, impulsiveness, and vulnerability) was also established. It should be noted, however, that these studies did not differentiate between self- and other-forgiveness.

Ross and colleagues (2004) expanded upon this initial research by evaluating which personality constructs are related to self- and other-forgiveness. Results indicated that self-forgiveness was negatively related to Neuroticism and unrelated to Agreeableness, while other-forgiveness was unrelated to Neuroticism and positively related to Agreeableness. In general terms, people who display empathy and are more able to trust are more likely to engage in other-forgiveness, however, individuals who are

emotionally stable and are not experiencing symptoms of depression, anxiety, or feeling vulnerable are more likely to engage in self-forgiveness. Given these differences, the researchers suggested that their findings support the notion that self- and other-forgiveness are distinct constructs and not simply opposite poles of a continuum (Ross et al., 2004).

The finding that self-forgiveness is negatively related to Neuroticism, fits with the description of self-forgiveness as an intropunitive style (Mauger et al., 1992), as both constructs are similar (i.e., the intropunitive style described as someone who views themselves as damaged, not worthy of acceptance, and who tends to internalize blame, while neuroticism is characterized by anxiety, depression, self-consciousness, impulsiveness, and vulnerability). Furthermore, many of the personality characteristics associated with the intropunitive style and neuroticism are facets of depression.

Recalling the cognitive behavioural conceptualization of depression as outlined by Beck (1967), people who are experiencing depression have negative views about themselves, the world, and the future. Thus, if an individual believes that s/he is damaged, is at fault, is unlovable, and lacks confidence s/he is more likely to experience symptoms of depression (which also fits with the definition of self-forgiveness outlined by Mauger et al., 1992). The findings from the present study support the notion that difficulty forgiving oneself and negative self-perceptions are related to higher levels of depressive symptomatology, and the reverse is also true. That is, Ross et al. (2004) found that depression was the best predictor of self-forgiveness. Therefore, not only do higher levels of self-forgiveness predict lower levels of self-reported depressive

symptomatology, but the more depressed someone is the less likely they are to forgive themselves.

Self-forgiveness emerging as the most significant predictor of self-reported depressive symptomatology in the present study, suggests that perhaps it is COAs' self-perceptions (rather than their interpersonal interactions) that are most related to self-reported depressive symptomatology. This means that if COAs believe that they have failed at something, have done something wrong or shameful, about which they feel guilty and are not able to forgive themselves, they are more like to experience depressive symptomatology. Therefore, conceptualizing self-forgiveness in terms of overcoming shame, failure, and guilt is theoretically consistent with the idea of self-forgiveness acting as a resiliency factor that protects against the development of depressive symptomatology.

Resiliency

The interpretation that self-forgiveness is a resiliency factor for COAs in the present study increases the generalizability of Osterndorf's (2000) findings, because the relation between forgiveness and self-reported depressive symptomatology exists in a sample that was not exposed to a forgiveness intervention. Forgiveness and self-forgiveness functioning as resiliency factors for people who have not experienced a direct forgiveness intervention, might help to explain why some COAs who have not received treatment may be functioning at a more optimal level as compared to other COAs. Based on the results of the present study, COAs who are more likely or able to forgive

themselves have lower levels of self-reported depressive symptomatology and are therefore more resilient.

The results of Osterndorf's (2000) work suggest that the action of increasing forgiveness or decreasing unforgiveness promotes resiliency by creating more positive outcomes, such as decreased depression and anxiety. This is turn suggests the possibility that inability to forgive may be a causal factor in the development of depression and anxiety. Inability to forgive may also act as a mediating factor that maintains a state of depression or anxiety. For example, if a neuro-chemical imbalance is the causal factor in the development of depression, inability to forgive may impede recovery even if inability to forgive is not the causal agent of depression. The causal relation between forgiveness and depression (if any) is not clear and a number of additional factors related to resiliency must be considered in conjunction with these constructs.

As might be expected resiliency is multi-faceted. In addition to self-forgiveness, self-esteem also predicted a significant proportion of self-reported depressive symptomatology for COAs. The negative relation between self-esteem and depression (i.e., higher levels of self-esteem are associated with lower levels of depression) is well established (e.g., see Hewinsohn, Hoberman, & Rosenbaum, 1988), but the relation between forgiveness, self-esteem, and depression is less clear. Osterndorf's (2000) work alluded to importance of considering self-esteem in the exploration of the relation between forgiveness and depression, as she included self-esteem as a variable of interest in her study. She utilized self-esteem and depression scores as an outcome measures, which did not address potential similarities or differences between forgiveness and self-esteem in relation to depression. The two concepts may be related as both self-esteem

and forgiveness have cognitive components. Self-forgiveness and self-esteem might be even more similar as they both involve perceptions about oneself. The present study demonstrated that self-forgiveness and self-esteem both predict self-reported depressive symptomatology, and that self-forgiveness predicts a unique portion of variance over and above self-esteem. This means that although there may be similarities between self-forgiveness and self-esteem, the two concepts are distinct and, therefore, both require consideration in terms of development, maintenance, and treatment of depressive symptomatology.

An additional proposed resiliency component of the present study was the role of intelligence, as measured by the Shipley Institute of Living Scale (Zachary, 2000). Although intelligence was not statistically important for this sample, this does not mean that intelligence does not play a role in COAs' resiliency. The relation between forgiveness and intelligence, however, is not well understood and requires more exploration and research.

Generalizability of Forgiveness as a Resiliency Factor

It is clear from the results of the present study that higher scores on measures of self-forgiveness and self-esteem are related to lower levels self-reported depressive symptomatology for COAs. The findings also suggest that the relation between forgiveness and self-reported symptomatology in COAs is somewhat generalizable across age, sex, and ethnic background. For example, in contrast to Osterndorf's (2000) study, the present study included a younger sample, males and females (as opposed to her almost exclusively female sample) and a more ethnically diverse sample (as opposed to

an almost exclusively Caucasian sample). The fact that elevated forgiveness scores significantly predicted lower levels of self-reported depressive symptomatology for a more diverse sample suggests that forgiveness may be an important resiliency factor in various stages of adulthood, regardless of sex or ethnicity.

