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Self-Forgiveness, Self-Criticism, and Psychological Well-Being:
Theory, Correlational Research, Intervention, and Case Studies

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Self-Forgiveness, Self-Criticism, and Psychological Well-Being: Theory, Correlational Research, Intervention, and Case Studies

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"Forgiveness is choosing to love. It is the first skill of self-giving love."

(Mahatma Gandhi)

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SELF-FORGIVENESS, SELF-CRITICISM, AND PSYCHOLOGICAL WELL-BEING: THEORY, CORRELATIONAL RESEARCH, INTERVENTION, AND CASE STUDIES

ABSTRACT

Several studies have highlighted the importance of self-forgiveness regarding the resolution of an emotional injury trough life. In the present moment, forgiveness and self-forgiveness are two complex and powerful constructs that are on the spotlight in the field of scientific research, such as social sciences, specifically, in clinical psychology.

Several researchers have been focusing their efforts on studies that regards the processes of forgiveness and self-forgiveness. Embracing the theory of such inspiring researchers and studies, the present PhD Thesis focuses on the process of self-forgiveness and its influence in psychological well-being. Self-forgiveness and psychotherapy research are growing among the world, since researchers started to embrace these processes in the change process of the client, regarding its positive benefits.

The lack of psychometric instruments that assesses self-forgiveness in Portugal was the primordial step to conduct the present PhD Thesis, highlighting its importance with the urgence to apply some of the knowledge in the clinical practice.

Positive indicators concerning to the study of the psychometric instruments in Portugal, such as the State Self-forgiveness Scale and the Differentiated Self-forgiveness Process Scale inspire to continue the study by embracing the notion of self-criticism.

While self-forgiveness is considered the relief of negative feelings resulting from an intrapersonal offense and an emotional damage (or, emotional injury), trough the enhancement of positive emotions such as self-generosity, self-acceptance, and the sense of respect of the own moral values of the person; self-criticism tend to be related to the negative aspects of the self, conducting the person to maladaptive issues, such as negative feelings, emotions, and behaviors, associated to negative emotions like shame or guilt. However, these emotions can be productive when the offender feels regret and tries to emend the situation in order to overcome it. The main issue enhances the need to balance the critical side that appears when the person commits an offense, and then try to overcome by the process of self-forgiveness. This process led to a more positive sense of the self, and as a consequence, to a better psychological well-being, and to the prevention of maladaptive clinical symptoms and pathologies, such as anxiety, depression, among others.

The empirical connection between self-forgiveness, self-criticism, and psychological well-being was found as being a positive indicator to the clinical practice, conducting to the development of a clinical intervention protocol (in the format of a feasibility study) in Emotion-Focused Therapy and REACH Forgiveness model, in order to comprehend how a person could resolve an emotional injury trough the theory of these models and trough the positive indicators of the previous studies.

A brief therapeutic intervention was conducted in order to comprehend how clients with unfinished businesses could resolve a negative event, through the process of self-forgiveness, following the guidelines of the models Emotion-Focused Therapy and REACH Forgiveness model. Since the results indicated that the majority of the clients in the phase of the post-treatment showed better indexes of positive emotions,

behaviors, and beliefs, it leaded to the need to study the impact of the clinical intervention in the clients.

Therefore, the present PhD Thesis ends up with qualitative studies, embracing the Theory-building Case Studies with the description of two case studies: 1) narrative of a good outcome case study, as a result of the therapeutic intervention; and, 2) description of a poor outcome, emphasizing the comprehension about self-criticism and its severity to the client, since the client ended the treatment with higher symptomatology. Besides the evidences of improvement in several aspects, the brief therapeutic intervention of six sessions was not enough in this particular case. Therefore, therapists need to be aware that brief therapies sometimes are just the beginning of a process. Finally, a quantitative study was conducted in order to ascertain the impact of the intervention in these clients, showing that the majority of the clients ended the therapy with significant reliable change index in the main constructs, namely, self-forgiveness and psychological well-being.

Keywords: Self-forgiveness; Psychological Well-being; Self-criticism; Tools Validation; Feasibility Study; Case Studies

AUTOPERDÃO, AUTOCRÍTICA E BEM-ESTAR PSICOLÓGICO: TEORIA, INVESTIGAÇÃO CORRELACIONAL, INTERVENÇÃO E ESTUDOS DE CASO

RESUMO

Vários estudos realçam a importância do autoperdão no que diz respeito à resolução do dano emocional causado por uma ofensa. Perdão e autoperdão são considerados dois constructos complexos e benéficos, estando no centro das atenções no campo da investigação científica, tais como as ciências sociais, especificamente, na psicologia clínica.

Abraçando a teoria de diversos investigadores que têm focado os seus estudos nestes mesmos processos e tendo-os como inspiração, a presente Tese de Doutoramento centra-se na compreensão do processo de autoperdão e a sua influência no bem-estar psicológico. A investigação no constructo do autoperdão e da psicoterapia têm vindo a motivar diversos autores, levando-os a compreender como estes processos se desenvolvem na prática clínica e como estão associados a indicadores positivos e benéficos no que respeita ao bem-estar da pessoa.

A falta de instrumentos psicométricos que avaliam o autoperdão em Portugal foi o ponto de partida para a realização do primeiro estudo, salientando a importância de compreender como se processa o autoperdão em contexto clínico e quais os seus benefícios. A *State Self-forgiveness Scale* e a *Differentiated Self-forgiveness Process Scale* são duas escalas que avaliam o autoperdão em diferentes dimensões. Os resultados evidenciaram a existência da relação positiva estatisticamente significativa entre autoperdão e bem-estar psicológico, motivando para a elaboração e compreensão

aprofundada sobre o processo de autocrítica, como sendo um mediador dos dois principais constructos.

Autoperdão é entendido como o alívio de sentimentos negativos resultantes de uma ofensa, e pelo aumento de sentimentos positivos tais como autoaceitação, autocompaixão, e o sentido de respeito perante os próprios valores morais da pessoa. A autocrítica tende a estar relacionada com os aspetos negativos do *self*, conduzindo a pessoa à experiência de emoções negativas (e.g., vergonha; culpa), bem como à contraproducência no que respeita aos seus comportamentos. Importa realçar que estas mesmas emoções negativas podem, de igual forma, ser benéficas se foram sentidas de forma apropriada, conduzindo o ofensor para a responsabilização da ofensa, e para a tentativa de reparar o dano causado. O foco prende-se com o equilíbrio entre o lado crítico e a resposta à necessidade de ultrapassar e resolver o conflito, promovendo a sensação positiva do *self*, e como consequência, maior bem-estar geral. Adicionalmente, quando estas situações são trabalhadas, existe também a possibilidade de prevenir sintomas clínicos psicopatológicos, tais como a ansiedade ou a depressão.

A correlação estatisticamente significativa entre autoperdão, autocrítica e bem-estar psicológico é um indicador positivo para a prática clínica, tendo motivado para a elaboração de um protocolo de intervenção clínica em Terapia Focada nas Emoções e no modelo *REACH Forgiveness*, com o intuito de compreender como uma pessoa poderia resolver um dano emocional, tendo por base os modelos e os estudos previamente referidos.

Foi elaborada uma intervenção clínica breve, tendo como foco a resolução de situações inacabadas e causadoras de malefícios para as pessoas. O foco da intervenção prendeu-se com o processo de autoperdão, seguindo as diretrizes dos modelos previamente referidos, i.e., Terapia Focada nas Emoções e modelo *REACH Forgiveness*.

Os resultados da terapia indicaram que a maioria dos participantes, na fase final do tratamento, sofreram uma mudança significativa, tendo em consideração os valores dos instrumentos psicométricos principais, bem como os valores do *Reliable Change Index*.

Neste sentido, a presente Tese de Doutoramento teve como finalidade apresentar dois estudos de caso: i) um caso de sucesso, associado à apresentação do protocolo de intervenção; ii) um caso de insucesso, seguindo por base a *Theory-building Case Study.* Importa realçar que o caso de insucesso, apesar das melhorias evidenciadas pelos mesmos trâmites anteriormente referidos, não foi suficiente para a terapia pré-estabelecida. Neste sentido, este caso em particular merece especial atenção para a continuação do processo, e para a fase em que o/a participante se encontrava. De igual forma foi também necessário compreender qual o impacto da intervenção clínica nos participantes. Os resultados indicaram que a maioria dos participantes terminou a terapia com valores acima do esperado, apresentando elevados índices de autoperdão e bem-estar psicológico, enquadrando-se em elevados índices de mudança significativa.

Palavras-chave: Autoperdão; Bem-estar Psicológico; Autocrítica; Validação de Instrumentos Psicométricos; Estudo de Exequibilidade; Estudos de Caso

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INTRODUCTION

INTRODUCTION

"If even God doesn't forgive me, how can I forgive myself?" (E., in a therapeutic session in 2014).

Indeed, a powerful question, the type that glues you in the therapist's chair to reflect on it; a question that, at the end of a therapeutic session, leads you into reflection. Therapists are human beings, and when you feel tremendous compassion towards your client, some situations tend to be inevitable regarding the impact they have on us.

E. was the client that helped me to change my perspective regarding unresolved situations, and thus, to enhance my appreciation of therapeutic processes and the complexity involved in these processes of change.

When *E.* questioned God and Forgiveness in a given session, I immediately put my entire life into perspective. Similar to a scenario in which I was the 3rd person observing, I saw my whole life in perspective, running along like a river. It is certainly not easy to talk about emotions, to confide our deepest thoughts to a stranger (assuming the role of a therapist), and dive into the unknown depths of the self, that represents all of us as human beings.

So yes, *E.* was an outstanding person/client, who, along with the main therapist and I (the three of us), talked about and discussed Forgiveness on so many occasions throughout his therapeutic process. And even though with a significant interlude in between, as this overall process started in a therapy room with *E.*, myself and my main advisor, incredibly, it is ending with them again. Life brings so many surprises; some just do not have an explanation, only chances and coincidences that sometimes shape who we are and what we do.

Forgiveness and Self-Forgiveness, two complex constructs; two outstanding processes that can change a person's life (e.g., Woodyatt et al., 2017) – such as *E.'s* life – and, in a sense, have also shaped my life, as a PhD researcher. Although self-forgiveness has been studied for several years among researchers all over the world (e.g., Greenberg et al., 2008; Woodyatt et al., 2017; Worthington, 2013), I will now take this opportunity to acknowledge my main theoretical influences here.

Everett L. Worthington, Jr. needs to be stated and recognized as a seminal influence in the present PhD Thesis, being the founder of the REACH Forgiveness model (2006) and a prominent forgiveness researcher. REACH Forgiveness can be considered a recent model, but at the same time with challenging studies in the past few years (e.g., Worthington et al., 2018; Toussaint et al., 2020).

In addition, Emotion-Focused therapy and especially the study conducted by Greenberg and colleagues (2008) was also a pivotal inspiration in our approach to study these constructs. This study aimed to analyze how clients resolved unfinished business/unresolved situations implicated in emotional injuries. The authors conducted a clinical trial involving Emotion-Focused therapy (EFT) as a treatment modality, where the Empty Chair task became under the spotlight. Indeed, this was a remarkable study, with outstanding results, especially for Forgiveness enthusiasts, evidencing the positive, indirect effects of EFT on Forgiveness when clients progressed during the resolution of emotional injuries and dealing with unfinished business (Greenberg et al., 2008).

The main question that made the present Thesis depart in 2015 was: What if Emotion-Focused Therapy can also be of benefit for Self-Forgiveness?

The process of self-forgiveness can be a challenge for the client, for the therapist, and for the researcher as well. However, when it comes at the right time, it can make outstanding changes in a person's life.

After this interlude on the history of this PhD and my personal experience, let's now talk about science, and the specific psychological perspectives that orient the contribution of the present PhD Thesis and our sense of knowledge. Specifically, in the next section, we will present the main constructs that help us understand what self-forgiveness involves and how the different studies underpinning this PhD Thesis become integrated.

PSYCHOTHERAPY RESEARCH ON SELF-FORGIVENESS

Self-forgiveness Theoretical Framework

Research on self-forgiveness has gathered momentum in the last decades (for reviews or research, see the edited book by Woodyatt et al., 2017). Nevertheless, even now, self-forgiveness is still likely to be considered the stepchild of forgiveness research (Hall & Fincham, 2005; for a meta-analysis, see Davis et al., 2015), due to the limitations in research studies. One reason for the relative infrequency of research on self-forgiveness may be its confinement to the United States and Australia and little investigation outside of the English language.

However, recent research has shifted the study of self-forgiveness more relationally, opening the door to the study of self-forgiveness in cultures more oriented to relationships – like collectivistic cultures in the Far East, Africa, many countries in South America, like Colombia, and cultures in Southern Europe, in countries like Spain, Italy, and Portugal (Costa et al., 20021; Prieto-Ursúa, 2015; Ordóñez-Carabaño & Prieto-Ursúa, 2021).

Emotional injury has been studied in the last years by several authors (e.g., Greenberg et al., 2008; Tangney et al., 1996; Wohl et al., 2008; Woodyatt et al., 2017;

Worthington, 2006). Wenzel and colleagues (2020) have theorized self-condemnation as one part of interpersonal interactions around offenses, causing therefore emotional injuries. Toussaint et al. (2020) enhanced the importance of working with emotional injuries and the process of healing through forgiveness. These shifts in the field of forgiveness studies suggest that new research is welcomed by countries that already value and contextualize behavior within relationships.

For example, Meneses and Greenberg (2019) enhances the importance of working with emotional injuries through the process of forgiveness, especially focused on the injured person, and Worthington et al. (2018) enhances the need to work on emotional injuries with the injured person (or offenders), through the self-forgiveness process.

Emotional injury comprehends the experience of having lingering, bad feelings deriving from an interpersonal situation/experience that is perceived as offensive, unjust and/or causing personal suffering (Greenberg et al., 2008; Woodyatt et al., 2017). Normally, when a person becomes aware of committing such an interpersonal offense on another person, the offender can experience negative emotions like guilt, shame, regret, and remorse (Tangney et al., 2005). This emotional appraisal of the wrongdoing can stimulate a higher level of maladaptive internal processes, such as excessive self-condemnation or severe self-criticism, which are connected with already present negative emotions (Gilbert & Woodyatt, 2017).

Overcoming emotional injury through self-forgiveness tends to be associated to the beneficial aspects of self-forgiveness, and is related to inflicting interpersonal offenses on others, experiencing negative relational experiences, or disappointing oneself (Greenberg et al., 2008; Wade et al., 2014; Wohl et al., 2008; Woodyatt & Wenzel, 2013; Wohl & McLaughlin, 2014; Woodyatt et al., 2017).

Self-forgiveness differs from forgiveness from the perspective of the offender: that is, while forgiveness of the other is an interpersonal process, self-forgiveness is a self-directed process, emphasizing the intrapersonal dimension of this construct (Toussaint & Webb, 2005; Webb et al., 2012).

Different authors have highlighted specific aspects of self-forgiveness.

Woodyatt and Wenzel (2013) theorize self-forgiveness as the process in which the offender recognizes their own guilt and worth, leading to the experience of negative emotions as a consequence of the interpersonal offense, however with the notion of responsibility for the offense. Thus, the authors also relate these processes to the promotion of attitudes and behaviors that lead to the attempt to understand the offense and to correct the values and morals of the self (Woodyatt & Wenzel, 2013).

Wohl and colleagues (2008) conceive self-forgiveness as the release of negative experiences, like the abandonment of negative thoughts, feelings, and behaviors related to the self (e.g., guilt; shame), enhancing the arrival of self-acceptance, self-generosity, and self-giving love (see also Woodyatt et al., 2017). Nevertheless, Wohl and colleagues (2008) also alert for the danger of a possible non-responsibility of the offense, connecting this behavior to the issues regarding some specific psychopathologies (e.g., addiction to substance abuse; gambling). Fisher and Exline (2006) relate the recognition of one's own culpability and perhaps even of maladaptive emotions like shame, as the first step toward self-forgiveness, which can repair and restore a relationship and lead to the development of an offender's well-being.

Other authors hypothesize that self-forgiveness is beyond regarding the absence of positive affirmations concerning one's own moral values (Wenzel et al., 2012; Wohl & McLauhglin, 2014). Thus, it also involves the requirement to use different approaches to

achieve a lessening of self-criticism, guilt and shame, in order to improve positive emotions such as self-compassion and self-acceptance (Woodyatt et al., 2017).

Woodyatt and colleagues (2017) consider self-forgiveness as an internal process with different stages: i) a person recognizes oneself as an offender, whose actions were hurtful, damaging or wrong (i.e., against some form of moral order) toward another person (i.e. the victim); ii) this process leads the offender to experience negative emotions – such as shame, guilt, regret, or anger – toward themselves; and, afterwards, iii) in case of an increase of self-forgiveness, the offender experiences a reduction of these negative feelings and an increase of more positive feelings toward themselves, such as self-acceptance, self-compassion or self-understanding (Hall & Fincham, 2008; Woodyatt & Wenzel, 2013; Worthington, 2013; Worthington & Langberg, 2012).

Ripley and Worthington (2014) theorize the behavior of offenders and victims, and as a consequence its significance within the self-forgiveness process. Offenders and victims have choices for pushing the relationship toward reestablishment (reconciliation) or further split. For instance, the offender might feel acceptable by having perpetrated an unfairness upon the victim. Another explanation concerns the offender redirecting guilt and shame to self-justify their own acts by blaming the victim, thus easing the offender's shame and guilt to the degree that self-justification can do so. Either way would push the relationship towards its end.