In order to access a longitudinal perspective of forgiveness and depression, participants' were asked to rate level of forgiveness and depression from 0-100 across three specific time periods ("Past" = five years before the time of the study, "Present" = two weeks within the time of the study, and "Future" – five years from the time of the study). Participants' forgiveness ratings increased across all three time periods supporting the notion that forgiveness may act as a resilience factor across periods of adult development, because regardless of participants' age (which ranged from 18 to 54 years), forgiveness ratings were greatest for the "Future" time period. This suggests that participants believe that they are likely to continue to develop forgiveness related skills and believe that they will become more adept at forgiveness in the future (i.e., become more forgiving).

In contrast to steadily increasing forgiveness ratings, depression ratings were more stable from the "Past" to "Present" time periods, but ratings decreased significantly for the "Future" time period. This suggests that participants viewed "Past" and "Present" levels of depression as very similar, but expect to experience less depression in the "Future" time period.

The inverse relation between participants' forgiveness and depression ratings (i.e., forgiveness ratings increasing across time periods and depression ratings lowest in the "Future" time period) fits with the notion of forgiveness as a resiliency factor.

Correlations between the ratings did not mirror this negative relation, which may be related to a number of factors. First, the correlations may not have been significant given that there was not a significant difference between COAs "Past" and "Present" depression ratings. This means that the relation between depression and time is not uniformly linear, which in turn, may have influenced the relation between forgiveness and depression ratings. Second, perhaps the sample size of the COA group was not large enough to demonstrate the relation. Third, correlations among forgiveness measures indicated that self-forgiveness was not correlated with the forgiveness timeline ratings, which suggests that when the participants rated forgiveness on the timelines, they were focusing on other- and not self-forgiveness. As self-forgiveness was the greatest predictor of self-reported depressive symptomatology for COAs, it may stand to reason that significant correlations were not found between the forgiveness and depression timeline ratings, because the relation between depression and forgiveness is better predicted by self- and not other-forgiveness. In order to better understand the relation between depression and forgiveness for COAs, results were compared to a similar sample of non-COAs to provide a contextual reference point.

Similarities and Differences Between COAs and non-COAs

Historically, research on COAs has focused on how to determine how COAs differ from non-COAs. Failure to adequately describe each sample has hampered this goal. In the present study, efforts were made to obtain a diverse sample including similar number of males and females with varied cultural/ethnic backgrounds. In terms of demographic characteristics, the COA and non-COA samples were generally quite

similar. For example, similar numbers of males and females participated (99 females and 105 males participated) and ethnic/cultural distributions were similar across the COA and non-COA samples. Beyond demographic characteristics, COAs and non-COAs scored very similarly on measures of self-esteem, forgiveness, IQ, and self-reported depressive symptomatology. There were also no significant sex differences across these scores, which is most notable with regards to depressive symptomatology where there was an expectation of sex differences.

The failure to find sex differences was unexpected, however, the result is commensurate with a growing body of work that has suggested the possibility that previously established sex differences in prevalence rates of depression may have been a result of reporter bias, that is, females may have been more likely to report symptoms of depression as compared to males (e.g., Hunt, Auriemma, & Cashaw, 2003; Scarpa, Fikretoglu, Bowser, Hurley, Pappert, Romero, & Van Noorhees, 2002; Dozois, Dobson, & Ahnberg, 1998).

One significant difference between the COA and non-COA samples was age, with the average COA age being significantly older (27.3 versus 21.7 years). This is potentially relevant because age might be related to how items on the Children of Alcoholics Screening Test (CAST; Jones, 1983) were endorsed. Given their average older age, it is possible that COAs in the present sample were further removed from their family of origin as compared to non-COAs and thus able to look back at experiences within their family of origin with increased objectivity. Experiences that may have affected COAs' objectivity might include moving out of the family home to live independently, meeting a wider variety of people and learning about different families of

origin, becoming intimately involved with another family system through dating or marriage, or starting one's own family by becoming a parent. Reflection upon similarities and differences among families could result in increased awareness of atypical parental behaviour and alcohol consumption in the family of origin that may have been less evident when COAs were younger and/or living with their family of origin. If this is the case, it is possible that within time, a portion of non-COAs would respond differently to the items on the CAST and may meet criteria for COA status (i.e., score six or higher on the CAST). A change in COA status might be especially likely for those non-COAs who scored just below the COA cutoff (e.g., scored four or five on the CAST). An implication of this finding is that for younger participants lower cut-off scores than previously outlined may be indicative of parental drinking problems.

Differences between COAs and non-COAs were also found when their responses to the Forgiveness and Depression Timelines were compared. At the Past time period, COAs rated themselves as significantly less forgiving and significantly more depressed as compared to non-COAs. This raises the issue of determining the factors that may have differed between COAs and non-COAs over the past five-years, which in turn may have impacted perceptions of forgiveness and depression (e.g., exploring situations related to stress, losses, or trauma). The difference may also reflect stage of life discrepancies with differing concerns and responsibilities, as five years prior to the study the average age of COAs would have place them in young adulthood, while the average age of non-COAs would have placed them in the midst of high school.

Another difference, which may be specific to this sample but is worth exploring, is the fact that although the two main resiliency predictors for COAs and non-COAs were

the same (i.e., FOS and RSES), FOS predicted a greater proportion of self-reported depressive symptomatology for COAs, while RSES predicted a greater proportion of self-reported depressive symptomatolgoy for non-COAs. In the context of previous discussions of self-forgiveness and self-esteem, the reversal may suggest that greater predictive value of self-forgiveness for COAs reflects a greater sense of guilt, shame, or failure as compared to non-COAs. Although no direct measure of guilt or shame was included in the present study, an effort was made to explore this possibility by comparing COAs' and non-COAs' ratings on selected terms from the PANAS that reflect forgiveness and self-esteem (i.e., guilty, proud, ashamed, worthless, and forgiving). There were no significant differences between COAs' and non-COAs' responses, given however, the disparity in sample size (i.e., 43 COAs and 161 non-COAs) and the crude measurement of guilt and shame, the question of comparing experiences of guilt, shame, and failure between the two groups should be further explored.