On the other hand, the offender often experiences remorse and regret over wrongs done to the victim. The level to which the offender can feel and act with appropriate vulnerability can affect the responses of the victim. The offender might attempt relationally reparative actions, like accepting responsibility for the wrong or at least for the offender's part in the wrong, apologizing, expressing empathy for the victim, offering to make reparations, promising not to offend again, and asking for forgiveness

(Ripley & Worthington, 2014). Concerning the victims, Ripley and Worthington (2014) also posit that several choices can be helpful or not for the offender's expressions of contrition or self-justification.

Similar to the theory of the offender, how the victim acts can impulse the relationship apart or back together (as reconciliation). If the victim takes a severe retributive justice stance and maintains it regardless of what the offender does, the relationship is likely to involve into conflict and the offender is not likely to forgive the self. Nevertheless, if the victim tends to forgive and expresses empathy, the relationship might follow a path for reconciliation. In this sense, this way might be helpful for the offender to forgive oneself (Ripley & Worthington, 2014).

Research has shown that self-forgiveness often motivates the person to deal productively with the wrongdoing, by doing actions that promote positive interpersonal and personal effects (Tangney et al., 2005; Woodyatt et al., 2017). Self-forgiveness involves the abandonment of negative beliefs, feelings, and behaviors related to the self (e.g., guilt; shame; blame), and stimulate positive affect such as self-compassion, generosity and self-giving love (e.g., Wohl et al, 2008; Tangney et al., 1996; Worthington et al., 2018).

An Empirical Connection between Self-forgiveness and Psychological Well-being

The relationship between self-forgiveness and psychological well-being has been studied during the last few years by several authors (e.g., Woodyatt et al., 2017; Worthington, 2006). It has been challenging, but also productive in terms of the significant knowledge and advancement brought into the field of social sciences on this topic (see Handbook of Self-Forgiveness; Woodyatt et al., 2017).

Woodyatt and colleagues have found that self-forgiveness reduces mental health symptoms and promotes psychological well-being (Woodyatt et al., 2017) in a variety of cultures. Possibly, the most commonly accepted theory explaining why, implicates the role of self-forgiveness in stress and coping theory. Interpersonal offenses are stressors that are appraised and reacted to physiologically, emotionally, cognitively, motivationally, and behaviorally - with many stress reactions. Usually, the majority of people cope with stress reactions in several ways, but forgiving oneself if one sees oneself as an offender, is a path that people can use to mitigate stress reactions, change their considerations, and also affect the meaning of the stressors. Thus, the benefits of forgiving oneself are well recognizable (for reviews, see Toussaint et al., 2015).

Cornish and Wade (2015) theorize that self-forgiveness, mental health, and well-being are also related. For example, Davis and colleagues (2015) showed evidence of a connection between self-forgiveness, positive mental health, and well-being, suggesting that higher values of self-forgiveness, positive mental health, and well-being were correlated with lower levels of depression. Similarly, Liao and Wei (2015) found a correlation between self-forgiveness and positive mental health indicators in a sample of undergraduate students, indicating that higher levels of self-forgiveness were associated with lower levels of perceived stress and symptoms of depression.

Indeed, several studies have been conducted regarding self-forgiveness and well-being, and the massive constructs that exist in the field of clinical psychology, such as psychopathology, emotional injuries, self-criticism, negative affect, among others (Cornish & Wade 2015; Davis et al., 2015; Liao & Wei, 2015; Toussaint et al., 2020; Woodyatt et al., 2017). It is also important to identify the findings regarding its benefits in relation to decreased mental illness, such as severe self-criticism and depression.

Self-forgiveness has an important role in relation to self-criticism (Gilbert & Woodyatt, 2017), leading to the reduction of rumination and acute negative emotions (Wohl et al., 2010). In this sense, pervasive, or chronic negative emotions are associated with rumination and negative health outcomes (Gilbert & Andrews, 1998; Whelton, 2000; Wohl et al., 2010). However, self-forgiveness can reduce rumination and pervasive negative emotions (Wohl et al., 2010), allowing the person to reintegrate a positive sense of moral value, restored without self-condoning (Thompson et al., 2005). Under this psychological perception, self-forgiveness tends to be beneficial for the person, promoting their ability to tolerate negative emotions and use them productively (in terms of social and intrapersonal functioning).

Whether this happens or not can be affected by how strongly self-critical or self-reassuring people are (Woodyatt et al., 2017). That will affect the likelihood of developing depression and holding a positive sense of psychological well-being (Woodyatt et al., 2017). In turn, positive acts by offenders will make it more likely that the offended person will react with openness to reconciliation (Massengale et al., 2017; Woodyatt & Wenzel, 2013).

Usually, offenders feel shame, which is a feeling that oneself is defective, inadequate or wrong, as demonstrated by the wrongdoing (Leach, 2017; Tangney et al., 1996). Another possibility is that the wrongdoing is seen as a negatively transformative act for one's moral self (turning the self from positive to negative). Such reactions can often lead to excessive rumination (Graham et al., 2017). Thus, it can enhance the likelihood of depression (Graham et al., 2017; Whelton, 2000), leading to a poorer sense of psychological well-being (Massengale et al., 2017; Woodyatt et al., 2017), and also reduce the likelihood of reconciliation (Massengale et al., 2017; Wohl et al., 2017; Woodyatt & Wenzel, 2013).

Other authors such as Costa and colleagues (2021) argue that self-forgiveness acts directly or indirectly with depression and psychological well-being through self-criticism after an interpersonal offense (as we will see in Chapter II). Thus, there are positive indicators which highlight positive emotions and positive psychological responses, such as in self-criticism, psychological well-being, and depression (Costa et al., 2021).

In this sense, self-forgiveness is the process where the person releases their negative feelings, behaviors and emotions, in order to balance them with positive responses (Woodyatt & Wenzel, 2013; Worthington, 2006), leading to better psychological well-being (Costa et al., 2021; Massengale et al., 2017; Woodyatt et al., 2017). Thus, it can lead to positive attitudes towards the self, regaining the sense of value and the moral reintegration of the self (Peterson et al., 2017; Thompson et al., 2005).

Self-forgiveness is also related to better psychological well-being (Cornish & Wade, 2015; Costa et al., 2021; Davis et al., 2015; Liao & Wei, 2015; Wohl et al., 2010), highlighting the importance of the present research and encouraging other researchers to continue exploring these constructs.

Self-forgiveness in the Clinical Context

Self-forgiveness is considered a deep process that the client needs to be prepared and predisposed to do, as well as the therapist and the dyad between them (Woodyatt et al., 2017).

Concerning the clinical context, Greenberg and colleagues (Greenberg et al., 2008; Meneses & Greenberg, 2019) described the positive benefits of Emotion-Focused Therapy (EFT) concerning the processes of forgiveness and letting go after an emotional injury. Despite being indirect effects (Greenberg et al., 2008), these are

significant positive indicators regarding the change process of the client. Thus, it was essential for to entail a replication of this study, switching the focus to the construct of self-forgiveness. This focus addresses our third study (and subsequent clinical studies), stated in the present PhD Thesis.

Several researchers (e.g., Worthington, 2006; Woodyatt et al., 2017) suggest that self-forgiveness tends to be associated with motivation and consciousness of the change process. Therefore, it concerns a person's feelings about letting go of negative emotions, giving space for new meanings and positive affect.

These are important signs for therapists, concerning the opportunity for a client to experience a deep process of change, regarding self-forgiveness (Woodyatt et al., 2017).

Enright and Fitzgibbons (2000), as well as Woodyatt and colleagues (2017), theorize that the clues given by the client in a therapy session need to be considered by the therapist as keys that will guide the client to address their own needs (e.g., higher self-criticism, combined with a higher sense of shame, will be noticed by the conflict identities that the client may show or feel about himself or herself, i.e., a conflict split of the self). For example, if the client presents a conflict split in their identity, triggered by the responsibility of the offense, the therapist needs to be aware and pay attention to this aspect as a possible key to open a door to the process of self-forgiveness (Woodyatt et al., 2017).

These same authors, as well as Enright and Fitzgibbons (2000), state that in the perspective of the offender, these can be repair processes of the self, involving the acceptance of the moral social values. Thus, it can benefit the therapeutic process if the therapist is aware of and verbalizes/pin points to the client these inner conflicts, in order to promote a higher consciousness for the client, and work towards reestablishing a reconciliation between the two parts of the self.

Several therapies can promote self-forgiveness processes, such as Emotion-Focused Therapy (Pos & Greenberg, 2007), as well as the REACH Forgiveness model (Worthington, 2006). Some of them promote self-forgiveness directly (e.g., REACH Forgiveness model), and others have an impact through indirect effects (e.g., EFT).

The present PhD Thesis used both models, focused on our third, fourth, and fifth studies.

> *"Genuine forgiveness and self-forgiveness are always morally appropriate and desirable goals of psychotherapy for those patients who are willing and able to achieve them." (Holmgren, 2002, p. 116).*

According to the theory of Holmgren (2002), indeed self-forgiveness turns to be a deep and challenging process, where the client, therapist, and the goals of therapy need to be in congruence. In this sense, EFT and the REACH Forgiveness model were two models that were matched together here and complemented each other in a clinical protocol, focused on studying the process of self-forgiveness in offenders of (non-severe) emotional injuries and interpersonal offenses to a significant other. This clinical protocol was implemented on a feasibility study (as a step closer to a clinical trial), with a pilot sample of young adults (university students).

Concerning the process of self-forgiveness and regarding the perspective of Emotion-Focused Therapy, the focus on (and expression of) emotions is considered one of the main features on the therapeutic process. Literature shows evidence of the benefits of this process through the resolution of emotional injury resulting from an interpersonal offense, through the process of self-forgiveness, using for example the

Empty-Chair Task for unfinished business, and/or Two-Chair Dialogue for inner conflict splits (Elliott et al., 2021; Greenberg et al., 2008; Meneses & Greenberg, 2019).

Elliott and colleagues (2004), Pos and Greenberg (2007), and Greenberg and Goldman (2018) theorize Emotion-Focused Therapy as one of the main therapies that focuses on explicitly (and purposefully) working with emotions, while they are activated/aroused. It is possible to state that an emotion is the GPS of the client that guides them to their needs.

In this sense, EFT theory combines client-centered empathy (Pos & Greenberg, 2007; Elliott et al., 2021), with the dialectics between emotion (as activated and bodily-felt) and symbolization of the emotion (conceptual understanding), which become the focus of the therapy. Regarding the therapist stance, EFT combines empathic exploration (*following*) with directive techniques to facilitate the enactment and exploration of emotions and experiences (*guiding*). The main goal is to promote emotional self-regulation and emotional transformation, which is associated with the core issue of the client, as well as the elaboration of new meanings (Elliott et al., 2004; Greenberg & Goldman, 2018).

Lazarus and Shahar (2018) stated thar traumatic events can lead to the experience of maladaptive emotions. Therefore, the person tends to develop negative memories (affective and cognitive). At a certain moment in the person's life, when those negative memories are activated, they tended to be experienced in a maladaptive way (Lazarus & Shahar, 2018; Shahar, 2013, 2015). These processes of self-regulation (i.e., experiential processes) guide the client to the enactment of the experience and lead to self-awareness. In this sense, becoming aware of and understanding emotions (and emotional reactions) becomes a primordial step in EFT (Elliott et al., 2021; Greenberg & Goldman, 2018), leading to a deep comprehension of the experience, to the

recognition of the core issue/vulnerability and the accompanying core needs, and to decrease emotional suffering. These processes allow the client to change maladaptive emotions into adaptive emotions (Pos & Greenberg, 2007; Elliott et al., 2021).

In turn, Worthington (2006) and Wade et al. (2014) propose the therapeutic model REACH Forgiveness, focusing on the resolution of emotional injuries, and established to directly promoting change at the level of interpersonal forgiveness and/or self-forgiveness (the present PhD Thesis focuses on self-forgiveness, particularly).

Specifically, the REACH Forgiveness model proposes five steps, namely:

> R) RECALL THE HURT, which implies the healing and owning the responsibility for the committed offense;
>
> E) EMPATHIZE with your partner, or in this case with one self, which calls for empathy when putting oneself on the other person's chair;
>
> A) ALTRUISTIC GIFT, which concerns to conceiving and giving forgiveness as an unselfish, altruistic gift;
>
> C) COMMITMENT, which implies the commitment to forgive oneself by, for example, writing a note/letter to ourselves;
>
> H) HOLD ONTO FORGIVENESS, which implies embracing (self-) forgiveness even when moments are hard, and entails the readiness to write notes of forgiveness, written on the last step, or writing new ones, in order not to forget that the person actually forgave himself or herself (Worthington, 2006; Wade et al., 2014).

The question that arises at this point is: Why use these two models combined here? or even better: Why the need to use EFT and techniques from the REACH Forgiveness

model if the client has provided clues and committed to a process of self-forgiveness? These questions relate to our studies three, four, and five (see Chapters III, IV, and V).

Some authors (e.g., Greenberg et al., 2008; Worthington, 2006; Woodyatt et al., 2017) suggest that the key process in self-forgiveness tends to be associated with the awareness of the change process. Moreover, this awareness regards to how the client feels about the process of letting go of the negative emotions (e.g., self-criticism, shame, anger) and allowing positive emotions, such as self-compassion, self-generosity and/or self-acceptance. Regarding all of those previous processes, these are important clues and notions that therapists need to be aware of, concerning the possibility of clients needing to experience a deeper process of change, regarding self-forgiveness (Woodyatt et al., 2017).

The challenge of conflict identities and conflict splits integrates the acceptance of the responsibility for the offense and self-forgiveness responses. For the offender, these can be restored and repair processes of the self, which involves the acceptance of moral social values (Enright & Fitzgibbons, 2000; Woodyatt et al., 2017). In this sense, EFT and REACH Forgiveness combined can be very productive and beneficial to the client, regarding psychological well-being.

The perception of a committed offense tends to be associated with dysphoria and an emotional state of inferiority, which can be maladaptive to the client. These types of situations can promote depression and other clinical problems (Enright & Fitzgibbons, 2000; Gilbert & Andrews, 1998; Woodyatt et al., 2017).

Nevertheless, if the sense of shame and/or guilt is experienced in an adaptive way (e.g., in a therapeutic session in EFT), it can promote a more adaptive inner experience (e.g., restoration of conflict identities), and lead to a commitment regarding to self-forgiveness and self-compassion. These are positive responses towards the self, which

can promote positive emotions and restore well-being (Enright & Fitzgibbons, 2000; Gilbert & Andrews, 1998; Woodyatt et al., 2017).

Clinical Protocol in Emotion-Focused Therapy and REACH Forgiveness model for Self-forgiveness: A Combination of Theory and Techniques

The present PhD Thesis brings innovation by presenting a brief and integrative clinical protocol (addressed in Chapter III), based on the principles of the models Emotion-Focused Therapy – EFT (Greenberg & Goldman, 2018; Meneses & Greenberg, 2019) and REACH Forgiveness model (Worthignton, 2006; Wade et al., 2014).

The clinical protocol is proposed with five phases plus three follow up sessions. It was established to study the clinical results of the participants, especially, if the participants show positive outcomes regarding their negative experiences, with a special focus on self-criticism around the interpersonal offense and clinical symptoms, concerning, for example, depression (Graham et al., 2017) and/or overall symptomatology (Barkham et al., 2013).

EFT is a well-known therapeutic model, with several studies conducted for a variety of clinical problems (for a review on the clinical outcomes of EFT, see Elliott et al, 2021). Some of these clinical studies especially related to the resolution of emotional injuries, showed direct or indirect effects of EFT in letting go and forgiveness processes (Greenberg et al., 2008; Meneses & Greenberg, 2008). The REACH Forgiveness model (Worthignton, 2006; Wade et al., 2014) focus directly on the work with forgiveness and/or self-forgiveness (e.g., Toussaint et al., 2020; Worthignton et al., 2018). According to Toussaint et al. (2020), the clients who overcome emotional injuries through the process of forgiveness tend increase the positive affect and self-esteem.

López et al., 2021 also indicated that the clients who received forgiveness intervention showed higher indexes of predisposition to forgive, and these same results extended to the decrease of stress, anger, and/or depression. Thus, the positive affect was also in evidence, sense the clients demonstrate higher levels of psychological well-being (López et al., 2021).

Previous studies found positive benefits for EFT in the forgiveness process. These clinical outcomes established EFT as an intervention that contributes to several change processes in clients, not only at the level of clinical symptoms, but also promoting their overall well-being, even if the outcomes related to forgiveness were, in the majority of the times, indirect effects (Greenberg et al., 2008; Meneses & Greenberg, 2019).

A brief description of EFT needs to emphasize the therapeutic work focused on emotions, which are explored, symbolized and transformed, while activated (Elliott et al., 2021; Greenberg & Goldman, 2018; Pos & Greenberg, 2007; Elliott et al., 2021). The authors state that emotions are connected with the basic needs of the person. This process becomes crucial for facilitating emotion regulation and for finding a way to use these emotions properly, i.e., in an adaptive way.

However, in the same perspective, emotions can also become maladaptive. For example, when the person experiences traumatic events and intense emotional reactions, these create learning opportunities for establishing affective and cognitive memories (at an explicit and implicit level), which may cause maladaptive emotional reactions in future situations, when those emotions when activated (Paivio & Pascual-Leone, 2010; Shahar, 2013).