Forgiveness as an Intervention

The results of the present study are consistent with existing studies that have documented positive outcomes associated with forgiveness in general. These positive outcomes may be further enhanced by therapeutic forgiveness interventions. An increasing number of studies utilizing forgiveness as a therapeutic intervention strategy have been completed (e.g., Al-Mabuk et al., 1995; Coyle & Enright, 1997; Freedman & Enright, 1996; Hebl & Enright, 1993; Lin, Mack, Enright, Krahn, & Baskin, 2004; McCullough & Worthington, 1995; McCullough et al., 1997; Osterndorf, 2000; and Worthington & Scherer, 2004). In a recent meta-analysis of forgiveness intervention

studies, Baskin and Enright (2004) concluded that forgiveness interventions could be construed as "Probably Efficacious Treatment," which means that forgiveness as a clinical intervention has empirical support. The utility of using forgiveness as an intervention technique is further underscored by the fact that Baskin and Enright (2004) reported that significant positive changes were maintained for a number of months after the intervention, as many as 14 months in one study. As such, they suggest that forgiveness interventions should be directed at a wide variety of populations, such as people struggling with conduct disorder, oppositional defiant disorder, mood disorders, and anxiety disorders (as described by the DSM-IV-TR; APA, 2000).

The finding that self-forgiveness can be construed as a resiliency factor adds important information to the literature base exploring forgiveness as an intervention strategy. Based on results from the present study and research exploring personality correlates of self- and other-forgiveness (e.g., Ross et al., 2004), the specific content of the forgiveness intervention must be carefully considered. For example, it appears that individuals experiencing internalizing problems such as depression may benefit more from exploring self-forgiveness, while individuals experiencing more externalizing problems associated with anger and hostility may benefit more from exploring other-forgiveness.

Future research needs to compare self- and other-forgiveness interventions within similar populations in order to determine which format is most effective. For example, in terms of COA research, future studies could investigate COAs' perception of their role in relation to negative events, examining the responsibility or blame that they assign to themselves, as well as their perceptions of their alcoholic parent(s). Given that

individuals' interpretations of events in relation to forgiveness can be quite subjective (Schmitt, Gollwitzer, Forster, & Montada, (2004), it would also be important to explore whether or not the perceptions are realistic before deciding if and how forgiveness should be explored (i.e., Did COAs actually do anything wrong? How/where did they learn messages pertaining to shame and guilt?). Participants' or clients' perceptions, most notably self-perceptions, could have especially important implications for development and treatment of depressive symptomatology (i.e., when to promote acceptance of thoughts or situations and when to challenge potentially distorted views). In order to maximize effectiveness, exploration of forgiveness should also include clients' forgiveness related expectations, as well as other potentially important factors such as religious or spiritual beliefs (Walker & Gorsuch, 2004; Leach & Lark, 2004) and cultural/ethnic background (Fu, Watkins, & Hui, 2004).

Measuring Forgiveness

The final purpose of the present study was to explore the utility of various forgiveness measures. Correlation results indicated that for the most part, measures of forgiveness were positively related to one another, with the exception of the FOS and FOO. The FOS and the FOO, however, are negatively worded scales and, therefore, negative correlations with other forgiveness measures are conceptually consistent as the FOS and FOO are in fact measures of "unforgiveness."

The existence of two distinct forms of forgiveness (i.e., self- and other-forgiveness) was supported by findings that the FOS only correlated significantly with the HFS, which has a self-forgiveness subscale, while the FOO scale correlated

significantly with most other measures of forgiveness, but not the FOS. These distinctions underscore the importance of researchers being very clear in defining forgiveness and carefully considering their choice of forgiveness measures accordingly.

The importance of measure selection is further underscored by the finding that the FOS measure was a significant predictor of self-reported depressive symptomatology, while HFS-self was not. This may reflect differences in the measures themselves or the concepts they purportedly assess. For example, by reviewing the items on the FOS, one gets a sense that major components of the scale are guilt (sample items include, "I feel guilty because I don't do what I should for my loved ones," "I often feel that no matter what I do now I will never make up for the mistakes I have made in the past," and "I frequently apologize for myself.") and failure ("I often feel like I have failed to live the right kind of life," and "I frequently put myself down for failing to work as hard as I should."). The HFS-self scale, on the other hand, is much briefer and somewhat less specific (e.g., "Although I feel badly at first when I mess up, over time I can give myself some slack," and "With time I am understanding of myself for mistakes I've made.").

Factor analysis can be utilized to clarify definitional issues by evaluating how various items and measures "group together" in order to determine if concepts are similar. Ross et al., (2004) completed such a study and found that the FOS scale and HFS-self subscale did group together, however, the HFS-situation subscale also loaded on the self-forgiveness factor, which suggests that discussions surrounding how to define and thereby measure forgiveness are far from over.

An additional measurement issue is whether or not participants' conceptualizations of forgiveness are similar to those proposed by the researcher(s).

Research has suggested that participants' views of forgiveness are idiosyncratic (Orr, Sprague, Goertzen, Cornock, & Taylor, in press; Mullet, Girard, & Bakhshi, 2004; Younger, Piferi, Jobe & Lawler, 2004). This is relevant as research has also suggested that people's expectations about forgiveness and their motivations for forgiveness (i.e., self-oriented versus other-oriented) may differentially impact forgiveness related outcomes (Younger et al., 2004). For example, Younger and his colleagues (2004) suggested that if forgiveness occurs for interpersonal reasons without a corresponding intrapsychic change there might be fewer positive outcomes for the forgiver. It appears that Younger and his colleagues (2004) may actually be describing psuedo- or false-forgiveness, which by definition should not result in similarly positive outcomes as compared to a more "pure" form of forgiveness. Their point, however, that participants' conceptualizations must be taken into account is well taken and, therefore, researchers must be very clear as to how they define and measure forgiveness. This process of deriving a better understanding of participants' conceptualizations of forgiveness in research is analogous to exploring individual's perceptions and experiences of forgiveness within a therapeutic context before utilizing forgiveness as an intervention technique.

Results of the present study demonstrate factors that should be taken into consideration when measuring forgiveness. For example, the Present Forgiveness Timeline was significantly positively correlated with most measures of forgiveness, but not the FOS. This suggests that most measures of forgiveness are best suited to measuring current other-forgiveness levels, which means that studies interested in exploring self-forgiveness or forgiveness levels in the past should employ other

measures. For example, in the case of past levels of forgiveness, perhaps a qualitative/narrative format could be utilized or the wording of items could be modified to ask participants to consider their past behaviours, cognitions, and/or emotions. The fact that the Present Forgiveness Timeline did not correlate with the FOS measure also suggests that participants had a tendency to view forgiveness in other-focused terms. This finding provides additional support for the necessity of incorporating both self- and other-forgiveness constructs in forgiveness research.