In this sense, the key in EFT regards to the dialectics that occurs between emotions and its symbolization and comprehension (Greenberg & Goldman, 2018). EFT combines empathic exploration with directive techniques of enactment and emotion

exploration, conducting to emotion self-regulation and emotion transformation. This process requires the access to the pain/core issue (Greenberg & Goldman, 2018; Pos & Greenberg, 2007) and, while emotions are activated, helping clients symbolize their experiences and access their core unmet needs. This may then lead to using more adaptively their emotions in the present (i.e., informed by their needs), being able to regulate their intensity and expression and lead the way to transform maladaptive emotional reactions into adaptive ones. In the end, this personal change and ways of being with oneself leads to the facilitation of self-narrative reconstruction (Angus & Greenberg, 2011; Cunha et al., 2017).

Studies shows evidence of benefits through the resolution of an emotional injury resulting from an interpersonal offense, by the process of forgiveness (Greenberg et al., 2008; Meneses & Greenberg, 2019). Meneses and Greenberg (2019) stated that overcoming emotional injuries is a non-linear process, achieving consolidation over time. Thus, in their latest proposal detailed in Meneses and Greenberg (2019), the authors elaborate on an intervention proposal across several phases (for individuals and couples, although we focus on individuals only here), and recommend this to become a non-prescriptive treatment (i.e., as a clinical orientation that may require adjustment or personalization to the client). Focusing on the individual therapy, Meneses and Greenberg (2019) elaborate a therapeutic protocol with five phases, enhancing the work self-interrupted processes and the emerged markers for the resolution of the unfinished business, through the process of forgiveness. Thus, the sessions were periodically, i.e., one session per week, during one hour.

The results tend to be productive for the clients when they overcome an emotional injury through forgiveness. Greenberg and colleagues (2008) focused on the importance to access to the core pain through the Empty-Chair task, and its promotion to overcome

an emotional injury through the process of forgiveness. The gains that the person achieve are related to let go the negative feelings and associated with the decrease of general symptomatology.

In turn, the REACH Forgiveness model focuses on the resolution of emotional injuries, related to interpersonal offenses, by demonstrating a direct work on, and subsequent effects of, the processes of forgiveness and self-forgiveness (Wade et al., 2014; Worthington, 2006; Worthington et al., 2018; Toussaint et al., 2020). Based on the REACH Forgiveness assumptions and adapting to the work with the offenders, they theorize the model in the five phases, previously referred, under the acronym REACH: Recall the hurt; Empathize; Altruistic gift; Commitment; Hold onto forgiveness.

The intervention with the REACH Forgiveness tends to be in a group context, directing to the format of psychoeducation, and with more sessions during several weeks. Studies demonstrated positive results with REACH Forgiveness, as for example, in the study of Toussaint et al. (2020), which showed evidence with group of Indian university students who overcome emotional injuries through the process of forgiveness. Participants who received immediate forgiveness training showed significant and large positive changes in forgiveness and unforgiveness, as well as, more positive affect and increased self-esteem in contrast to wait-list comparisons. Perceiving one's offender as having a similar spirituality to oneself was a consistent predictor of response to the REACH Forgiveness program. Specifically, perceiving the offender as having a similar spirituality was related to less growth of unforgiveness and more growth in empathy, positive affect, and emotional forgiveness (Toussaint et al., 2020). Kazoun (2018) also found negative effects of unforgiveness and its individual impact, in terms of psychological, physical, and social symptoms regarding a clinical sample. The

overall results indicated the importance of overcome an emotional injury trough forgiveness, sense it enhanced the positive benefits associated, such as acceptance.

Given this previous theoretical and empirical framework, the clinical protocol presented in this PhD Thesis (see Chapter III) adjusts the clinical intervention based on EFT principles of EFT proposed by Meneses and Greenberg (2019, among other influences, such as Greenberg & Goldman, 2018) and integrates the steps of the REACH Forgiveness model to facilitate self-forgiveness (Worthington, 2006; Wade et al., 2014). This clinical protocol was planned to be implemented or conducted during six weeks (one session per week, during one hour). The treatment proposed integrated five phases, namely:

I) Establishment of the therapeutic alliance and negotiation of the clinical intervention goals regarding the emotional injury/interpersonal offense under focus (EFT);

II) Empathic exploration and Evocative and Enactment work (EFT) on the emotional injury. This entails recalling the hurt (step 1 in REACH Forgiveness) and also involves working with emerging EFT markers, namely: the UFB Markers through the Empty Chair task or Self-criticism (markers of negative treatment of the self) through the Two Chair Dialogue task, given will of the client to work with self-forgiveness (step 1 and step 2 of REACH Forgiveness);

III) Imaginary Confession. During this stage of the work, there is usually a shift to the Imaginary Confession task (according to REACH Forgiveness), wich is an adaptation of the Empty Chair task to resolve Unfinished Business – UFB (see Meneses & Greenberg, 2019) to work towards self-forgiveness.

This stage usually involves further work with Self-criticism (e.g., Two Chair Dialogue - EFT) and Self-interruption processes (e.g., Two Chair Work - EFT) and other markers that can emerge in this therapeutic work towards self-forgiveness, especially when the client shows difficulties in the Imaginary Confession task (e.g., expression of the guilt, self-criticism, sadness or self-interruption). Here, the therapist proposes the corresponding therapeutic task to address each difficulty or block. Proceed working with Steps 3 – Altruistic gift, and Step 4 – Commitment to self-forgive (REACH Forgiveness);

IV) Facilitate Hold on to Self-Forgiveness. Continuum of the work with primary/secondary emotions, and depending on the EFT markers emerging, proceed to consolidate the previous therapeutic work on self-forgiveness, following the pace of the client. Work with Step 5 - Hold on to Self-Forgiveness/REACH Forgiveness combine with Therapist empathic validation/EFT;

V) Consolidation of the changes and Termination: This phase entails consolidation of the changes, namely by fostering new meanings around the emotional injury and the self, combined with step 5/REACH Forgiveness regarding Hold on to Self-Forgiveness. Also, this process involves enhancing the autonomy of the client and addressing issues related to the end of the clinical intervention (for detailed information, see Table I in Chapter III).

One of the crucial moments of this intervention regards the Empty Chair task to resolve Unfinished Business – UFB (Meneses & Greenberg, 2019), here adjusted to the

work on self-forgiveness through the form of an Imaginary Confession (proposed in the REACH Forgiveness model – see Worthington, 2006; Wade et al., 2014). As an example, this task involves an Imaginary Confession about the committed offense to the Significant Other who was hurt (imaginatively placed on the Empty Chair, in front of the client). This task is carried out in order to promote self-responsibility and, ultimately, lead into a change of positive affect (such as empathy or compassion from the Significant Other, and later on, from oneself, during the self-forgiveness process). This task is one of the key points of this intervention proposal, allowing to access and express the pain of the offender during the recognition of the harm that was inflicted upon the other and helping the person to overcome this core suffering. However, as this process unfolds, there is usually the emergence of self-criticism and self-condemnation (as a process that has to be dealt with before advancing toward self-forgiveness).

Hence, another one of the crucial moments of this intervention implies the Two-Chair Dialogue task for resolving conflict splits, such as the self-criticism and self-condemnation as specific forms of negative treatment of the self-implicated in the client's experience of the interpersonal offense). Here, the experience of self-criticism is normally intense; which calls upon an empathic affirmation from the therapist, where the therapist needs to validate the vulnerability and intense negative emotions that can come up at this stage of the process.

In sum, these different tasks and intervention proposals coming from these two different models were integrated, in a congruent form – both at a theoretical and clinical form – in order to better respond to the client's needs at any precise moment of these sessions and specify the work towards self-forgiveness.

INTRODUCING THE CURRENT STUDIES

The present PhD Thesis includes five studies, all with different methodologies. However, the author believes their results show a connection between all of the studies, one by one.

Construct Validity of Two Measures of Self-forgiveness in Portugal: A Study of Self-forgiveness, Psychological Symptoms, and Well-being

The first study, namely *Construct Validity of Two Measures of Self-forgiveness in Portugal: A Study of Self-forgiveness, Psychological Symptoms, and Well-being*, involves the validation of two instruments, namely two self-report measures that assess self-forgiveness: *The State Self-forgiveness Scale* and *The Differentiated Self-forgiveness Process Scale*. The reason behind studying these two scales concerns the need to assess self-forgiveness in different dimensions and develop reliable measures to assess clinical outcomes related to the process of self-forgiveness. Thus, this first study is presented on Chapter I.

Wohl and colleagues (2008) conceived The State Self-forgiveness Scale (SSFS). The SSFS was the first self-report measure to evaluate self-forgiveness. Specifically, it is a scale that assesses feelings of self-forgiveness, beliefs, and actions regarding the committed offense by the offender. The scale is subdivided into two dimensions, namely: (a) Self-forgiveness Feelings and Actions (e.g., "*Considering what I did wrong, I feel rejection of myself*"; "*Considering what I did wrong, I punish myself*"); and, (b) Self-forgiveness Beliefs (e.g., "*Considering what I did wrong, I believe that I am worthy of love*").

Woodyatt and Wenzel (2013) conceived The Differentiated Self-forgiveness Process Scale (DSFPS). The DSFPS is a self-report measure that assesses self-forgiveness related to an interpersonal offense (e.g., infidelity; betrayal of trust). Thus, it classifies the degree of the severity of the offense through three subscales, namely: (a) Pseudo Self-forgiveness (e.g., "*I feel that the other person had what he deserved*"); (b) Self Punitive (e.g., "*I deserve to suffer for what I have done*"); and, (c) Genuine Self-forgiveness (e.g., "*Since I've made my mistake, I've been trying to change*").

In Portugal, none of these scales have been translated yet, nor have their psychometric properties been studied. Therefore, the main goal of the first study (Chapter I) is to study the psychometric properties of the State Self-forgiveness Scale and the Differentiated Self-forgiveness Process Scale for the Portuguese population in a sample of university students, given that the scales are complementary for the assessment of the self-forgiveness construct. That is, the two scales assess different dimensions of self-forgiveness.

Self-forgiveness Acts Directly and Indirectly to Affect Psychological Well-being and Depression through Self-criticism and Self-reassurance after an Interpersonal Offense

The second study (see Chapter II), named *Self-forgiveness Acts Directly and Indirectly to Affect Psychological Well-being and Depression through Self-criticism and Self-reassurance after an Interpersonal Offense,* focuses on whether self-forgiveness acts directly or indirectly on depression and psychological well-being through self-criticism and self-reassurance after an interpersonal offense.

According to the theory, self-criticism was expected to influence, directly and indirectly, the relationship between self-forgiveness and psychological well-being. In

this sense, self-forgiveness could have an important role in the reduction of self-criticism (Gilbert & Woodyatt, 2017) leading, therefore, to the reduction of rumination and acute negative emotions (Wohl et al., 2010). Under this psychological perspective, self-forgiveness tends to be beneficial to the person, promoting their capacity to tolerate negative emotions and to use them productively (in terms of social and intrapersonal functioning). Therefore, the person can reconstruct a more positive attitude towards the self that allows moral reintegration and restoration without condoning their own negative behavior (Peterson et al., 2017; Thompson et al., 2005).

As stated before, these first two studies focused on the validation of the self-forgiveness scales in order to apply them in clinical practice. Thus, it was important to comprehend how self-forgiveness was associated with the main constructs of the present PhD Thesis, such as psychological well-being, self-criticism, and depression.

The second part of the overall PhD project was focused on a pilot study, which was delineated in the form of a clinical trial. However, given the difficulties related to recruiting and treating a larger sample within the scope of this PhD, the clinical studies shown in the second part of this Thesis were approached in the format of a feasibility study (addressed in our third study).

Self-forgiveness and Psychological Well-being: Clinical intervention protocol in Emotion-Focused Therapy and REACH Forgiveness model

The third study, named *Self-forgiveness and Psychological Well-being: Clinical intervention protocol in Emotion-Focused Therapy and REACH Forgiveness model,* had the main focus to present an intervention protocol combining EFT and the REACH Forgiveness model (elaborated above), for the resolution of emotional injuries related to interpersonal offenses, focusing on the experience of the offender (see Chapter III).

The third study aggregates two sub-studies: 1) A feasibility protocol study which aims to assess the effects of a brief therapeutic intervention for the resolution of a non-severe emotional injuries; and 2) A good outcome case study to describe the evolution of a self-forgiveness process during the evolution of this clinical intervention.

Study 1 is an adaptation of the study conducted by Greenberg and colleagues (2008), Cornish and Wade (2015) and is inspired in other examples of feasibility studies (e.g., Hoddinott, 2015; Lancaster, 2015; Yardley et al., 2015). It presents a feasibility protocol for the assessment of an innovative clinical intervention to promote self-forgiveness, combining the models of Emotion-Focused Therapy (EFT) and REACH Forgiveness Model, in a clinical sample of university students, all of them seeking help to deal with negative affect and unfinished business related to being authors of an interpersonal offense/emotional injury toward a significant other.

This study aims to comprehend the effects of a brief therapeutic intervention (6 sessions plus 3 follow up sessions) to resolve emotional injury resulting from a non-severe interpersonal offense (consult topic Exclusion Criteria). Specifically, we intend to analyze the changes that occur in self-forgiveness, psychological well-being and clinical symptomatology (depressive and general) in a sample of university students struggling to deal with the negative experiences related to having committed (a non-severe) emotional injury to a significant other. Thus, it aims to contribute to answering the following central research question: Will EFT and the REACH Forgiveness Model be effective in the promotion of change at the level of the main clinical variables (self-forgiveness, psychological well-being) and secondary variables (general and depressive symptomatology), when comparing the evolution of the client between pre and post treatment?

Study 2 is a description of a good outcome case study – The case of "Christina", based on the guidelines of the Theory-building Case Study, theorize by William B. Stiles (2010; 2015; 2021). In this sense, and inspired in other cases studies (Cornish & Wade, 2015; Meneses & Greenberg, 2019), the case of "Christina" is described based on the theory of EFT and REACH Forgiveness model, proposed in Study 1. Thus, it is intended to demonstrate the evolution of "Christina" during treatment, comparing the main variables at pre, middle and post-treatment phases (see Chapter III).

The case of "Chloe": A poor outcome case in Emotion-Focused Therapy and the REACH Forgiveness model

The fourth study is described in Chapter IV in the form of a qualitative study, named *The case of "Chloe": A poor outcome case in Emotion-Focused Therapy and REACH Forgiveness Model.*

This study describes the case of "Chloe", and it focuses on the evolution of a poor outcome case, regarding the outcome of a brief therapeutic intervention integrating EFT and the REACH Forgiveness model to resolve an emotional injury resulting from a non-severe interpersonal offense. Specifically, this study analyzes the changes that occurred during the treatment when comparing the evolution of "Chloe" between pre and post treatment, in the measures of self-forgiveness, self-criticism, and psychological responses (psychological well-being, depressive, and general symptoms).

The description of this case followed the guidelines of Stiles (2015, 2021) concerning Theory Building Case-Studies, contrasting and enriching the theories of EFT (Greenberg & Goldman, 2018; Meneses & Greenberg, 2019) and REACH Forgiveness models for fostering self-forgiveness processes in (non-severe) offenders (Worthington, 2006; Wade et al., 2014).

Clinical Outcomes of a Self-forgiveness Intervention Integrating Emotion-Focused Therapy and REACH Forgiveness Model

The fifth study, named *Clinical Outcomes of a Self-forgiveness Intervention Integrating Emotion-Focused Therapy and REACH Forgiveness Model,* describes the outcome of a brief clinical intervention study in self-forgiveness, self-criticism, psychological well-being, and depression, regarding the resolution of an emotional injury (see Chapter V). It presents the results of the implementation of the feasibility study described before (see Chapter III), focusing on the clinical outcomes of this innovative clinical intervention integrating Emotion-Focused Therapy and the REACH Forgiveness model.

Addressing one main hypothesis: 1) We hypothesized that a person with individual brief intervention in EFT and REACH Forgiveness model would accomplish the following: (a) decrease the presence of general symptomatology from the pre- to post-treatment; (b) reduce the negative affect towards the self (as measured by the Letting Go Measure); (c) show improvement in self-forgiveness and its correlation with other constructs (self-criticism, negative affect, and depression).

According to Elliott and colleagues (2004), Worthington (2006), as well as Costa and colleagues (2021), these models have previously shown positive benefits towards well-being and mental health concerning the resolution of unfinished business related to emotional injuries. Therefore, the present study – specifically focusing on the experience of offenders –, aimed to ascertain if this clinical intervention proposal facilitated an improvement in the participants' clinical symptomatology and emotions towards the self and sense of moral value.

CHAPTER I

CONSTRUCT VALIDITY OF TWO MEASURES OF SELF-FORGIVENESS IN PORTUGAL: A STUDY OF SELF-FORGIVENESS, PSYCHOLOGICAL SYMPTOMS, AND WELL-BEING

ABSTRACT[1]

Several studies have suggested that self-forgiveness promotes psychological well-being. The State Self-forgiveness Scale (SSFS) and the Differentiated Self-forgiveness Process Scale (DSFPS) are two self-report questionnaires that assess self-forgiveness in psychotherapy, personal change, and health. Aims: The present study aims to examine the psychometric properties of the SSFS and the DSFPS in a Portuguese sample, highlighting reliability and validity properties for scores on both scales. We examine the relationships among self-forgiveness, self-criticism, psychological well-being, and global psychopathological symptoms. Method: The two scales were completed in a random nonclinical sample of 475 university students. The Psychological Well-Being Scale was used to explore the relation between self-forgiveness and well-being. Results: Our findings show evidence of a good estimated internal consistency for scores on both scales – SSFS and DSFPS. Conclusion: Self-forgiveness is related to higher indexes of positive feelings (e.g., self-compassion, self-esteem) such as positive behaviors and beliefs about the self. Thus, self-criticism (e.g., hated self) tends to decrease while self-forgiveness feelings and actions, as well as positive feelings of the self (self-compassion; self-love) tends to increase. In clinical practice these are positive indicators, which can lead to personal improvement, as well as positive affect and lower symptomatology (e.g., symptoms of depression).