Future Directions

The main purpose of the present study was to explore the robustness of the relation between forgiveness and depressive symptomatology. This was accomplished by exploring forgiveness and self-reported depressive symptomatology in a non-clinical population (i.e., participants were not exposed to a forgiveness intervention) that was diverse in terms of sex and ethnic/cultural background. Although the main question of whether or not forgiveness is a resiliency factor was addressed (i.e., self-forgiveness does appear to be a resiliency factor as defined by lower levels of self-reported depressive symptomatology for COAs and non-COAs), a number of questions remain.

First, the sample of COAs was relatively small, which did not allow for within group comparisons. Utilizing a larger, more community based (i.e., non-university) COA sample would be useful to explore questions of whether or not there may be differences in terms of variables of interest (such as levels of forgiveness, self-esteem, shame, and guilt). A larger sample would also allow for exploration of sub-samples of COAs to determine if various factors such as having one or two alcoholic parents, whether the

alcoholic parent is male or female, and if length/severity of parental alcoholism should be considered. A larger sample may also be better suited to explore the possibility of sex differences and may be more informative in terms of exploring the relation between forgiveness and intelligence (which was not a predictive factor in this study) as well as the nature of forgiveness across the lifespan. Furthermore, longitudinal studies of larger samples would aid in understanding the nature of forgiveness as a resiliency factor (i.e., whether forgiveness is best described as a compensatory, challenging, or immunizing resilience factor; Garmezy et al., 1984), and may also clarify whether or not COA status changes over time (i.e., if participants' conceptualizations of parental drinking behaviour change over time).

Second, it would be useful to compare the relation between forgiveness and self-reported depressive symptomatology in other at-risk groups besides COAs, such as children of depressed parents or children who have been abused. Comparisons should include measurement of concepts related to self- and other-forgiveness, such as guilt, shame, empathy, and hostility to aid in understanding the scope of forgiveness as a resiliency factor. Exploring forgiveness and factors related to forgiveness across various groups would also aid in learning more about who may benefit from forgiveness interventions. Utilizing larger, diverse samples and varied comparison groups will help to address the long-standing question of whether or not COAs constitute a unique group.

Finally, greater care needs to be taken in ensuring that researchers and therapists are cognizant of both self- and other-forgiveness. In terms of research, designs that reflect both forms of forgiveness will enable the research community to better understand the process of forgiveness, associated outcomes, and who is likely to benefit from

engaging in the forgiveness process. Additionally, greater care in ascertaining participants' understanding of forgiveness constructs must be undertaken. Findings from research can then be directly applied to clinical settings. In therapeutic contexts, therapists must take the time to address clients' motivations, intentions, and expectations related to forgiveness so as to maximize understanding, which in turn should facilitate implementation of the technique so as to obtain maximum effectiveness.

Concluding Comments

Forgiveness is a concept that has been utilized successfully at individual, organizational, and global levels. Despite the relative infancy of psychological research on forgiveness, it is heartening to observe such a wide variety of studies and applications of forgiveness interventions. Perhaps, even more heartening are the positive results that are emerging. With increasing personal demands associated with busy lifestyles, the clashing of cultures that accompanies globalization, and widespread social instability, it appears that ample opportunities to explore and possibly encourage forgiveness exist. As the research community gains understanding about how to best implement forgiveness, both as a personal quality and intervention strategy, the benefits associated with forgiveness should continue to proliferate.

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APPENDIX A: MEASURES

DEMOGRAPHIC INFORMATION

To help us describe the group of people that participated in this study, please answer the following questions. You may omit questions that you do not wish to answer. You are, however, encouraged to answer as many questions as possible.

1. Your age:_____
2. Your sex: Female [ ] Male [ ]
3. Your marital status: Married, engaged, or living with partner [ ]
   Single (divorced, separated, or widowed) [ ]
   Single (never married) [ ]
4. Living arrangement:
   Alone [ ] Family [ ] Partner/Spouse [ ]
   Relative [ ] Roommate(s) [ ] Other:_____
5. As a child did you feel emotionally close to your mother? Yes [ ] No [ ]
6. Do you currently feel emotionally close to your mother? Yes [ ] No [ ]
7. As a child did you feel emotionally close to your father? Yes [ ] No [ ]
8. Do you currently feel emotionally close to your father? Yes [ ] No [ ]
9. As a child, were you emotionally close to an adult besides your parent (e.g., a positive adult mentor such as a neighbour, grandparent, aunt/uncle, family friend) Yes [ ] No [ ]
10. Your program of study: Major:_____ Minor:_____
11. Your year of study: First [ ] Second [ ] Third [ ] Fourth [ ]
12. To which ethnic or cultural group(s) do you belong? _____
13. Do you believe in a god? Yes [ ] No [ ]
14. Do you believe in a higher power? Yes [ ] No [ ]
15. Do you identify with a particular religious group? Yes [ ] No [ ]
    If yes: What religious group do you belong to? _____
    How long have you been a member of this group?_____
    Do you attend religious gatherings regularly? Yes [ ] No [ ]
16. Have you ever sought therapy or counselling in the past? Yes [ ] No [ ]
    If so, for how long? _____
17. Are you currently participating in therapy or counselling? Yes [ ] No [ ]
    If so, for how long? _____

APPENDIX A: CHILDREN OF ALCOHOLICS SCREENING TEST (CAST)

Please √ the answer below that best describes your feelings, behaviour, and experience related to a parent's alcohol use. Take your time and be as accurate as possible. Answer all 30 questions by checking either "yes" or "no."