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INTRODUCTION

Self-forgiveness has been found to reduce mental health symptoms and to promote psychological well-being (Woodyatt et al., 2017) in a variety of cultures. Perhaps the most widely accepted theory explaining why is the role of self-forgiveness in stress and coping theory. Offenses are stressors that are appraised and reacted to physiologically, emotionally, cognitively, motivationally, and behaviorally—with many stress reactions. People cope with stress reactions in many ways, but forgiving oneself if one sees oneself as offender, is a way that people can mitigate stress reactions, change their appraisals, and also affect the meaning of the stressors. The benefits of forgiving oneself are well documented (for many reviews, see Toussaint et al., 2015).

Numerous studies have provided evidence for the beneficial aspects of facilitating self-forgiveness in overcoming emotional injury related to inflicting interpersonal offenses on others, experiencing negative relational experiences, or disappointing oneself (Greenberg et al., 2008; Wade et al., 2014; Wohl et al., 2008; Woodyatt & Wenzel, 2013; Wohl & McLaughlin, 2014; Woodyatt et al., 2017). Yet, it is still necessary to deepen our comprehension of this concept in non-clinical samples as also its role on personal development. To achieve this endeavor, we focus on the translation and adaptation of these instruments in a new language. We also aim to study the relation between self-forgiveness and both mental health symptoms and other well-being indicators in a sample of Portuguese population.

Emotional injury is understood here as the experience of having lingering, bad feelings deriving from an interpersonal situation that is perceived as offensive, unjust and/or causing personal suffering (Greenberg et al., 2008). Frequently, when a person becomes aware of committing such an interpersonal offense on another person, the

offender can experience negative emotions like guilt, shame, regret, and remorse. This emotional evaluation of the offense can arouse a higher level of maladaptive internal processes, such as high self-condemnation or intense self-criticism, which are coupled with already present negative emotions.

Fisher and Exline (2006) see this recognition of one's own culpability and perhaps even of maladaptive emotions like shame as a first step toward self-forgiveness, which can repair and reestablish a relationship and lead to an improvement in an offender's well-being.

Recently, research on self-forgiveness has accelerated (for reviews or research, see the edited book by Woodyatt et al., 2017). However, even now, self-forgiveness is likely still considered the "stepchild of forgiveness research" (Hall & Fincham, 2005; for a meta-analysis, see Davis et al., 2015). One reason for the relative infrequency of research on self-forgiveness is its confinement to the United States and Australia and investigation using the English language.

Individualistic, self-oriented cultures—like those in the USA, Australia, New Zealand, England, and some of Northern Europe (e.g., Amsterdam, Germany) and Scandinavia—might be particularly vulnerable to people who struggle with self-condemnation, because they construe the wrongs they have done and their disappointments in terms of the injury to the self. Thus, they might be particularly in need of knowledge about self-forgiveness, which has led to heightened research interest in the topic.

However, recent research has recast the study of self-forgiveness more relationally, which opens up the study of self-forgiveness to cultures more oriented to relationships—like collectivistic cultures in the Far East, Africa, many countries in South America, and cultures in Southern Europe like Spain, Italy, and Portugal. For

example, Wenzel and colleagues (2020) have conceptualized self-condemnation as one part of interpersonal interactions around offenses and offense.

Namely, offenders and victims have many options for pushing the relationship toward restoration or further division. For example, the offender might feel justified in having inflicted an injustice on the victim. Or the offender might be motivated by guilt and shame to self-justify his or her own acts by blaming the victim, thus easing the offender's shame and guilt to the degree that self-justification can do so. Either way would push the relationship toward dissolution. On the other hand, the offender often experiences remorse and regret over wrongs done to the victim. The offender might then attempt relationally reparative actions, like accepting responsibility for the wrong or at least for the offender's part in the wrong, apologizing, expressing empathy for the victim, offering to make reparations, promising not to offend again, and asking for forgiveness. The degree to which the offender can feel and act with appropriate vulnerability can affect the responses of the victim.

The victim also has many choices that might precede or follow the offender's expressions of contrition or self-justification. Similarly, how the victim acts can push the relationship apart or back together. If the victim takes a harsh retributive justice stance and maintains it regardless of what the offender does, the relationship is likely in for conflict and the offender is not likely to forgive the self. On the other hand, if the victim is forgiving, expresses empathy and forgiveness, and aims the relationship at reconciliation, the relationship has a good likelihood of being repaired, and the offender is more likely to forgive the self.

In the *Handbook of Forgiveness, 2nd ed.* (Worthington & Wade, 2020), numerous authors expressed more interest in seeing research in the future on the interpersonal

context of offenses rather than what has been the case in the first 20 years of intensive research on forgiveness—a focus on the internal forgiveness processes of the victim.

These shifts in the field of forgiveness studies suggests that new research is welcome from countries that already value and contextualize behavior within relationships. A key step to advance further research on self-forgiveness is to develop robust psychometric measures to assess this construct that can be used in more collectivistic cultures.

Hence, our efforts here focus on the adaptation and assessment of self-forgiveness measures to a Portuguese sample of young adults. We will also look at how self-forgiveness relates with other complementary variables (such as self-criticism, psychological well-being, depression, and global psychopathological symptoms). The investment in developing such measures is a cornerstone to provide further evidences regarding the contribution of this variable to psychological well-being and for the facilitation of personal development and the resolution of interpersonal problems.

Self-forgiveness – A Brief Construct Review

A psychological perspective on self-forgiveness conceives this as an internal process (Woodyatt et al., 2017), usually implying several steps: (a) a person recognizes oneself as an offender, whose actions where hurtful, damaging or wrong (i.e., against some form of moral order) toward another person (victim); (b) this leads the offender to experience negative emotions – such as shame, guilt, regret, or anger – toward him or herself, and, afterwards, (c) in case of an increase of self-forgiveness, the offender experiences a reduction of these negative feelings and an increase of more positive feelings toward him or herself, such as self-acceptance, self-compassion or self-

understanding (Hall & Fincham, 2008; Woodyatt & Wenzel, 2013; Worthington, 2013; Worthington & Langberg, 2012).

Different authors have highlighted specific aspects of self-forgiveness. Woodyatt and Wenzel (2013) propose self-forgiveness as, "The process in which the offender of the wrongdoing recognizes the victim's own guilt and worth, experiencing emotions resulting from the interpersonal offense, and providing attitudes and behaviors that lead to the attempt to understand the offense and to the attempt to correct (...) the moral self" (p.231).

For Fisher and Exline (2006), self-forgiveness occurs only when the person in the role of the offender can forgive oneself. Self-forgiveness differs from forgiveness from the point of view of the offender: that is, while forgiveness of the other is an interpersonal process, self-forgiveness is a self-directed process, emphasizing the intrapersonal dimension of this construct (Toussaint & Webb, 2005; Webb et al., 2012). Other authors suggest that self-forgiveness is not only about the absence of positive affirmations concerning one's own moral values (Wenzel et al., 2012; Wohl & McLauhglin, 2014), but also involves the need to use different strategies to achieve a reduction of self-criticism, guilt and shame, in order to enhance positive emotions such as self-compassion and self-acceptance (Woodyatt et al., 2017). To Wohl and colleagues (2008), self-forgiveness is understood as the liberation of a negative experience, like the abandonment of negative thoughts, feelings and behaviors related to the self (e.g., guilt; shame), thus enhancing the arrival of self-acceptance, self-generosity and love for oneself (see also Woodyatt et al., 2017).

A key aspect of self-condemnation is self-criticism, which is implied in two of aspects of self-forgiveness: first, in the awareness of the offense committed and the recognition that one’s actions where hurtful, damaging or wrong; second, it is implied,

through its decrease, when one begins to transform negative emotions into more positive emotions towards the self (Woodyatt et al., 2017). Whelton (2000) highlights that self-criticism is often harmful to the individual. The person can experience high levels of self-condemnation. That results in experiences of sadness and shame and, consequently, in the inability to control one's maladaptive internal state. That lack of control results in depression. High self-criticism tends to maintain maladaptive shame, resulting in emotional distress, negative affect, low self-esteem, and avoidance when one recalls the offense committed (Gilbert & Andrews, 1998; Gilbert et al., 2004). Also, they suggest that maladaptive shame tends to contribute to: (a) problems of depression, anxiety, and low self-esteem, when the emotion of shame is internalized; or (b) problems of hostility and aggression when the emotion of shame is externalized. The authors also suggest that self-forgiveness is related to dysphoria about the perceived offense. Dysphoria results in an emotional state of inferiority that consequently blocks self-forgiveness. This hinders a person's predisposition to self-forgive (Gilbert & Andrews, 1998; Gilbert et al., 2004).

Self-forgiveness and Well-being

Previous studies have highlighted the relation between self-forgiveness, mental health, and well-being (e.g., Cornish & Wade, 2015b; Wilson et al., 2008). More specifically, pervasive, or chronic negative emotions are linked with rumination and negative health outcomes (Gilbert & Andrews, 1998; Whelton, 2000; Wohl et al., 2010). Yet, self-forgiveness can reduce rumination and pervasive negative emotions (Wohl et al., 2010) and allows the individual to reintegrate a positive self-image, restored without condoning (Thompson et al., 2005).

A meta-analysis on self-forgiveness by Davis and colleagues (2015) showed evidence of a connection between self-forgiveness, positive mental health, and well-being (average $r = -0.45$). They found a negative correlation with depression and anxiety (e.g., depression average $r = -.48$). Thus, higher values of self-forgiveness, positive mental health, and well-being were correlated with lower levels of depression. Liao and Wei (2015) also showed evidence of a link between self-forgiveness and positive mental health indicators in a sample of undergraduate students. Higher levels of self-forgiveness were related to lower levels of perceived stress and symptoms of depression. Self-forgiveness is also related to better psychological well-being (Cornish & Wade, 2015b; Davis et al., 2015; Liao & Wei, 2015; Wohl et al., 2010), highlighting the importance of the present research and encouraging other researchers to continue investigating these constructs.

The Present Study

Previous studies have been carried out internationally for developing measures for self-forgiveness (e.g., Recoder et al., 2019). From these, we focus on the State Self-Forgiveness Scale (Wohl and colleagues, 2008) and on the Differentiated Self-Forgiveness Process Scale (Woodyatt & Wenzel, 2013). These two measures have been used the longest to asses states of self-forgiveness.

The State Self-Forgiveness Scale was the first self-report measure to evaluate self-forgiveness. Specifically, it is a scale that purports to assess self-forgiveness feelings, beliefs, and actions regarding the offense the person committed. The scale is subdivided into two dimensions, namely: (a) Self-Forgiveness Feelings and Actions (e.g., "Considering what I did wrong, I feel rejection of myself"; "Considering what I did wrong, I punish myself"); and, (b) Self-Forgiveness Beliefs (e.g., “Considering what I

did wrong, I believe that I am worthy of love"). Both subscales had adequate psychometric properties. The alphas ranged from .74 to .89 (Wohl et al., 2008).

The Differentiated Self-forgiveness Process Scale is a self-report measure to assess self-forgiveness related to an interpersonal offense (e.g., infidelity; betrayal of trust). The DSFPS classifies the degree of severity of the offense through three subscales, namely: (a) Pseudo Self-forgiveness (e.g., "I feel that the other person had what he deserved"); (b) Self Punitive (e.g., "I deserve to suffer for what I have done"); and, (c) Genuine Self-forgiveness (e.g., "Since I've made my mistake, I've been trying to change"). All subscales showed good psychometric properties. Alphas ranging from .81 to .85 (Woodyatt & Wenzel, 2013).

In Portugal, none of such scales have been translated. Nor have their psychometric properties been studied. Therefore, our main goal is to culturally adapt and to study psychometric properties of the State Self-forgiveness Scale and the Differentiated Self-forgiveness Process Scale for the Portuguese population in a sample of university students given that the scales are complementary. That is, the two scales assess different dimensions of self-forgiveness. Therefore, in this study, we computed estimated reliability of the scores, and we sought to examine whether evidence exists supporting the predictive construct validity of the scales. To provide evidence regarding validity, we computed the relationships between self-forgiveness and other constructs. Because the scales should ostensibly assess the same construct, they should be correlated highly with each other, and the subscales should also be intercorrelated. Evidence of predictive construct validity of the scores would be positive correlations with constructs that self-forgiveness should strongly predict, namely self-criticism and self-reassurance. Self-forgiveness should theoretically be less strongly correlated with psychological well-being; and symptoms of depression and psychopathological symptoms (both negative

correlations). Finally, discriminant construct validity should be shown by a zero correlation with social desirability. This progression of decreasing strength of associations (e.g., the other measure of self-forgiveness → self-criticism and self-reassurance → psychological well-being and symptoms → social desirability) illustrates a nomological network of associations.

METHOD

Participants

Our participants were *N* = 475 university students (230 women, 48.4%; 245 men, 51.6%), with ages between 18 and 55 years old. The mean age of the total sample is 21.98 (*DP* = 5.78). There were no statistically significant differences between men and women in terms of age, $t(473) = -.620$; $p = .535$.

Measures

State Self-Forgiveness Scale (SSFS; Wohl et al., 2008). The State Self-forgiveness Scale is a self-report measure that evaluates self-forgiveness. It consists of 17 items, with response options from 1 to 6, where 1 = *Strongly Disagree* to 6 - *Strongly Agree*. The SSFS integrates two subscales, namely the (a) Self-forgiveness Feelings and Actions (SSFA; e.g., Self-forgiveness Feelings - *"*Considering what I did wrong, I feel acceptance of myself"; e.g., Self-forgiveness Actions - *"*Considering what I did wrong, I punish myself *"*); and (b) Self-forgiveness Beliefs (SFB; e.g., *"*Considering what I did wrong, I believe I am decent*"*). This measure also contains a final, single response item (*"*Considering what I did wrong, I forgive myself...*"*), with response options from 0 = *"Not at all"* to 3 = *"Completely"* Wohl and colleagues (2008) reported Cronbach's alpha

for both subscales: for SFFA, α = .74; for SFB, α = .89. In the present study, the SFFA had α = .77, *IC 99%* [.72 - .81], Ωcategorial = .91 and the SFB had α = .84, *IC 99%* [.81 - .86], Ωcategorial = .93).

Differentiated Self-forgiveness Process Scale (DSFPS; Woodyatt & Wenzel, 2013). The DSFPS is a self-report instrument that evaluates self-forgiveness, initiated by a question to define the type of offense committed (e.g., infidelity; betrayal of trust) and then assessing the degree of severity of that offense through three subscales, namely: Pseudo Self-forgiveness (PSF; e.g., "I think the other person was guilty of what I did"); Self Punitive (SP; e.g., "*What I did is unforgivable"*); and Genuine Self-forgiveness (GSF; e.g., "*I'm trying to learn with my mistake"*). The subscales comprised a total of 20 items, rated on seven-point response options from 1 = *Strongly Disagree* and 7 = *Strongly Agree*. The original results obtained by Woodyatt and Wenzel (2013) report Cronbach's alphas as Pseudo Self-forgiveness (α = .81); Self Punitive (α = .85); Genuine Self-forgiveness (α = .85). In the present study, the Differentiated Self-forgiveness Process Scale had Cronbach's alphas for the three weakly related subscales – Pseudo Self-forgiveness (α = .64, *IC 99%* [.56 - .70], Ωcategorial = .70); Self Punitive (α = .80, *IC 99%* [.77 - .84], Ωcategorial = .75); Genuine Self-forgiveness (α = .82, *IC 99%* [.79 - .85], Ωcategorial = .79).

Forms of Self-Criticism and Reassuring Scale (FSCRS; Gilbert et al., 2004; Portuguese version by Castilho & Gouveia, 2011). The FSCRS is a self-report measure that evaluates self-criticism and self-reassurance in situations of failure. It is composed with 22 items constituting three subscales (e.g., "I cannot accept failures without feeling inadequate"; *"I have a feeling of disgust for myself*"). The subscales are Inadequate

Self, Self-reassurance, and Hated Self. Responses options are from 0 = *Not at all like me* to 4 = *Extremely like me)*. Gilbert and colleagues (2004) reported Cronbach's alphas for all subscales – Inadequate Self (*α* = .90); Self-reassurance (*α* = .86); Hated Self (*α* = .86). Castilho and Gouveia (2011) also had similarly strong Cronbach alphas– Inadequate Self (*α* = .89); Self Reassurance (*α* = .87); Hated Self (*α* = .62). In the present study, Cronbach's alpha for the Forms of Self-criticism and Reassuring Scale was *α* = .70, *IC 99%* [.65 - .75], Ωcategorial = .90). Cronbach's alphas for the subscales were, for the Inadequate Self *α* = .87, *IC 99%* [.84 - .89], Ωcategorial = .82 and for the Self-reassurance, *α* = .87, *IC 99%* [.85 - .89], ωcategorial = .82. Cronbach's alpha for the subscale Hated Self was low, (*α* = .52, *IC 99%* [.42 - .61], Ωcategorial = .90).

Psychological Well-being Scale (PWBS; Ryff, 1989; Portuguese version by Novo et al., 1997). The PWBS is a self-report measure to evaluate psychological well-being. This brief version contains 18 items (e.g., *"I gave up trying to make big improvements or changes in my life a long time ago"; "I like most aspects of my personality"*), distributed across the following six dimensions: Self-acceptance; Personal Growth; Purpose in Life; Positive Relations; Environmental Mastery, and, Autonomy. Response options were from 1 = *Strongly Disagree* to 6 = *Strongly Agree*. Ryff (1989) reported Cronbach's alpha ranging from .83 (Self-acceptance) to .68 (Personal Growth). The results obtained by Novo and colleagues (1997) showed evidences of a low estimated internal consistency for all subscales—Self-acceptance (*α* = .52), Personal Growth (*α* = .40), Purpose in Life (*α* = .33), Positive Relations (*α* = .56), Environmental Mastery (*α* = .49), Autonomy (*α* = .37). In the present study, the Psychological Well-being Scale (total) had a strong Cronbach's alpha (*α* = .84, *IC 99%* [.82 - .87], Ωcategorial = .96), as well as for the subscales Self-acceptance (*α* = .66, *IC 99%* [.94 - .96], Ωcategorial = .86)

and Purpose in Life (α = .62, *IC 99%* [.96 - .97], Ωcategorial = .76). The subscales Personal Growth, Positive Relations, Environmental Mastery and Autonomy showed evidence of a low estimated internal consistency: Personal Growth (α = .52, *IC 99%* [.94 - .96], Ωcategorial = .80); Positive Relations (α = .50, *IC 99%* [.96 - .97], Ωcategorial = .77); Environmental Mastery (α = .54, *IC 99%* [.96 - .97], Ωcategorial = .86); Autonomy (α = .40, *IC 99%* [.96 - .97], Ωcategorial = .83).

Personal Health Questionnaire (PHQ-9; Kroenke et al., 2001; Portuguese version by Ferreira et al., 2019). The PHQ-9 is a self-report measure that evaluates the severity of symptoms of depression according to the criteria of the Diagnostic and Statistical Manual of Mental Disorders. This measure has 9 items (e.g., *"I feel little interest or pleasure in doing things"; "I feel that I don't like myself or feel disappointed about myself or others"*) that use a four-point response options from 0=*Not at all* to 3=*Nearly every day*. Kroenke and colleagues (2001) found strong Cronbach's alphas from α = .86 to .89. The Portuguese version by Ferreira and colleagues (2019) also had alphas from α = .61 to .77. In the present study, the PHQ-9 has α = .86, *IC 95%* [.83 - .88], Ωcategorial = .93.

Brief Symptom Inventory (BSI; Derogatis & Spencer, 1982; Portuguese version by Canavarro, 1995). The BSI is a self-report measure that evaluates psychopathological symptoms and contains 9 dimensions: Somatization; Obsession-compulsion; Interpersonal Sensitivity; Depression; Anxiety; Hostility; Phobic Anxiety; Paranoid Ideation; Psychoticism. The scale contains 53 items and uses response options from 0=*Not at all* to 4=*Extremely*. Derogatis and Spencer (1982) found alpha to be α = .95,

and Canavarro (1995) found alpha to be α = .93 for the Portuguese version of this scale. In this present study, the BSI had α = 98, *IC 95%* [.97 - .98], Ωcategorial = .99.

Marlowe-Crowne Social Desirability Scale (MC-SDS; Ballard, 1992; Portuguese version by Pechorro et al., 2012). The MCSDS is a self-report instrument that assesses the tendency of the person to respond in a socially accepted way. It uses 13 items that are responded to by either *True* or *False* (e.g., "I already pretended to be sick to get out of a situation"; "I'm always nice, even if people are rude to me"). Ballard (1992) found α = .70 and Pechorro and colleagues (2012) α = .60 to .61 for the Portuguese version of this scale. In the present study, the Marlow-Crowne Social Desirability Scale had α = .64, *IC 95%* [.58 - .70], Ωcategorial = .99.

Procedures

The main researcher contacted the authors of all measures to obtain authorizations for their use. The present study was approved by the Ethical Committee of the University. The data collection for the present study was carried out across several phases. After obtaining the authors' consent, the State Self-forgiveness Scale and the Differentiated Self-forgiveness Process Scale were translated into Portuguese according to the guidelines of Beaton and colleagues (2000). The process of translation went through different steps. First, the translation was carried out by two independent researchers who speak both languages. Second, a synthesis of the first translation was carried out by the main researcher. Third, the back-translation and the revision were performed by a specialized translator.

After translation of the two self-forgiveness instruments, all instruments were given to a random sample of student's participants. The researcher (first author) explained the

main goals of the study and provided information regarding confidentiality (to guarantee the anonymity of each participant during reporting of results). An email contact was provided to the participants to provide additional information on this study or referral to psychological help after participation, if they wished such. After this, each participant signed an informed consent form and provided their sociodemographic data. These procedures occurred in a university context.

Data Analysis

Confirmatory factor analysis (CFA) was conducted, on the SSFS, to examine whether the original two-factor structure proposed by Wohl and colleagues (2008) presented an adequate fit to the studied sample. A CFA was also conducted on the DSFPS, to examine whether the three-factor structure proposed by Woodyatt and Wenzel (2013) existed in the Portuguese sample.

The Goodness-of-Fit (GOF) was assessed using the Chi-square ($\chi 2/df$). A ratio of 3 or under is considered to indicate an adequate model. The fit of the model was considered good for the Comparative Fit Index (CFI) and the Tucker Lewis Index (TLI) values above .90 (Tucker & Lewis, 1973), Standardized Root Mean Square Residual (SRMR) for values below 0.08 (Kline, 2016), and Root Mean Square Error of Approximation (RMSEA) for values below 0.08 (Byrne, 2010; McDonald & Ho, 2002).

All statistical analyses were performed with R (R Core Team, 2018) and RStudio (RStudio Team, 2018). To assess multivariate normality, we used Mardia's multivariate kurtosis (Mardia, 1970), and it was calculated using the psych package (Revelle, 2018). The lavaan package (Rosseel, 2012) was used to compute the CFA using the Weighted Least Squares Means and Variances (WLSMV) estimation method (Muthén, 1983). The

adjustment of the model was made from the modification indexes (higher than 11; $p < .001$) based on theoretical considerations.

Pearson's correlation coefficients were used to examine evidence of convergent and discriminant construct validity. Higher correlations values between the measures analyzed were regarded to a greater indicator of convergent construct validity. Lower correlation values indicated a greater evidence of discriminant construct validity (Fayer, 2007). As a level of statistical significance, a modified Bonferroni corrected alpha of .001 was used.

RESULTS

Missing data diagnostics revealed that no data were missing. Omega point estimates were satisfactory (Nunnally & Bernstein, 1994). Descriptive statistics (means and standard deviations), bivariate associations, and estimates of internal consistency for the study variables are displayed in Table I.

Content Validity—Confirmatory Factor Analysis

We performed a confirmatory factor analysis (CFA) on both scales. Regarding the CFA of the State Self-forgiveness Scale (SSFS), we analyzed two factors gathering the items founded in the original version. The structural model fit the data reasonably well, $\chi2(102) = 390.53$, $p < .001$, RMSEA = .077 (90% C.I. = [.069, .085], $p < .001$), CFI = .935, TLI = .913 and SRMR = .085 (Model 1). However, because $\chi2$ /df and the SRMR were both slightly higher than desirable, we examined individual items. Items 1 and 6 of Self-forgiveness Feelings and Actions (SFFA), as well as items 2, 3, 5 and 7 of Self-forgiveness Beliefs (SFB) were not adequate, because factor loads are lower than .50

(being λ = .29, λ = .39, λ = .43, λ = .44, λ = .47, λ = .45, respectively). We removed those six items, and repeated the CFA. According to this replication, the structural model fit the data better, $\chi 2(43) = 115.99$, $p < .001$, RMSEA = .060 (90% C.I. = [.047, .073], p = .103), CFI = .969, TLI = .960 and SRMR = .073 (Model 2). We found that composite estimated reliability values exceeded the recommended minimum of .60 (Bagozzi & Kimmel, 1995). Also, Cronbach's alphas had values higher than .70 (Field, 2019) (see Table I).

Concerning the CFA of the Differentiated Self-forgiveness Process Scale (DSFPS), we analyzed its three factors from the original version. The structural model did not fit the data adequately, $\chi 2(167) = 870.92$, $p < .001$, RMSEA = .094 (90% C.I. = [.088, .0101], $p < .001$), CFI = .817, TLI = .792 and SRMR = .104 (Model 1). However, item 11 and 13 of Pseudo Self-forgiveness (Pseudo SF), as well as item 18 of Self Punitive were not adequate; their factor loadings were lower than .50 (being λ = .20, λ = .41, λ = .44, respectively). We removed those three items, repeated the CFA, and the structural model fit the data well, $\chi 2(43) = 263.84$, $p < .001$, RMSEA = .053 (90% C.I. = [.045, .061], p = .263), CFI = .950, TLI = .940 and SRMR = .068 (Model 2). We found that composite reliability values exceeded the recommended minimum of .60 (Bagozzi & Kimmel, 1995) and Cronbach's alpha values were higher than .70 (Field, 2019) (Table I).

Table I

SSFS and DSFPS Factor weights, Cronbach alpha (α) and composite reliability (CR)

	Factor/Items	*λ*	***α***	***CR***
SSFS	**SFFA**		**.78**	**.75**
	Item 1 (SFF 1)	.29		
	Item 2 (SFF 2)	.55		
	Item 3 (SFF 3)	.67		
	Item 4 (SFF 4)	.51		
	Item 1 (SFA 1)	.78		
	Item 2 (SFA 2)	.39		
	Item 3 (SFA 3)	.52		
	Item 4 (SFA 4)	.57		
	SFB		**.83**	**.84**
	Item 1 (SFB 1)	.77		
	Item 2 (SFB 2)	.43		
	Item 3 (SFB 3)	.44		
	Item 4 (SFB 4)	.66		
	Item 5 (SFB 5)	.47		
	Item 6 (SFB 6)	.53		
	Item 7 (SFB 7)	.45		
	Item 8 (SFB 8)	.68		
	Item 9 (SFB 9)	.71		
DSFPS	**Pseudo SF**		**.63**	**.70**
	Item 8 (Pseudo SF 8)	.54		
	Item 9 (Pseudo SF 9)	.65		
	Item 10 (Pseudo SF 10)	.62		
	Item 11 (Pseudo SF 11)	.20		
	Item 12 (Pseudo SF 12)	.62		
	Item 13 (Pseudo SF 13)	.41		
	SP		**.80**	**.80**
	Item 1 (SP 1)	.53		
	Item 2 (SP 2)	.59		
	Item 3 (SP 3)	.60		
	Item 4 (SP 4)	.59		
	Item 5 (SP 5)	.57		
	Item 6 (SP 6)	.71		
	Item 7 (SP 7)	.63		
	GSF		**.82**	**.82**
	Item 14 (GSF 14)	.50		
	Item 15 (GSF 15)	.53		
	Item 16 (GSF 16)	.81		
	Item 17 (GSF 17)	.68		
	Item 18 (GSF 18)	.44		
	Item 19 (GSF 19)	.55		
	Item 20 (GSF 20)	.69		

Note. Abbreviations are as follows: SSFS = State Self-Forgiveness Process Scale; SFFA = Self-Forgiveness Feelings and Actions; SFF = Self-Forgiveness Feelings; SFB = Self-Forgiveness Beliefs; DSFPS = Differentiated Self-Forgiveness Process Scale; SP = Self-Punitive; GSF = Genuine Self-Forgiveness; Pseudo SF = Pseudo Self-Forgiveness; *λ* = Factor weights; α = Cronbach alpha; CR = Composite reliability.

$^{*}p < .001$

Construct Validity Using a Brief Nomological Network of Associations

We provided evidence supporting construct validity by evaluating correlations within a nomothetic network of associations. This network examines construct validity by computing correlations of the scores of the two self-forgiveness measures (and their subscales) with scores on measures at varying degrees of theoretical closeness to the construct under consideration.

Construct validity. Thus, using scores on measures with the closest degree of theoretical similarity, the scores were correlated with each other, and using correlations of scores on each self-forgiveness measure with Forms of Self-criticism and Reassuring Scale (FSCRS). Typically, these should be high.

Predictive convergent construct validity. Evidence of predictive convergent construct validity would be provided by assessing correlations of scores on the self-forgiveness measures with scores on measures that might be expected to be predicted by self-forgiveness. We used two mental health measures as criteria--the Personal Health Questionnaire, PHQ-9, symptoms of depression and the nine subscales of the Brief Symptom Inventory – BSI, (Somatization; Obsession-compulsion; Interpersonal Sensitivity; Depression; Anxiety; Hostility; Phobic Anxiety; Paranoid Ideation; and Psychoticism, and for General Symptomology) and a measure of well-being (Psychological Well-being Scale). Discriminant validity is the extent that measures of a construct are not related to measures that they theoretically should not be related. We used the Marlow-Crowne Social Desirability Scale (MC-SDS) scale as our measure of discriminant validity. Theoretically, we expected that correlations under (1) construct validity would be reasonably high (~.5 or higher); (2) predictive construct validity would be moderate (~.2 to .3) and related negatively to mental health symptoms and positively to well-being; and (3) discriminant construct validity would be low (~.0). All

correlations between these variables were statistically significant and occurred in the expected direction, as can be seen in Table II.

For both SSFS subscales (Self-forgiveness Feelings and Action and Self-forgiveness Beliefs) and DSFPS (e.g., Genuine Self-Forgiveness DSFPS), the higher the score on SSFS and DSFPS, the lower are the rates of self-criticism (e.g., Inadequate Self FSCRS). Also, the higher the score on SSFS subscales (Self-forgiveness Feelings and Action and Self-forgiveness Beliefs) the higher the rates of self-reassurance (e.g., SR FSCRS). The higher is the score on DSFPS Punitive Self (which indicates a reluctance to forgive the self), the lower are the rates of self-reassurance (e.g., SR FSCRS), which is theoretically consistent.

Concerning symptoms of depression (e.g., Depressive Symptoms PhQ-9) and other psychopathological symptoms (e.g., Somatization BSI or Obsession-Compulsion), the higher is the score on SSFS (Self-forgiveness Feelings and Action and Self-forgiveness Beliefs) and the higher are the rates of psychological well-being (e.g., Total Psychological Well-being PWBS). The higher is the score on DSFPS (e.g., Punitive Self—i.e., a non-self-forgiving stance), the lower are the rates of psychological well-being (e.g., Total Psychological Well-being PWBS), which again is theoretically consistent and provides evidence of predictive construct validity.

Regarding the subscales Self-forgiveness Feelings and Actions and Self-forgiveness Beliefs, belonging to the SSFS, and the subscales Pseudo Self-forgiveness and Genuine Self-forgiveness, belonging to the DSFPS, the same procedures were carried out. Results are similar: i.e., the higher are the scores for these subscales, the higher are the rates of self-reassurance and psychological well-being, and lower are self-criticism and symptoms of depression (Table II).

Discriminant construct validity. Low–correlations can be seen in Table II between social desirability and the subscales: Self-forgiveness Feelings and Actions; Self-forgiveness Beliefs; Self Punitive; and, Genuine Self-forgiveness.