Sex: Male:_____ Female:_____ Age:_____

YES	*NO*	*QUESTION*
		1. Have you ever thought that one of your parents had a drinking problem?
		2. Have you ever lost sleep because of a parent's drinking?
		3. Did you ever encourage one of your parents to quit drinking?
		4. Did you ever feel alone, scared, nervous, angry, or frustrated because a parent was not able to stop drinking?
		5. Did you ever argue or fight with a parent when s/he was drinking?
		6. Did you ever threaten to run away from home because of a parent's drinking?
		7. Has a parent ever yelled at or hit you or other family members when drinking?
		8. Have you ever heard your parents fight when one of them was drunk?
		9. Did you ever protect another family member from a parent who was drinking?
		10. Did you ever feel like hiding or emptying a parent's bottle of liquor?
		11. Do many of your thoughts revolve around a problem drinking parent or difficulties that arise because of his/her drinking?
		12. Did you ever wish that a parent would stop drinking?
		13. Did you ever feel responsible for and guilty about a parent's drinking?
		14. Did you ever fear that your parents would get divorced due to alcohol misuse?
		15. Have you ever withdrawn from and avoided outside activities and friends because of embarrassment and shame over a parent's drinking problem?
		16. Did you ever feel caught in the middle of an argument or fight between a problem drinking parent and your other parent?
		17. Did you ever feel that you made a parent drink alcohol?
		18. Have you ever felt that a problem drinking parent did not really love you?
		19. Did you ever resent a parent's drinking?
		20. Have you ever worried about a parent's health because of his/her alcohol use?
		21. Have you ever been blamed for a parent's drinking?
		22. Did you ever think your father was an alcoholic?
		23. Did you ever wish your home could be more like the homes of your friends who did not have a parent with a drinking problem?

YES	*NO*	*QUESTION*
		24. Did a parent ever make promises to you that s/he did not keep because of drinking?
		25. Did you ever think that your mother was an alcoholic?
		26. Did you ever wish that you could talk to someone who could understand and help the alcohol-related problems in your family?
		27. Did you ever fight with your brothers and sisters about a parent's drinking?
		28. Did you ever stay away from home to avoid the drinking parent or your other parent's reaction to the drinking?
		29. Have you everfelt sick, cried, or had a "knot" in your stomach after worrying about a parent's drinking?
		30. Did you ever take over any chores and duties at home that were usually done by a parent before s/he developed a drinking problem?
		31. Would you say that your parent(s) still have a drinking problem?
		32. Has/have your parent(s) with the drinking problem ever received treatment to address the problem?
		33. Was the treatment successful?
		34. Has/have your drinking parent(s) ever received medical attention because of a drinking?
		35. Do you still live with the parent(s) who has/have/had the drinking problem?
36. What length of time would you estimate that your parent(s) has/have struggled with a drinking problem (please check one): < 5 years [ ] 5-10 years [ ] 10-15 years [ ] 15-20 years [ ] >20 years [ ]		

APPENDIX A: FORGIVENENSS OF SELF & FORGIVENESS OF OTHERS

Read each statement and consider if it describes you. Circle the number that you feel best represents how well the statement describes you. For example, circle "7" if you strongly agree that the statement describes you, circle "1" if you strongly disagree that the statement describes you, circle "4" would mean that you are not sure if the statement describes you.

Circle only one number. If you circle one and then want to change your answer, cross out your original answer.

Statement	Strongly Disagree.....						Strongly Agree
1. If another person hurts you first it is all right to get back at him/her.	1	2	3	4	5	6	7
2. I would secretly enjoy hearing that someone I dislike had gotten into trouble.	1	2	3	4	5	6	7
3. I feel that other people have done more good than bad for me.	1	2	3	4	5	6	7
4. When other people insult me I tell them off.	1	2	3	4	5	6	7
5. If a person hurts you on purpose you deserve to get whatever revenge you can.	1	2	3	4	5	6	7
6. It is hard for me to forgive those who hurt me.	1	2	3	4	5	6	7
7. It is not right to take revenge on a person who tries to take advantage of you.	1	2	3	4	5	6	7
8. I have grudges which I have held on to for months or years.	1	2	3	4	5	6	7
9. I would get frustrated if I could not think of a way to get even with someone who deserves it.	1	2	3	4	5	6	7
10. When someone insults or hurts me, I think for hours about things I could have said or done to get even.	1	2	3	4	5	6	7
11. I believe that when people say they forgive me for something I did they really mean it.	1	2	3	4	5	6	7
12. When someone treats me unfairly, I feel like telling others all the bad things I know about him or her.	1	2	3	4	5	6	7
13. I often use sarcasm when people deserve it.	1	2	3	4	5	6	7
14. I am able to make up pretty easily with friends who have hurt me in some way.	1	2	3	4	5	6	7
15. People who criticize me better be ready to take some of their own medicine.	1	2	3	4	5	6	7
16. I feel guilty because I don't do what I should for my loved ones.	1	2	3	4	5	6	7
17. I often feel that no matter what I do now I will never make up for the mistakes I have made in the past.	1	2	3	4	5	6	7
18. I rarely feel as though I have done something wrong or sinful.	1	2	3	4	5	6	7
19. I regret things I do more often than other people seem to							

regret things.	1	2	3	4	5	6	7
20. A lot of times I have feelings of guilt or regret for the things I have done.	1	2	3	4	5	6	7
21. I often feel like I have failed to live the right kind of life.	1	2	3	4	5	6	7
22. I often get into trouble for not being careful to follow the rules.	1	2	3	4	5	6	7
23. I don't think of myself as an evil person.	1	2	3	4	5	6	7
24. I frequently put myself down for failing to work as hard as I should.	1	2	3	4	5	6	7
25. I find it hard to forgive myself for some things that I have done.	1	2	3	4	5	6	7
26. I frequently apologize for myself.	1	2	3	4	5	6	7
27. I am often angry at myself for the stupid things I do.	1	2	3	4	5	6	7
28. If hear a sermon, I usually think about things that I have done wrong.	1	2	3	4	5	6	7
29. It is easy for me to admit that I am wrong.	1	2	3	4	5	6	7
30. I brood or think a lot about all the troubles that I have.	1	2	3	4	5	6	7

APPENDIX A: HEARTLAND FORGIVENESS SCALE

Directions: In the course of our lives negative things may occur because of our own actions, the actions of others, or circumstances beyond our control. For some time after these events, we may have negative thoughts or feelings about ourselves, others, or the situation. Think about how you typically respond to such events. Next to each item, **circle the number** from the 7 point scale that best describes how you *typically* respond to the type of negative situation described. There are no right or wrong answers. Please be as open as possible in your answers and be sure to respond to each situation.