Table II

SSFS/DSFPS and PHQ-9, BSI, PWBS, FSCRS, MC-SDS Construct, Convergent and Discriminant Validity

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Construct validity (gold standard)																				
1. SFFA SSFS	-																			
2. SFB SSFS	0.527*	-																		
3. SP DSFPS	–0.473*	–0.450*	-																	
4. GSF DSFPS	0.195*	0.099	–0.373*	-																
Convergent predictive construct validity (strong association)																				
5. IS FSCRS	–0.448*	–0.304*	0.426*	–0.287*	-															
6. SR FSCRS	0.384*	0.286*	–0.324*	0.059	–0.379*	-														
Convergent predictive construct validity (moderate association)																				
7. Depressive symptoms PHQ-9	–0.280*	–0.195*	0.336*	–0.122*	0.483*	–0.374*	-													
8. Somatization BSI	–0.203*	–0.219*	0.283*	–0.080	0.375*	–0.319*	0.625*	-												
9. Obsession-compulsion BSI	–0.264*	–0.224*	0.293*	–0.111	0.471*	–0.401*	0.682*	0.722*	-											
10. Interpersonal sensibility BSI	–0.322*	–0.262*	0.327*	–0.107	0.532*	–0.462*	0.654*	0.702*	0.769*	-										
11. Depression BSI	–0.300*	–0.206*	0.347*	–0.076	0.513*	–0.457*	0.734*	0.688*	0.794*	0.842*	-									
12. Anxiety BSI	–0.290*	–0.256*	0.319*	–0.115	0.481*	–0.419*	0.702*	0.824*	0.794*	0.804*	0.790*	-								
13. Hostility BSI	–0.243*	–0.223*	0.301*	–0.076	0.439*	–0.290*	0.660*	0.680*	0.738*	0.703*	0.746*	0.780*	-							
14. Phobic anxiety BSI	–0.174*	–0.207*	0.217*	–0.044	0.353*	–0.303*	0.528*	0.736*	0.671*	0.698*	0.653*	0.792*	0.618*	-						
15. Paranoid ideation BSI	–0.222*	–0.204*	0.243*	–0.090	0.440*	–0.268*	0.592*	0.634*	0.691*	0.748*	0.710*	0.671*	0.683*	0.567*	-					
16. Psychoticism BSI	–0.334*	–0.291*	0.355*	–0.111	0.519*	–0.427*	0.704*	0.710*	0.813*	0.837*	0.848*	0.820*	0.759*	0.721*	0.733*	-				
17. Total BSI	–0.300*	–0.265*	0.348*	-106	0.522*	–0.425*	0.760*	0.855*	0.892*	0.893*	0.903*	0.927*	0.852*	0.810*	0.813*	0.916*	-			
18. Total psychological well-being PWBS	0.268*	0.202*	–0.310*	–0.021	–0.440*	0.496*	–0.491*	–0.359*	–0.502*	–0.578*	–0.592*	–0.453*	–0.396*	–0.489*	–0.418*	–0.565*	–0.545*	-		
Discriminant predictive construct validity (zero association)																				
19. Pseudo SF DSFPS	0.080	0.052	0.031	0.075	–0.036	–0.003	0.026	0.042	0.042	–0.004	0.025	0.014	0.093	0.022	0.089	0.025	0.043	–0.035	-	
20. Total MC-SDS	0.111	0.103	–0.173*	0.022	–0.241*	0.105	–0.277*	–0.210*	–0.295*	–0.245*	–0.240*	–0.258*	–0.438*	–0.250*	–0.264*	–0.291*	–0.313*	0.248*	–0.118*	-
M	310.86	410.06	170.44	220.05	10.60	20.60	60.18	0.61	0.94	0.82	0.85	0.79	0.95	0.48	10.03	0.70	0.79	40.55	200.06	60.45
SD	70.09	70.73	70.15	80.09	0.86	0.81	50.02	0.71	0.81	0.89	0.85	0.78	0.85	0.69	0.84	0.78	0.70	0.67	60.12	20.53

Note. In this nomothetic network of associations, theoretically, we expect those correlations under (1) construct validity will be reasonably high (~.5 or higher); (2) predictive validity will be moderate (~.2 to .3) and related negatively to mental health symptoms and positively to well-being; and (3) discriminant validity will be low (~.0). Abbreviations are as follows: SFFA = Self-forgiveness Feelings and Actions; SFB = Self-forgiveness Beliefs; SP = Self-punitive; GSF = Genuine Self-forgiveness; IS = Inadequate Self; SR = Self-reassurance; SSFS = State Self-Forgiveness Scale: DSFPS = Differentiated Self-Forgiveness Process Scale; PHQ-9 = Personal Health Questionnaire ; BSI = Brief Symptom Inventory; PWBS = Psychological Well-being Scale; FSCRS = Forms of Self-Criticism and Reassuring Scale; Pseudo SF = Pseudo Self-forgiveness; MC-SDS = Marlow Crown Social Desirability Scale; Total Psy. = Total Psychological Well-Being. *Modified Bonferroni-corrected *$p \leq .001$.

DISCUSSION

The present study had the main goal to study the psychometric properties of the State Self-forgiveness Scale and the Differentiated Self-forgiveness Process Scale, for the Portuguese population in a sample of university students.

Regarding the analysis of the psychometric characteristics of the scales, the results suggest that these measures present good psychometric properties for the evaluation of self-forgiveness in the present sample, as occurred in the original studies for each scale (Wohl et al., 2008; Woodyatt & Wenzel, 2013), as well as with other self-forgiveness measures, previously mentioned (e.g., Enright & Rique, 2004; Recoder et al., 2019; Thompson et al., 2005).

Concerning the CFAs for the two scales, in general the structure of the English-versions of both scales was similar to the Portuguese versions. However, as is often true with translations across cultures, a few items simply did not work as well with the Portuguese sample (Beaton et all, 2000). However, with relatively few items dropped (six for the SSFS and three for the DSFPS) the structure was the same.

At this moment, aspects concerning the discriminant validity of the self-forgiveness construct should also be addressed. Overall, our results suggest that self-forgiveness is not significantly influenced by social desirability, as measured by the MCSDS. More specifically, results indicate a low correlation between social desirability and the Self-forgiveness Feelings and Actions, Self-forgiveness Beliefs, and Genuine Self-forgiveness subscales. However, contrary to expectations, social desirability seems to be more related to the Self-punitive and Pseudo Self-forgiveness subscales (given the statistically significant correlation found between these variables). A possible explanation for this outcome is related to the need of the offender to block the self-

forgiveness process in order to achieve an expected and social response (especially implicated in Pseudo Self-Forgiveness), due to maladaptive shame and emotional avoidance, related to the recognition of having committed an offense (Gilbert & Andrews, 1998).

As previously mentioned, self-forgiveness is a cognitive, behavioral, and emotional process carried out by an offender (i.e., someone who recognizes having committed an offense). Self-condemnation entails self-criticism and negative emotions and feelings—like guilt, shame, remorse, and low feelings of self-esteem—that are related to regret subsequent to the offense (Woodyatt et al., 2017). Some people stew in those feelings, which Woodyatt and Wenzel (2013) called self-punitiveness. This typically is not good for mental health. People often alleviate those negative feelings by what Woodyatt and Wenzel (2013) called pseudo-self-forgiveness, which amounts to letting oneself irresponsibly off of the hook. While people feel better, this is detrimental to relationships. Relational health typically requires responsible reparative actions prior to self-forgiveness, which Woodyatt and Wenzel called genuine self-forgiveness. In fact, previous studies have emphasized the importance of receiving interpersonal forgiveness from the injured party as a facilitator of self-forgiveness by the offender. When forgiveness from the victim is accompanied by genuine self-forgiveness, this is usually beneficial for the mental health and overall well-being of the person (e.g., Cornish & Wade, 2015b; Davis et al., 2015; Liao & Wei, 2015) as well as for the relationship. In the present study, we found systematic support for this theorizing by examining a nomological network of associations with the two self-forgiveness measures. The measures were highly correlated with each other, as expected. They were also highly negatively correlated with symptoms of self-condemnation (i.e., self-criticism) and positively correlated with self-reassurance (Wenzel et al., 2012; Wohl & McLauhglin,

2014). The mental health benefits of self-forgiveness were more distal than were symptoms, and smaller correlations were anticipated, and were found. Overall, these results are congruent with the literature (e.g., Cornish & Wade, 2015b; Wilson et al., 2008), providing further empirical evidence for the positive link between self-forgiveness and psychological well-being. In contrast, our results concerning a negative relation between psychological well-being and the punitive self can be understood, following Wohl and colleagues (2010), as related to the negative emotions and actions (such as shame, regret, remorse, and self-punishment) that characterize self-condemnation.

Moreover, the transgressor's predisposition to self-forgive, combined with self-awareness and self-responsibility (e.g., Woodyatt & Wenzel, 2013), may lead to a lower self-criticism (Wohl et al. 2008). This process implies emotional change, represented by transforming negative emotions by positive emotions related to the self (Woodyatt et al., 2017; see also, Cornish & Wade, 2015b; Greenberg et al., 2008).

The present study provides psychometric justification for using Portuguese versions of the two instruments (with certain items removed) within Portuguese populations. We have provided the Portuguese versions in the Appendix. The Woodyatt and Wenzel (2013) Differentiated Self-Forgiveness Process Scale is particularly apt for applying to Portuguese culture because it considers not just internal feelings of self-forgiveness, but also relationship-centered responsibilities of people who have offended, which is more likely to yield valid findings in cultures that might be more collectivistic than United States cultures.

CONCLUSION, LIMITATIONS AND IMPLICATIONS FOR FUTURE RESEARCH

The State Self-forgiveness Scale and the Differentiated Self-forgiveness Process Scale exhibited good psychometric properties in the current study. Nevertheless, the present research used a specific sample of Portuguese university students, which in consequence, does not allow generalizing the results to other segments of the Portuguese population. We also did the research cross-sectionally, so (a) it was not possible to conduct temporal stability computations and (b) we could not demonstrate causal predictive validity of the scores. Nonetheless, we supported other theoretically consistent empirical findings using cross-sectional research (Cornish & Wade, 2015b; Davis et al., 2015; Liao & Wei, 2015) and other samples (Wohl et al., 2010). In terms of clinical implications, if the correlational findings can be supported longitudinally, that would provide additional evidence that self-forgiveness is a valid target for psychotherapy, especially when a patient is predisposed to work during psychotherapy toward the goal of self-forgiveness (Woodyatt et al., 2017). However, further studies are required to deepen our knowledge upon the process of self-forgiveness in psychotherapy and in terms of its applicability in clinical and non-clinical populations.

Thus, the present research suggests that it would be useful for future studies to focus on other samples of the general population. In addition, it would be useful to examine clinical samples to expand the present study results.

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CHAPTER II

SELF-FORGIVENESS ACTS DIRECTLY AND INDIRECTLY TO AFFECT PSYCHOLOGICAL WELL-BEING AND DEPRESSION THROUGH SELF-CRITICISM AND SELF-REASSURANCE AFTER AN INTERPERSONAL OFFENSE

ABSTRACT[2]

When people have committed an interpersonal offense, apart from the interpersonal consequences of the offense, they often experience self-criticism or self-condemnation. We focus on the internal experience of offenders. We especially consider self-forgiveness, which can repair and overcome self-criticism related to the offense and increase psychological well-being. We focus on the relationships among self-forgiveness and both psychological well-being and depressive symptoms acting directly and also indirectly through self-criticism and self-reassurance. We recruited a non-clinical sample of 475 young undergraduate adults. Participants were assessed in terms of self-forgiveness, self-criticism and self-reassurance, psychological well-being, and clinical symptoms. We tested several models regarding the relationships among variables including multiple regression for detecting direct and indirect effects among variables. Self-forgiveness acts indirectly through self-punishment and self-reassurance to affect psychological well-being and depressive symptoms. Findings supported the claim that self-forgiveness leads to a better mental health.

[2] *Note.* The present study has been submitted in a peer-review international journal and is currently under review.

INTRODUCTION

When people perpetrate an interpersonal offense, they frequently experience guilt, regret, and remorse (Fisher & Exline, 2006; Gilbert & Andrews, 1998; Gilbert et al., 2004; Woodyatt et al., 2017). Those emotions often motivate people to deal productively with the offense, by doing acts that promote positive interpersonal and personal effects (Tangney et al., 2005). These can include admitting responsibility for the offense, apologizing, making amends, asking for forgiveness, and doing other acts that restore the offender's sense of moral balance (Woodyatt & Wenzel, 2013). Such acts might involve showing kindnesses for others, seeking to set up conditions that make similar offenses less likely, and (for religious people) seeking to make things right with the Sacred (Davis et al., 2015; Worthington, 2013). Thus, such acts can not only delimit rumination over the offense, but also re-orient one's moral compass to a more positive direction (Griffin et al., 2015; Woodyatt & Wenzel, 2013).

Whether this occurs, can be affected by the degree to which people are either self-critical or self-reassuring (Woodyatt et al., 2017). That will affect the likelihood of developing depression and holding a positive sense of psychological well-being (Woodyatt et al., 2017). Positive acts by offenders will make it more likely that the offended person will react with openness to reconciliation (Massengale et al., 2017; Woodyatt & Wenzel, 2013).

Sometimes offenders feel shame, which is a feeling that oneself is defective or wrong as illustrated by the offense (Leach, 2017; Tangney et al., 1996), or the offense is seen as a negatively transformative act for one's moral self. Such responses can often lead to excessive rumination (Graham et al., 2017), which keeps the offense and the person's personal attributions of being defective salient and inhibits adaptive responses,

and enhance self-criticism, which can inhibit self-reassurance (Leach, 2017; Tangney et al., 1996) and delay or prevent moral reorientation back to a more positive moral stance. These responses can increase the likelihood of depression (Graham et al., 2017; Whelton, 2000), lower the sense of positive psychological well-being (Massengale et al., 2017; Woodyatt et al., 2017), and lessen the likelihood of reconciliation (Massengale et al., 2017; Wohl et al., 2017; Woodyatt & Wenzel, 2013).

Of course, the time sequence of events varies greatly with individuals. One typical time sequence can be for an offender to experience guilt, regret, and remorse, and then forgive the self, which creates self-reassurance and reduces self-criticism. That might lead to reduced depression and increased psychological well-being. Another typical time sequence could be the experience of shame intermixed with guilt, regret, and remorse. Those negative emotions inhibit self-forgiveness, elevate self-criticism, and lower self-reassurance. That in turn makes depression more likely and lowers psychological well-being.

We have sought to assess the direct effects of self-forgiveness on both depression and psychological well-being at a single time point. Because the levels of self-criticism and of self-reassurance will likely affect mental health, we have also assessed the degree to which self-forgiveness might act indirectly to produce both depression and psychological well-being.

Self-forgiveness, Self-criticism and Self-reassurance, and Psychological Response: An empirical connection?

Previous authors (e.g., Cornish & Wade, 2015b; Costa et al., 2021) have studied the complex relationships between self-forgiveness, self-criticism, self-reassurance, and psychological responses. Acute emotions of blame or guilt can promote adaptive

changes in the behavior of the offender by stimulating the assumption of responsibility for a committed offense (Woodyatt & Wenzel, 2013). However, when those negative emotions become chronic or pervasive, they tend to be linked with negative coping responses, such as interpersonal avoidance that perpetuates conflicts (Gilbert & Andrews, 1998; Whelton, 2000; Wohl et al., 2010) and with internal rumination. Those internal events can lead to negative health outcomes for individuals (e.g., self-criticism, leading to negative emotions and consequently, to the enhancement of depressive symptoms).

According to the theory, self-criticism is expected to influence, directly and indirectly, the relationship between self-forgiveness and psychological well-being. In this sense, self-forgiveness can have an important role in the reduction of self-criticism (Gilbert & Woodyatt, 2017), leading therefore to the reduction of rumination and acute negative emotions (Wohl et al., 2010). Under this psychological perspective, self-forgiveness tends to be beneficial to people, promoting their capacity to tolerate negative emotions and use them productively (in terms of social and intrapersonal functioning). Therefore, people can reconstruct a more positive attitude towards the self that allows moral reintegration and restoration without condoning their own negative behavior (Peterson et al., 2017; Thompson et al., 2005).

The present study seeks to contribute to understand how these constructs—i.e., self-forgiveness, self-criticism, self-reassurance, depression, and psychological well-being—are interrelated. We test the direct and indirect effects of self-forgiveness on psychological well-being and depression by addressing four hypotheses:

*Hypothesis 1***.** Self-forgiveness is directly (and negatively) related to depression.

Hypothesis 2. Self-forgiveness is directly (and positively) related to psychological well-being.

Hypothesis 3. Self-forgiveness is indirectly related to depression through both self-criticism and self-reassurance.

Hypothesis 4. Self-forgiveness is indirectly related to psychological well-being through both self-criticism and self-reassurance.

METHOD

Participants

The present sample is N = 475 university students (230 women, 48.4%; 245 men, 51.6%) from the North of Portugal. Participants were from several majors (e.g., business management; psychology; criminology; marketing; physical education) and had a mean age of 21.98 years (*SD* = 5.78). This sample was previously used by (Costa et al., 2021) to establish psychometric properties of self-report measures for Portuguese adults – State Self-Forgiveness Scale (SSFS), also linked with the theme of self-forgiveness.

Measures

State Self-forgiveness Scale (SSFS; Wohl et al., 2008; Translated and adapted by Costa et al, 2021). The State Self-Forgiveness Scale is a self-report measure that evaluates self-forgiveness. It consists of 17 items, with response options ranging from 1 = *Strongly Disagree to* 6 = *Strongly Agree*. Wohl and colleagues (2008) showed evidence of estimated internal consistency of total scale scores (α = .89). Costa and colleagues (2021) also found estimated internal consistency for the Portuguese version (α = .86). For the present study, estimated internal consistency is ω = .87.

Forms of Self-criticism and Reassuring Scale (FSCRS; Gilbert et al., 2004; Portuguese version by Castilho & Gouveia, 2011). The FSCRS is a self-report measure that evaluates self-criticism and self-reassurance in situations of failure. It incorporates three subscales, namely: Inadequate Self, Self-Reassurance, and Hated Self. The subscales of inadequate self and hated self-assess two types of self-criticism. The FSCRS has 22 items with response options ranging from 0 = *Not at all like me* to 4 = *Extremely like me*). Gilbert and colleagues (2004) showed evidence supporting estimated internal consistency for scores on all three subscales and the total score (α = .87). They found alpha = .90 for Inadequate Self and alpha = .86 for Self-Reassurance. In the present sample, the alpha for Hated Self was unacceptably low; thus, we used only the two other subscale scores for inadequate self and self-reassurance. Castilho and Gouveia (2011) found evidence supporting estimated internal consistency for Inadequate Self (α = .89) and Self-Reassurance (α = .87). In the present study, we found estimated internal consistency for both Inadequate Self and Self-Reassurance to be ω = .84. Both variables were used in the study.

Psychological Well-being Scale (PWBS; Ryff, 1989; Portuguese version by Novo et al., 1997). The PWBS is a self-report measure that evaluates psychological well-being. This scale incorporates 18 items, with response options ranging from 1 =*Strongly Disagree* to 6= *Strongly Agree*. Ryff (1989) reported estimated internal consistency α = .83 for the full-scale scores. The present study has estimated internal consistency ω = .85 for the full-scale scores.