1	2	3	4	5	6	7
Almost Always False of Me		More Often False of Me		More Often True of Me		Almost Always True of Me

Negative Situation	*Almost Always False of Me*						*Almost Always True of Me*
1. Although I feel badly at first when I mess up, over time I can give myself some slack.	1	2	3	4	5	6	7
2. I hold grudges against myself for negative things I've done.	1	2	3	4	5	6	7
3. Learning from bad things that I've done helps me get over them.	1	2	3	4	5	6	7
4. It is really hard for me to accept myself once I've messed up.	1	2	3	4	5	6	7
5. With time I am understanding of myself for mistakes I've made.	1	2	3	4	5	6	7
6. I don't stop criticizing myself for negative things I've felt, thought, said, or done.	1	2	3	4	5	6	7
7. I continue to punish a person who has done something that I think is wrong.	1	2	3	4	5	6	7
8. With time I am understanding of others for the mistakes they've made.	1	2	3	4	5	6	7
9. I continue to be hard on others who have hurt me.	1	2	3	4	5	6	7
10. Although others have hurt me in the past, I have eventually been able to see them as good people.	1	2	3	4	5	6	7
11. If others mistreat me, I continue to think badly of them.	1	2	3	4	5	6	7
12. When someone disappoints me, I can eventually move past it.	1	2	3	4	5	6	7
13. When things go wrong for reasons that can't be controlled, I get stuck in negative thoughts about it.	1	2	3	4	5	6	7
14. With time I can be understanding of bad circumstances in my life.	1	2	3	4	5	6	7
15. If I am disappointed by uncontrollable circumstances in my life, I continue to think negatively about them.	1	2	3	4	5	6	7
16. I eventually make peace with bad situations in my life.	1	2	3	4	5	6	7
17. It's really hard for me to accept negative situations that aren't anybody's fault.	1	2	3	4	5	6	7
18. Eventually I let go of negative thoughts about bad circumstances that are beyond anyone's control.	1	2	3	4	5	6	7

APPENDIX A: TENDENCY TO FORGIVE & ATITUDES TOWARD FORGIVENESS

Read each statement and consider how well if it describes you. Circle "1" if you strongly disagree that the statement describes you, or "7" if you strongly agree that the statement describes you. Circle "4" if you are not sure if the statement describes you. If you circle one and then want to change your answer, cross out your original answer.

Statement	Strongly Disagree.....Strongly Agree						
1. I tend to get over it quickly when someone hurts my feelings.	1	2	3	4	5	6	7
2. If someone wrongs me, I often think about it a lot afterward.	1	2	3	4	5	6	7
3. I have a tendency to harbour grudges.	1	2	3	4	5	6	7
4. When people wrong me, my approach is just to forgive and forget.	1	2	3	4	5	6	7
5. I believe that forgiveness is a moral virtue.	1	2	3	4	5	6	7
6. Justice is more important than mercy.	1	2	3	4	5	6	7
7. It is admirable to be a forgiving person.	1	2	3	4	5	6	7
8. I have no problem at all with people staying mad at those who hurt them.	1	2	3	4	5	6	7
9. Forgiveness is a sign of weakness.	1	2	3	4	5	6	7
10. People should work harder than they do to let go of the wrongs they have suffered.	1	2	3	4	5	6	7

APPENDIX A: BECK DEPRESSION INVENTORY-II

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements careful then pick out the one statement in each group that best describes the way you have been feeling during the past t weeks, including today. Circle the number beside the statement you have picked. If several statements in the grou seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than on statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness

0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure

0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than us
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happen

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

11. Agitation

0 I am no more restless or wound up than usual.

1 I feel more restless or wound up than usual.

2 I am so restless or agitated that it's hard to stay still.

3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.

1 I am less interested in other people or things than before.

2 I have lost most of my interest in other people or things.

3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.

1 I find it more difficult to make decisions than usual.

2 I have much greater difficulty in making decisions than I used to.

3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.

1 I don't consider myself as worthwhile and useful as I used to.

2 I feel more worthless as compared to other people.

3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.

1 I have less energy than I used to have.

2 I don't have enough energy to do very much.

3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.

1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.

2b I sleep a lot less than usual.

3a I sleep most of the day.

3b I wake up 1–2 hours early and can't get back to sleep

17. Irritability

0 I am no more irritable than usual.

1 I am more irritable than usual.

2 I am much more irritable than usual.

3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.

1b My appetite is somewhat greater than usual

2a My appetite is much less than before.

2b My appetite is much greater than usual.

3a I have no appetite at all.

3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.

1 I can't concentrate as well as usual.

2 It's hard to keep my mind on anything for very long.

3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.

1 I get more tired or fatigued more easily thai usual.

2 I am too tired or fatigued to do a lot of the I used to do.

3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be

2 I am much less interested in sex now.

3 I have lost interest in sex completely.

APPENDIX A: POSITIVE AFFECT AND NEGATIVE AFFECT SCALES

This scale consists of a number of words that describe different feelings and emotions. Reach each item and then CIRCLE the appropriate number in the space next to that word. Indicate to what extent you generally feel this way, that is, how feel on average. Use the following scale to record your answers.

1	2	3	4	5	6	7
Very Slightly Or Not at All			Moderately			Extremely

WORDS	RATING						
Interested	1	2	3	4	5	6	7
Distressed	1	2	3	4	5	6	7
Excited	1	2	3	4	5	6	7
Upset	1	2	3	4	5	6	7
Strong	1	2	3	4	5	6	7
Guilty	1	2	3	4	5	6	7
Scared	1	2	3	4	5	6	7
Hostile	1	2	3	4	5	6	7
Enthusiastic	1	2	3	4	5	6	7
Proud	1	2	3	4	5	6	7
Irritable	1	2	3	4	5	6	7
Alert	1	2	3	4	5	6	7
Ashamed	1	2	3	4	5	6	7
Inspired	1	2	3	4	5	6	7
Nervous	1	2	3	4	5	6	7
Determined	1	2	3	4	5	6	7
Attentive	1	2	3	4	5	6	7
Jittery	1	2	3	4	5	6	7
Active	1	2	3	4	5	6	7
Afraid	1	2	3	4	5	6	7
Withdrawn	1	2	3	4	5	6	7
Hopeful	1	2	3	4	5	6	7
Sad	1	2	3	4	5	6	7
Forgiving	1	2	3	4	5	6	7
Pessimistic	1	2	3	4	5	6	7
Worthless	1	2	3	4	5	6	7

APPENDIX A: PERCEIVED STRESS SCALE

The questions in this scale ask you about your feelings and thoughts **during the last month**. In each case, you are to circle the appropriate number to indicate how often you felt or thought a certain way.

1	2	3	4	5	6	7
Never			Sometimes			Very Often

Negative Situation	*Never ………………………….Very Often*						
1. In the last moth, how often have you been upset because of something that happened unexpectedly?	1	2	3	4	5	6	7
2. In the last month, how often have you felt that you were unable to control the important things in your life?	1	2	3	4	5	6	7
3. In the last month, how often have you fet nervous or "stressed?"	1	2	3	4	5	6	7
4. In the last month, how often have your confident about your ability to handle your personal problems.	1	2	3	4	5	6	7
5. In the last month, how often have you felt that things were going your way?	1	2	3	4	5	6	7
6. In the last month, how often have you found that you could not cope with all the things that you had to do?	1	2	3	4	5	6	7
7. In the last month, how often have you been able to control irritations in your life?	1	2	3	4	5	6	7
8. In the last month, how often have you felt that you were on top of things?	1	2	3	4	5	6	7
9. In the last month, how often have you been angered because of things that were outside of your control?	1	2	3	4	5	6	7
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	1	2	3	4	5	6	7

APEENDIX A: ROSENBERG SELF-ESTEEM SCALE

INSTRUCTIONS: BELOW IS A LIST OF STATEMENTS DEALING WITH YOUR GENERAL FEELINGS ABOUT YOURSELF. CIRCLE THE NUMBER THAT BEST REPRESENTS HOW WELL THE STATEMENT DESCRIBES YOU. FOR EXAMPLE, IF YOU STRONGLY AGREE, CIRCLE **7**, IF YOU STRONGLY DISAGREE WITH THE STATEMENT, CIRCLE **1,** IF YOU ARE NOT SURE, CIRCLE **4.**

	Strongly Disagree.....Strongly Agree						
1. On the whole, I am satisfied with myself.	1	2	3	4	5	6	7
2. At times I think I am no good at all.	1	2	3	4	5	6	7
3. I feel that I have a number of good qualities.	1	2	3	4	5	6	7
4. I am able to do things as well as most other people.	1	2	3	4	5	6	7
5. I feel I do not have much to be proud of.	1	2	3	4	5	6	7
6. I feel I do not have much to be proud of.	1	2	3	4	5	6	7
7. I feel that I'm a person of worth, at least on an equal plane with others.	1	2	3	4	5	6	7
8. I wish I could have more respect for myself.	1	2	3	4	5	6	7
9. All in all, I am inclined to feel that I am a failure	1	2	3	4	5	6	7
10. I take a positive attitude toward myself.	1	2	3	4	5	6	7

APPENDIX A: SHIPLEY INSTITUTE OF LIVING SCALE

AutoScore™ Form

WPS

Part I

Instructions: In this test, the first word in each line is printed in capital letters. Opposite it are four other words. Circle the *one word* which means the *same thing*, or most nearly the same thing, as the first word. If you don't know, guess. Be sure to circle the one word in each line that means the same thing as the first word, as in the example below.

EXAMPLE

LARGE red (big) silent wet

Usual Occupation ______ Date ______

1. TALK	draw	eat	speak	sleep
2. PERMIT	allow	sew	cut	drive
3. [illegible]	forgive	pound	divide	tell
4. COUCH	pin	eraser	sofa	glass
5. REMEMBER	swim	recall	number	defy
6. TUMBLE	drink	dress	fall	think
7. HIDEOUS	silvery	tilted	young	dreadful
8. CORDIAL	swift	muddy	leafy	hearty
9. EVIDENT	green	obvious	skeptical	afraid
10. IMPOSTER	conductor	officer	book	pretender
11. MERIT	deserve	distrust	fight	separate
12. FASCINATE	welcome	fix	stir	enchant
13. INDICATE	defy	excite	signify	bicker
14. IGNORANT	red	sharp	uninformed	precise
15. FORTIFY	submerge	strengthen	vent	deaden
16. RENOWN	length	head	fame	loyalty
17. NARRATE	yield	buy	associate	tell
18. MASSIVE	bright	large	speedy	low
19. HILARITY	laughter	speed	grace	malice
20. SMIRCHED	stolen	pointed	remade	soiled
21. SQUANDER	tease	belittle	cut	waste
22. CAPTION	drum	ballast	heading	ape
23. FACILITATE	help	turn	strip	bewilder
24. JOCOSE	humorous	paltry	fervid	plain
25. APPRISE	reduce	strew	inform	delight
26. RUE	eat	lament	dominate	cure
27. DENIZEN	senator	inhabitant	fish	atom
28. DIVEST	dispossess	intrude	rally	pledge
29. AMULET	charm	orphan	dingo	pond
30. INEXORABLE	untidy	involatile	rigid	sparse
31. SERRATED	dried	notched	armed	blunt
32. LISSOM	moldy	loose	supple	convex
33. MOLLIFY	mitigate	direct	pertain	abuse
34. PLAGIARIZE	appropriate	intend	revoke	maintain
35. ORIFICE	brush	hole	building	lute
36. QUERULOUS	maniacal	curious	devout	complaining
37. PARIAH	outcast	priest	lentil	locker
38. ABET	waken	ensue	incite	placate
39. TEMERITY	rashness	timidity	desire	kindness
40. PRISTINE	vain	sound	first	level

Part II

Instructions: Complete the following by filling in either a number or a letter for each dash (___). Do the items in order, but don't spend too much time on any one item.