Brief Symptom Inventory (BSI; Derogatis & Spencer, 1982; Portuguese version by Canavarro, 1995). The BSI is a self-report measure that evaluates psychopathological

symptoms across nine dimensions: Somatization; Obsession-compulsion; Interpersonal Sensitivity; Depression; Anxiety; Hostility; Phobic Anxiety; Paranoid Ideation; Psychoticism. The BSI consists of 53 items, with response options ranging from 0 = *Not at all* to 4 = *Extremely*. Derogatis and Spencer (1982) showed evidence of estimated internal consistency of total scores on the scale (α = .95). Canavarro (1995) found estimated internal consistency of α = .93 for the Portuguese version. In the present study, we used only the subscale Depression for statistical analyses. Estimated internal consistency was ω = .88.

Procedures

Data analysis

The study was approved by the Ethics Committee of the University. Participants participated voluntarily in this study. A researcher explained the goals of the study and provided information regarding confidentiality and how sociodemographic data were to be handled in adherence to the 1964 Helsinki declaration and its later amendments or comparable ethical standards, as well as to the General Data Protection Regulation, adopted by the European Union (Directive 95/46/EC), in the context of scientific research (Chassang, 2017). An email contact was also provided to allow participants to request (if desired) additional information or referral to psychological help. Participants gave their informed consent. Thus, this study is in accordance with the procedures of Song et al. (2020) and Juan et al. (2020), which conducted similar procedures regardless the collected sample in one single moment.

Statistical analyses were performed in *R* program (R Core Team, 2017) and a structural equation model was conducted by using *R Lavaan package* (Rosseel, 2012). Moreover, we performed an evaluation of the standardized 3 scores for each variable

which did not indicate any univariate outliers ($z < |2.26|$, $p < .001$; Tabachnick & Fidell, 2013). Concerning the estimated internal consistency of scores, we used omega to decrease measurement assumptions and unbiased point estimates compared to other techniques such as Cronbach's alpha (Dunn et al., 2013). Regarding Pearson correlations (along with 95% confidence intervals), computations were conducted to focus and explore associations between the variables. The values regarding effect sizes were classified using Cohen (1992) for Pearson's correlation (r). Thus, the significance level was established as $\alpha = .05$ in all analyzed data.

The hypotheses of the present study tested indirect effects by using structural equation models (SEM). Latent variables were constructed by using the totality of the items ratings for each scale(s) or subscale(s) as indicators. Indirect effects were calculated by multiplying the path from the predictor to the mediator by the path from the mediator to the consequent variable. As an example of the formula: a1*b1 is the indirect effect of X1 on Y2 through M1. Concerning bootstrapped confidence intervals, they served as statistical tests for all parameter estimates, as well as standardized values of estimates served as effect-size measures of all indirect effects (Preacher & Kelley, 2011).

As last, the evaluation of the model fit was performed through global fit and testing by observing approximate fit values: CFI (Comparative Fit Index $\geq .95$); TLI (Tucker-Lewis Index $\geq .90$); RMSEA (Root Mean Square Error of Approximation $\leq .08$); RMSR (Root Mean Square of Residuals $\leq .08$) (Hair et al., 2014). Computations were conducted via local fit and tested by observing residual covariance matrices (Kline, 2016).

RESULTS

Intercorrelations and descriptive statistics are presented in Table I. Hypothesis 1 and 2 were supported. Self-forgiveness was negatively correlated with depression (*r* = -.29) and positively correlated with psychological well-being (*r* = .27). Also, self-forgiveness was negatively correlated with self-criticism (*r* = -.44) and positively related to self-reassurance (*r* = .38). Self-criticism was positively correlated with depression (*r* = .55) and self-reassurance was negatively correlated with depression (*r* = .46).

By testing the structural equation model, the SEM did not fit the data perfectly, $\chi 2$ (6) = 435.28, $p < .001$. Nevertheless, the approximate fit statistics met the necessary conditions for indicating acceptable fit, with the following values: RMSEA = .07 (< .08), CFI = .98 (> .95), TLI = .92 (> .90), and SRMR = .03 (< .08). Thus, by examining the residual correlation matrix, it helped to identify local misfit. The data showed low correlations between residuals Self-Forgiveness, Self-Criticism, Self-Reassurance, and Depression (< .10, Kline, 2016).

Table I

Intercorrelations, and descriptive statistics for all study variables

	Unst.	*95% CI*	*St.*
Depression			
Total effect	**- .320**	- .416 ; - .224	**- .287**
Direct effect of Self-Forgiveness	- .016	- .090 ; .058	- .018
Indirect effect through Self-Reassurance	**- .216**	- .273 ; - .159	**- .194**
Indirect effect through Self-Criticism	**- .120**	- .173 ; - .077	**- .108**
Psychological well-being			
Total effect	**.235**	.158 ; .311	**.267**
Direct effect of Self-Forgiveness	.016	- .076 ; .108	.014
Indirect effect through Self-Reassurance	**.127**	.086 ; .168	**.144**
Indirect effect through Self-Criticism	**- .124**	-.104 ; - .145	**.141**

Note. PWBS – Total; BSI – Depression; SSFS - Self-forgiveness; FSCRS - Self-reassurance; FSCRS - Self-criticism, Correlations, M, and SD, (n =475). Correlations are significant (p ≤ .001) for r >| .27|.

In Table II, we summarize the values regarding the total, direct, and indirect effects. The first column shows unstandardized estimates. The second column displays 95% confidence intervals (which indicate statistical significance when they do not include 0). The third column shows standardized estimates. Self-forgiveness had significant indirect effects on depression through its influence on self-reassurance. Also, self-forgiveness contributed to a higher self-reassurance, which contributed to a lower depression. Self-forgiveness had significant indirect effect on depression, through its influence on self-criticism. Self-forgiveness contributed to a lower self-criticism, which contributed to a lower depression, supporting Hypothesis 3. Self-forgiveness had significant indirect effect on psychological well-being through its influence on self-reassurance. Also, self-forgiveness contributed to a higher self-reassurance, which contributed to a higher psychological well-being. Self-forgiveness had significant indirect effects on psychological well-being, through its influence on self-criticism. Self-forgiveness contributed to a lower self-criticism, which contributed to a higher psychological well-being, supporting Hypothesis 4.

Table II

Total, Direct, and Indirect Effects

	Unst.	*95% CI*	*St.*
Depression			
Total effect	**- .320**	- .416 ; - .224	**- .287**
Direct effect of Self-Forgiveness	- .016	- .090 ; .058	- .018
Indirect effect through Self-Reassurance	**- .216**	- .273 ; - .159	**- .194**
Indirect effect through Self-Criticism	**- .120**	- .173 ; - .077	**- .108**
Psychological well-being			
Total effect	**.235**	.158 ; .311	**.267**
Direct effect of Self-Forgiveness	.016	- .076 ; .108	.014
Indirect effect through Self-Reassurance	**.127**	.086 ; .168	**.144**
Indirect effect through Self-Criticism	**- .124**	-.104 ; - .145	**.141**

Note. Unst. = unstandardized; St. = standardized. Significant effects are indicated in boldface type.

DISCUSSION

In the present study, we tested four hypotheses. Each was supported by the current data.

Concerning hypothesis 1, self-forgiveness was negatively related to depression. Higher levels of self-forgiveness tend to be related to less depression. Graham (2017) suggests that rumination leads to maladaptive responses, such as inhibition. That, in turn, can yield a state of negative responses towards the self, such as personal attributions of being defective (Tangney et al., 2005). Such shame-based attributions can lead to depression (Graham et al., 2017; Whelton, 2000).

Self-forgiveness was also directly related to positive psychological well-being in the current study. That finding supported Hypothesis 2.

Tangney et al. (2005) suggested that sometimes negative emotions about the offense can motivate the person to deal with it productively by doing acts that promote positive interpersonal and personal effects. Thus, these kinds of actions can include admitting responsibility for the offense, apologizing, making amends, asking for forgiveness, and doing other acts that restore the offender's sense of moral balance (Woodyatt & Wenzel, 2013).

In the present research, we focused on the indirect effects of the relation between self-forgiveness and depression, potentially through self-criticism and self-reassurance. The data supported hypothesis 3. Self-forgiveness had an indirect effect on depression through its influence on self-reassurance. Thus, self-forgiveness contributed to a higher self-reassurance, which contributed to a lower depression. Leach (2017) and Tangney et al. (1996) have indicated that sometimes an offender might feel shame, which occurs when a person feels defective or wrong (Leach, 2017; Tangney et al., 1996). These can

lead to excessive rumination (Graham et al., 2017), which keeps the offense and the person's personal attributions of being defective salient and inhibits adaptive responses. Whereas we did not assess rumination, our findings are consistent with Leach's and Tangney et al.'s theorizing.

Self-forgiveness had an indirect effect on depression through its influence on self-criticism. Self-forgiveness was related to lower self-criticism, which was also related to lower depression, and vice-versa. As Woodyatt and colleagues (2017) suggest, whether this occurs, can be affected by the degree to which one is either self-critical or self-reassuring, promoting therefore to depression (Woodyatt et al., 2017).

Hypothesis 4 was that self-forgiveness would have an indirect effect on psychological well-being through self-criticism and self-reassurance. This hypothesis was supported. Previous studies indicate that sometimes the person feels negative emotions (e.g., shame, guilt, or/and remorse), which can become chronic or pervasive. These emotions tend to be linked with negative coping resources, such as interpersonal avoidance that perpetuates conflicts (Gilbert & Andrews, 1998; Whelton, 2000; Wohl et al., 2010), leading to self-criticism and ultimately to negative health outcomes. Self-forgiveness can play an important role in the reduction of self-criticism (Gilbert & Woodyatt, 2017), leading therefore to the reduction of rumination and to acute negative emotions (Wohl et al., 2010). Our data showed that self-forgiveness had significant indirect effects on psychological well-being through its influence on self-reassurance.

Woodyatt et al. (2017) suggested that the degree to which one is either self-critical or self-reassuring can influence the levels of negative emotions and responses towards the self (see also Tangney et al., 2005). That will affect the likelihood of developing depression and holding a positive sense of psychological well-being (Woodyatt et al., 2017). Positive responses by the offender will make it more likely that the offended

person will be open to reconciliation (Massengale et al., 2017; Woodyatt & Wenzel, 2013) and to re-orienting one's moral compass back to a more positive direction (Griffin et al., 2015; Woodyatt & Wenzel, 2013).

Our findings are consistent with theorizing that an offender who experiences guilt, regret, and remorse, and then forgives the self, will develop self-reassurance and reduce self-criticism (Woodyatt et al., 2017). Those changes might lead to reduced depression and increased psychological well-being.

CONCLUSION, LIMITATIONS AND IMPLICATIONS FOR FUTURE RESEARCH

The goal of the present research focused whether self-forgiveness acted directly or indirectly on depression and psychological well-being through self-criticism and self-reassurance after an interpersonal offense. The results indicated that self-forgiveness is positive to the person, increasing her or his sense of psychological well-being, towards positive emotions and responses to the self.

The research focuses on only one moment of assessment. This is a limitation of the study. The indirect effects suggest that mediation could possibly be occurring but that would require longitudinal data to investigate. In addition, we used university students, and it is conceivable that older adults who have had more life experiences might behave differently.

It is important for future research to continue to study these constructs. The variables need to be studied also in different contexts and with different samples. Limitations notwithstanding, the findings suggest the need for longitudinal research with other populations to determine the external validity of the findings.

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CHAPTER III

SELF-FORGIVENESS AND PSYCHOLOGICAL WELL-BEING: CLINICAL INTERVENTION PROTOCOL IN EMOTION-FOCUSED THERAPY AND REACH FORGIVENESS MODEL

ABSTRACT[3]

Emotional injuries are a common phenomenon in interpersonal relationships. Different types of clinical interventions have been developed to facilitate its resolution and increase psychological well-being. Some of these interventions explicitly focus on promoting forgiveness and self-forgiveness (e.g., REACH Forgiveness model), while others see these processes as an alternative path for resolving emotional injuries (e.g., Emotion-Focused Therapy/EFT). Studies have demonstrated the benefits of the forgiveness and self-forgiveness processes; yet, most of them focus on the suffering of the victim, with little attention paid to the suffering or self-condemnation experienced the offender, especially when feeling responsible for an emotional injury to a significant other. Aims: a) Present a clinical protocol to study the effects of a brief clinical intervention, combining EFT and the REACH Forgiveness, for the resolution of the offender self-condemnation experience, in the case of the non-severe emotional injuries (study 1); b) Describe the evolution of a self-forgiveness process, illustrated by a good outcome case – "Christina" (study 2). Method: Describe the protocol of the clinical intervention and the steps of a feasibility study, implemented with a sample of university students. Combining the previous models, we established a six weeks clinical intervention and three follow up sessions. Results and Discussion: At the post-treatment, "Christina" demonstrated lower levels of depression. The clinical work allowed to access to the core pain and facilitated emotional transformation, particularly in self-criticism and self-forgiveness. The resolution of the unfinished business seems to have promoted better psychological well-being and the emergence of new meanings, positive emotions and positive attitudes toward the self and others.

[3] *Note.* The present study has been submitted in a peer-review international journal and is currently under review.

INTRODUCTION

The literature has been focusing on interpersonal forgiveness and self-forgiveness to comprehend how clients resolve emotional injuries during the psychotherapeutic process (e.g., Dixon et al., 2014; Enright & Fitzgibbons, 2015; Greenberg et al., 2008; Meneses & Greenberg, 2019; Hong & Jacinto, 2012; Kim & Enright, 2014; Rique & Camino, 2010; Wade et al., 2014; Wohl et al., 2008).

The present study highlights the self-forgiveness process as an important dimension for psychological well-being and its role on overcoming the emotional injuries resulting from a negative interpersonal event. In particular, we focus on the negative experience of feeling responsible to the emotional injury, i.e., the offender self-condemnation experience (e.g., Pelucchi et al., 2013; Woodyatt & Wenzel, 2013; Griffin et al., 2015), in contrast to previous studies which usually emphasize the experience of the victim (e.g., Greenberg et al., 2008; Meneses & Greenberg, 2019), in the case of non-severe emotional injuries (more on this below).

Brief Theoretical Framework for Self-forgiveness in Clinical Context

Wohl and colleagues (2008) define self-forgiveness as the release of negative emotions which involves the abandonment of negative beliefs, feelings and behaviors related to the self (e.g., guilt; shame; self-criticism) in order to promote positive emotions such as self-compassion, generosity and self-love. However, self-forgiveness is not only about the absence of moral values and positive attitudes towards the self (Wenzel et al., 2012; Wohl & McLauhglin, 2014), but also involves different strategies integrating the decrease of self-criticism, blame and/or shame, in order to promote

positive emotions and responses towards the self, such as self-acceptance (Woodyatt, 2017).

Thus, other authors (e.g., Greenberg et al., 2008; Worthington, 2009; Woodyatt et al., 2017) suggest that the key process in self-forgiveness tends to be linked with the awareness of the change process. This awareness regards on how the client feels about the process of letting go negative emotions (e.g., self-criticism, shame, anger) and allows oneself to feel positive emotions, such as self-compassion, self-generosity and/or self-acceptance. Regarding all of those previous processes, these are important clues and notions that the therapists need to be aware, concerning the possibility for a client to experience a deepest process of change, regarding self-forgiveness (Woodyatt et al., 2017).

When the therapist is aware about some clues that the client may give concerning the therapeutic sessions, such as higher self-criticism combined with a higher sense of shame, it will be notice by the conflict identities that the client may show or feel about himself or herself (Enright & Fitzgibbons, 2000; Woodyatt et al., 2017). This clue regards an inner conflict (e.g., conflict split in EFT) and it becomes important for the therapist to become aware and to verbalize these in order to promote a higher awareness for the client, and possibly propose to work in order to reestablish a reconciliation between the two identities (Woodyatt et al., 2017; Elliott & Greenberg, 2021).

The challenge of conflict identities integrates self-forgiveness responses and the acceptance of the responsibility of the offense. This perspective, through the lens of the offender, are restorers and repair processes of the self, that involves the acceptance of the moral social values (Enright & Fitzgibbons, 2000; Woodyatt et al., 2017). In this sense, the decrease of self-criticism process implies the repair and reconciliation of conflict identities, regarding: a) the one that accepts the responsibility towards the

violation of the one's social moral values, resulting, for example, on the experience of negative emotions like guilt and shame; and, b) the one that looks for self-acceptance through the relief of negative and/or stressful emotions related to the self (Enright & Fitzgibbons, 2000; Woodyatt et al., 2017).

In terms of conclusion, dysphoria about the perception of the committed offense tends to be linked with an emotional state of inferiority, which may block the self-forgiveness process, leading therefore to depression, anxiety, hostility or aggressivity, inability to control self-criticism, shame, guilt, sadness, avoidance, negative affect, among other negative effects (Enright & Fitzgibbons, 2000; Gilbert & Andrews, 1998; Woodyatt et al., 2017). Worthington (2013) refers to this as the offenders' experience of self-condemnation.

However, for example, if this sense of shame or guilt are experienced in an adaptive way, it can promote a better inner experiencer regarding the repair of the conflict identities, leading therefore to a connection with self-forgiveness commitment and repair responses towards the self, which will promote positive emotions and overall well-being (Enright & Fitzgibbons, 2000; Gilbert & Andrews, 1998; Woodyatt et al., 2017).