EXAMPLE

A B C D E

1. 1 2 3 4 5 ___
2. white black short long down ___ ___
3. AB BC CD D ___
4. Z Y X W V U ___
5. 12321 23432 34543 456 ___ ___
6. NE/SW SE/NW E/W N/___
7. escape scape cape ___ ___ ___
8. oh ho rat tar mood ___ ___ ___ ___
9. A Z B Y C X D ___
10. tot tot bard drab 537 ___ ___ ___
11. mist is wasp as pint in tone ___ ___
12. 57326 73265 32657 26573 ___ ___ ___ ___ ___
13. knit in spud up both to stay ___ ___
14. Scotland landscape scapegoat ___ ___ ___ ___ ee
15. surgeon 1234567 snore 17635 rogue ___ ___ ___ ___ ___
16. tam tan rib rid rat raw hip ___ ___ ___
17. tar pitch throw saloon bar rod fee tip end plank ___ ___ ___ ___ ___ meals
18. 3124 82 73 154 46 13 ___
19. lag leg pen pin big bog rob ___ ___ ___
20. two w four r one o three ___

APPENDIX A: PAST, CURRENT, AND FUTURE ESTIMATES OF FORGIVENESS & DEPRESSION LEVELS

For this section, think about generally how forgiving you have been in the past, how forgiving you currently are, and how forgiving you think you will be in the future. For each time period, make a vertical slash on the line that ranges from 0 (not at all forgiving) to 100 (completely forgiving).

PAST (5 years ago)

0 (not at all forgiving) 100 (completely forgiving)

PRESENT

0 (not at all forgiving) 100 (completely forgiving)

FUTURE (5 years from now)

0 (not at all forgiving) 100 (completely forgiving)

For this section, think about your experiences of depressive symptoms (e.g., feeling sad, feeling like a failure, problems concentrating, lack of interest in people or activities, irritability, or feeling guilty). Think about how much you have experienced these symptoms in the past, the present, and how things might be in the future and for each time period below, make one vertical slash on the line that ranges from 0 (no depressive symptoms) to 100 (most depressed I've ever been).

PAST (5 years ago)

0 (no depressive symptoms) 100 (most depressed I've ever been)

PRESENT

0 (no depressive symptoms) 100 (most depressed I've ever been)

FUTURE (5 years from now)

0 (no depressive symptoms) 100 (most depressed I've ever been)

RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. This study has been reviewed and received ethics clearance through the University of Windsor Research Ethics Board. If you have questions regarding your rights as a research subject, contact:

Research Ethics Coordinator
University of Windsor
Windsor, Ontario N9B 3P4
Telephone: 519-253-3000, ext. 3916
E-mail: ethics@uwindsor.ca

SIGNATURE OF RESEARCH SUBJECT & SIGNATURE OF INVESTIGATOR

I understand the information provided for the study **Resiliency In Young Adults** as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

_____ _____
Name of Participant Date

_____ _____
Signature of Investigator Date
These are the terms under which I will conduct research.

University of Windsor
Windsor, Ontario N9B 2N1
E-mail: ethics@uwindsor.ca

SIGNATURE OF INVESTIGATOR -

Signature of Investigator

Date

These are the terms under which I will conduct research.

APPENDIX B: FEEDBACK /DEBRIEFING LETTER

UNIVERSITY OF WINDSOR

Resiliency in Young Adults

Researchers: Becki L. Cornock, MA
R. Robert Orr, PhD

The concept of resiliency has gained importance as researchers have noted that not all people have bad outcomes after being exposed to negative events or adversity. An example of possible adversity is growing up in a home with a parent/caregiver struggling with depression or growing up with one or more alcoholic parents/caregivers. People react differently to negative experiences, so we wanted to learn about what factors might enable individuals to do well in spite of adversity. More specifically, this study is being conducted to try to determine if forgiveness is a resiliency factor.

Forgiveness has not been studied extensively from a psychological perspective, but understanding the possible link between forgiveness and positive outcomes (for example, decreased symptoms of depression) is important because some research has indicated that forgiveness can play an important part in therapeutic recovery. Therefore, a better understanding of forgiveness may eventually lead to improvements in therapeutic interventions for a variety of issues.

If, after participating in this research you have any questions or concerns that you would like to discuss, please contact any of the following resources:

- The Student Counselling Centre → 253-3000 x4616
  (located on-campus in the CAW Centre, 2nd Floor Room 293)
- Psychological Services Centre, House on Sunset → 253-3000 x7012 or 973-7012
  (located at 326 Sunset Avenue)
- Alanon/Alateen → 252-8474
- Alcoholics Anonymous → 256-9975
  Community Mental Health Association Windsor-Essex County Branch → 255-7440
  (located at 1400 Windsor Avenue)
- Family Service Windsor-Essex County → 256-1831
  (located at 450 Victoria Avenue - Lower Level)
- Teen Health Centre (Ages 12-24) → 253-8481
  (located at 1585 Ouellette Avenue)

The researchers would like to take this opportunity to thank you again for your participation. To ensure that everyone filling out our questionnaire has the same experience, we ask that you not discuss this information with any classmates or friends who may be participating in our study.

Remember that no individual results will be available, but once the study is completed (approximately April, 2005) overall results will be posted at:
http://ca.geocities.com/resiliencyinyoungadults_2004/Resiliency_2004.html

APPENDIX C: DISTRIBUTION OF CAST SCORES

		Frequency	Percent	Cumulative Percent
Valid	.00	126	61.8	61.8
	1.00	12	5.9	67.6
	2.00	7	3.4	71.1
	3.00	6	2.9	74.0
	4.00	5	2.5	76.5
	5.00	5	2.5	78.9
	6.00	5	2.5	81.4
	7.00	7	3.4	84.8
	9.00	3	1.5	86.3
	10.00	4	2.0	88.2
	11.00	1	.5	88.7
	12.00	3	1.5	90.2
	13.00	2	1.0	91.2
	14.00	3	1.5	92.6
	15.00	1	.5	93.1
	16.00	2	1.0	94.1
	19.00	4	2.0	96.1
	20.00	1	.5	96.6
	22.00	1	.5	97.1
	23.00	2	1.0	98.0
	24.00	2	1.0	99.0
	25.00	1	.5	99.5
	27.00	1	.5	100.0
	Total	204	100.0	

VITA AUCTORIS

Becki L. Cornock was born in Winnipeg, Manitoba in 1978. She obtained a B.Sc. Four-Year Specialist degree in Psychology from Brandon University in 2000. In 2002, she successfully completed her Master's degree in Clinical Psychology, with a subspecialty in Child Clinical Psychology, from the University of Windsor. She is currently completing the final requirements for her Ph.D. and plans to graduate from the University of Windsor in the fall of 2006.