Clinical Protocol in Emotion-Focused Therapy and REACH Forgiveness model for Self-forgiveness: A Combination of Theory and Techniques

Greenberg and colleagues (2008) described the positive benefits which Emotion-Focused Therapy/EFT promotes regarding forgiveness processes. Despite being indirect effects, these are important contributes for the change process of the client, as well as for his or her overall well-being. The present study was adapted to self-forgiveness

process, regarding the guidelines of Greenberg and colleagues (2008), as well as Meneses and Greenberg (2019).

EFT promotes the work with emotions, as also, indirectly, promotes the process of forgiveness/self-forgiveness (Greenberg et al., 2008; Meneses & Greenberg, 2019). REACH Forgiveness model from Worthington (2006) focus directly on the promotion of forgiveness and self-forgiveness.

The present study and enhancing its novelty, used both models, i.e., EFT and REACH Forgiveness model in a clinical protocol proposed with five phases plus three follow up sessions, in order to see the results of the participants, i.e., if the participants benefit from positive outcomes regarding their negative experiences associated to a higher self-criticism, as well as their higher symptomatology, regarding, for example, depressive (Graham et al., 2017) and overall symptomatology (Barkham et al., 2013).

Emotions are connected with the basic needs of the person, being important for the emotional regulation of the person, leading therefore to their adaptative use (Elliott et al., 2004). However, emotions can be maladaptive when the person experience traumatic events in their life, conducting in this sense to the development of affective and cognitive memories, which causes maladaptive function to the normal function of those emotions when activated (Shahar, 2013).

The dialectics between emotion and comprehension of the emotion becomes the focus of the clinical intervention. In this sense, on EFT the process combines empathic exploration with directive techniques of enactment and emotion exploration. The main goal is to promote emotional self-regulation, which is associated to the problem/core issue and to the elaboration of the client new meanings (Elliott et al., 2004). Concerning the process of self-forgiveness and regarding the perspective of Emotion-Focused Therapy, the expression of emotions is considered one of the main tasks in the process.

Literature shows evidence of benefits through the resolution of an emotional injury resulting from an interpersonal offense, by the process of self-forgiveness.

The REACH Forgiveness model, proposed by Worthington (2006), is a model which focuses on the resolution of emotional injuries and which promotes directly the process of interpersonal forgiveness and/or self-forgiveness. Concerning these two perspectives, a) interpersonal forgiveness regards the forgiveness of others, and b) self-forgiveness focus on the forgiveness of the self. The present study focuses on self-forgiveness in order to see if the clients decrease their self-critical side and enhance the positive benefits of let go and forgive theirs unfinished business's (Greenberg et al., 2008; Meneses & Greenberg, 2019).

REACH Forgiveness model implies six steps, namely: R) Recall the hurt, which implies the healing and the responsibility of the committed offense; E) Empathize with your partner, or in this case with ourselves, which focus on the empathy by putting ourselves on the other person's chair; A) Altruistic gift, which concerns to give forgiveness as an unselfish, altruistic gift; C) Commit, which implies the commitment to forgive by, for example, writing a note to ourselves; H) Hold onto forgiveness, which regards the readiness of the notes of forgiveness, written on the last step, or by writing new ones, in order to not to forget that the person actually forgave himself or herself (Worthington, 2009).

Regarding the clinical protocol proposed by the present study, its development includes five phases with six sessions that focus on the resolution of an emotional injury, caused by an offender to the participant (see Table I for detailed information): I) Establishment of the therapeutic alliance and focus for the clinical intervention goals (EFT); II) Evocative and empathic exploration work (EFT) which can regard to recall the hurt (REACH Forgiveness) – Work with emerging EFT markers (e.g., Experiential

formulation on EFT perspective on emotional injuries), and UFB Markers about the Empty Chair task. The will of the client to work with self-forgiveness (step 1 and step 2 of REACH Forgiveness); III) Work with self-interruption processes (e.g., Two Chair Dialogue (EFT) and markers that can emerge in therapeutic work on self-forgiveness (e.g., Empty Chair Task (EFT) and shift to Imaginary Confession (according to REACH Forgiveness) if the client shows difficulty in the task (e.g., expression of the guilt, self-criticism, sadness). Work with REACH Forgiveness: Step 3 - Altruistic gift, and Step 4 – Commitment to self-forgive; IV) Continuum of the work with primary/secondary emotions, and depending on the EFT markers emerging, proceed to consolidate the previous therapeutic work on self-forgiveness, following the pace of the client. Work with Step 5 - Hold on to Self-Forgiveness/REACH Forgiveness combine with Therapist empathic validation/EFT; V) Consolidation of the client change regarding new meanings and combine with step 5/REACH Forgiveness regardless to hold on to self-forgiveness. End of the clinical intervention.

Other example of our clinical protocol and one of the tasks that is in the spotlight the clinical intervention is the empty chair task, from EFT, which guides the client to an imaginary task, specifically to an empty chair where the client seats on and where the therapist guides the client to an imaginary dialogue with the author of the committed offense. In this case, the author of the offense is the client, so he or she will face the person and situation of that time. This task will stimulate implicit memories and meanings regarding to the situation and other past events, in order to promote the emotional change, as well as the perspective of the self (Elliott et al., 2008). This task is the key point of the present intervention, in order to activate multiple forms of resolution of unfinished businesses for the client.

As mentioned before, other tasks will be used and will have an important role on the intervention, regarding the two-chair dialogue, where the client will face internal conflict split regardless the presence of self-criticism, from EFT; imaginary confession and the five steps of the REACH Forgiveness model where the client confess the committed offense in order to promote responsibility and new meanings of the situation. These different tasks from different models will be linked, in order to respond to the client needs at the precise moment of the session/clinical intervention.

The Present Study

The present paper combines two different studies:

Study 1. The first study aims to present a feasibility protocol to assess the effects of a brief clinical intervention, integrating Emotion-Focused Therapy and the REACH Forgiveness model, to facilitate the resolution of non-severe emotional injuries, using a sample of university students. This feasibility protocol is an adaptation of the studies conducted by Greenberg and colleagues (2008), Cornish and Wade (2015a). The goals and description of study 1 follows other examples of feasibility studies (e.g., Fox et al., 2021; Hoddinott, 2015; Lancaster, 2015; Yardley et al., 2015). The novelty of study 1 focus on the study of self-forgiveness, while Greenberg and colleagues (2008) focused on forgiveness using EFT. Thus, the adaptation of this study also followed the guidelines of Cornish and Wade (2015b), where it is possible to understand the theorization of self-forgiveness, expanding the principles of EFT of Greenberg and colleagues (2008) and techniques of the REACH Forgiveness model. At last, the feasibility protocol in study 1 is the method that will evaluate the results of this novelty proposal of intervention in the patients that integrate the study.

Study 2. The second study follows a case-study design (Cornish & Wade, 2015a) where describes the evolution of a self-forgiveness process, illustrated by a good outcome case study. The present study aims to evidence the evolution of a brief clinical intervention (6 sessions plus 3 follow up sessions) to resolve an emotional injury resulting from a non-severe interpersonal offense (consult topic Exclusion Criteria). Specifically, we intend to analyze the changes in self-forgiveness, psychological well-being and clinical symptomatology (depressive and general), monitored throughout the clinical intervention.

STUDY 1. FEASABILITY PROTOCOL IN EFT & REACH FORGIVENESS MODEL

Study 1 is represented by the proposed clinical protocol, based on a brief and integrative clinical intervention, elaborated on the principles of the models Emotion-Focused Therapy (Greenberg & Goldman, 2018; Meneses & Greenberg, 2019) and REACH Forgiveness model (Worthington, 2006; Wade et al., 2014).

METHOD

Participants

Clients. Attending to the study of Greenberg and colleagues (2008), Cornish and Wade (2015a; 2015b) and other published feasibility studies (e.g., Fox et al., 2021; Hoddinott, 2015; Lancaster, 2015; Yardley et al., 2015), it was estimated that the present study would have a small size, however achievable concerning the literature and procedures of feasibility studies (e.g., Fox et al., 2021; Hoddinott, 2015; Lancaster,

2015; Yardley et al., 2015). In this sense, the sample size of the feasibility study ranges from 10 to 15 participants (N = 11), over the age of 18, who have experienced an emotional injury following a negative interpersonal event for more than a year. Experiences of severe situations (e.g., incest, sexual abuse or recurrent domestic violence) were excluded. The focus was on non-severe emotional injuries, which focus on negative experiences, i.e., non-severe offenses that can be overcome in brief clinical interventions (Cornish & Wade, 2015b) and which exclude personality disorders or more severe mental illness. The severe offenses highlight the work with, for example, people who are in institutions and which can focus on personality disorders as well (Wohl et al., 2014). The initial assessment was performed by using a semi-structured interview and the Structured Clinical Interview for DSM-5 Disorders - Clinician Version (SCID-5-CV). In that sense, the following exclusion criteria were applied - non-severe emotional injury experiences, such as experiences of sexual abuse, incest or domestic violence are excluded. Other relevant clinical issues, which require special clinical attention and would significantly condition the focus of clinical work, were also excluded: Experiences like suicide attempts or loss of a loved one in the last year, as well as substances abuse, severe Anxiety and Humor Disorders, and/or Personality Disorders (Greenberg et al, 2008).

Therapist and Researchers. The first author of the present study was the main therapist, a female psychologist with a Master's Degree in Clinical Psychology, with six years of clinical experience and with training in EFT. Clinical supervision was provided by her scientific advisor (sixth author), a female senior clinical psychologist, with a PhD in Clinical Psychology, trained in EFT and with more than 15 years of clinical experience. To safeguard the reliability of the of the assessment results, the initial

assessments and the assessments in the follow up sessions were carried out by two other female psychologists in the research team, both with a Master's Degree in Clinical Psychology, each with more than five years of clinical experience and who were otherwise not involved in the clinical intervention.

Measures

Diagnostic Measure

Structured Clinical Interview for DSM-5® Disorders: Clinician Version (SCID-V-CV; First et al., 2015). The SCID-V-CV is a semi-structured interview that allows to conduct a systematic assessment of clients, according to criteria of the Diagnostic and Statistical Manual of Mental Disorders - 5th Edition (DSM-5). The SCID-V-CV was used in the initial assessment to collect general information about the existence of psychopathology in the present and throughout the life cycle.

Outcome and Symptom Measures

Personal Health Questionnaire (PHQ-9; Kroenke et al., 2001; Portuguese version of Ferreira et al., 2018). The PHQ-9 is a self-report measure that evaluates the severity of depressive symptoms, according to DSM-5. It is constituted by 9 items, which varies from 0 to 3 points on a Likert scale.

The Clinical Outcome Routine Evaluation – Outcome Measure 10 (CORE-10; Barkham et al., 2013; Portuguese version of Sales et al., 2012). The CORE-1 is a self-report measure that evaluates the general symptomatology. The Likert scale varies from 1 to 4 points.

Psychological Well-being Scale (PWBS; Ryff 1989; Portuguese version of Novo et al., 1997). The PWBS is a self-report measure to evaluate psychological well-being. This brief version contains 18 response items, distributed in the following six dimensions: Self-Acceptance, Personal Growth, Purpose in Life, Positive Relations, Environmental Mastery and Autonomy. It's constituted by 18 items, varying on a Likert scale of 1 to 6 points.

Brief Symptom Inventory (BSI; Derogatis, 1993; Portuguese version of Canavarro, 1995). The BSI is a self-report measure that evaluates psychopathological symptoms and is constituted by 9 subscales, namely: Somatization, Obsessions-Compulsions, Interpersonal Sensibility, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoia Ideation. It is constituted by 53 items, varying between 0 and 4 points (Likert scale).

University of Rhode Island Change Assessment Scale (URICA; McConnaughy et al., 1983; Portuguese version of Lopes et al., 2007). The U|RICA is a self-report measure that assesses the indexes of changes in the motivation of the person, assessed on a Likert scale from 1 to 3 points.

Differentiated Self-forgiveness Process Scale (DSFPS; Woodyatt & Wenzel 2013; Portuguese version of Costa et al., 2020). The DSFPS is a self-report measure that evaluates self-forgiveness, consisting on 17 items, whose responses range in a Likert scale from 1 to 6 points. The scale integrates two subscales, namely: Self-forgiveness Feelings and Actions and Self-forgiveness Beliefs. This measure also contains a final single response item (*"Considering what I did wrong, I forgive myself..."*), which is assessed on a Likert scale between 0 to 3 points.

Specific Self-forgiveness Scale (Worthington et al., 2018). The Specific Self-Forgiveness Scale is a self-report measure assessing the type of the committed offense (through a brief description of the episode) and the responses and attitudes of self-forgiveness towards the self, assessed on a Likert scale from 1 to 5 points.

State Self-forgiveness Scale (SSFS; Wohl et al., 2008; Portuguese version of Costa et al., 2020). The DSFPS is a self-report measure that evaluates self-forgiveness, initiated by a question to define the type of offense committed (e.g., infidelity; betrayal of trust) and then assessing the degree of severity of that offense through three subscales, namely: Pseudo Self-forgiveness, Self Punitive and Genuine Self-forgiveness. The subscales comprehend a total of 20 response items, varying on a Likert scale between 1 and 7 points.

Self-compassion Scale (Neff, 2003; Portuguese version of Castilho & Gouveia, 2006). The SCS is a self-report measure that evaluates self-compassion. The 6 subscales (Warm/Comprehension, Self-Criticism, Human Condition, Isolation, Mindfulness and Over-Identification) ranges on a Likert scale between 1 and 6 points.

Forms of Self-criticism and Reassuring Scale (FSCRS; Gilbert et al. 2004; Portuguese version of Castilho & Pinto Gouveia, 2005). The FSCRS is a self-report measure that evaluates self-criticism and self-reassurance in situations of failure. It comprises three subscales, namely, Inadequate Self, Self-reassurance and Hated Self. This scale is constituted by 22 items, ranging on a Likert scale between 0 and 4 points.

Letting Go Measure (Greenberg et al., 2008). The Letting Go is a self-report measure that evaluates the existence of negative feelings against the offender (the self or the other). The *Likert* scale varies from 1 to 5 points.

The Working Alliance Inventory - Therapist (WAI-T; Horvath & Greenberg, 1989; Portuguese version of Machado & Horvath, 1999). The WAI-T is a self-report measure that assesses the therapeutic alliance, from the perspective of the therapist. The Likert scale varies from 1 to 7 points.

The Working Alliance Inventory – Client (WAI-C; Hatcher & Gillaspy, 2006; Portuguese version of Machado & Horvath, 1999). The WAI-C is a self-report measure that assesses the therapeutic alliance, from the perspective of the client. The Likert scale varies from 1 to 5 points.

Procedures

The present study was approved by the University Ethics Committee.

Study dissemination and recruitment of participants. This study was disseminated in a university context. Participants (university students) were contacted through their participation in a previous study concerning the validation and adaptation of psychometric scales related to self-forgiveness (Costa et al, 2021). This previous study required the description of an interpersonal offense committed by each participant and the assessment of their experiences regarding it, with data collected in an anonymous format. At the end of their participation in the prior validation study, researchers questioned each participant if they wanted to participate on a subsequent clinical study,

to allow them to deal with the type of offense that was addressed (i.e., the feasibility study reported here as Study 1). If the participant answered affirmatively, they provided researchers with a form of personal contact, which allowed the subsequent steps of the research procedures (Figure I).

Participant enrollment and Pre-Treatment, Initial Assessment. An individual evaluation interview over the telephone was then scheduled and conducted with each participant for the purpose of explaining the present feasibility study with more detail, obtaining voluntary participation and informed consent regarding the research procedures, and evaluating whether each participant fulfilled the inclusion criteria of the research (Figure I). The following inclusion criteria were applied: 1) Participant with age superior to 18 years, 2) who reported oneself as the offender/author of a non-severe emotional injury as a consequence of a negative interpersonal event, 3) which happened for at least one year but maintains an enduring quality of an unfinished business (something that is still unresolved), and 4) who experienced suffering/self-condemnation (e.g., guilt, regret, sadness, self-criticism).

Clinical Intervention. EFT and REACH Forgiveness Model are two empirically validated models, based on previous clinical trials and outcome studies, as the literature has been shown (e.g., Greenberg et al., 2008; Lambert, 2013; Worthington, 2009). Moreover, the treatment manual was based on the EFT proposal for working with emotional injuries (Greenberg et al., 2008; Greenberg & Goldman, 2018; Meneses & Greenberg, 2019) and the therapeutic principles for working with self-forgiveness according to the REACH Forgiveness model principles (Cornish & Wade, 2015a, 2015b; Worthington, 2006; Wade et al., 2014) (see Table I). The treatment occurred in

an individual format, during six weeks (one session per week, during one hour). All the sessions were monitored with the measures that were presented previously, in order to comprehend the evolution of the process and the client.

Table I. Outline of the Clinical Intervention

Phase I	- Establish the therapeutic alliance and the EFT empathic stance; - Empathic Exploration of the problematic experiences/EFT with a focus on the emotional injury; - Information regarding EFT in emotional injuries, self-forgiveness, intervention, and this clinical intervention (e.g., Emotion-Focused Therapy and REACH Forgiveness model), to allow for the establishment of personal goals on the clinical intervention.
Phase II	- Empathic Exploration of emotional injury and experiential formulation of the problem: • Exploring the emotional injury that the offender committed: Step 1 –REACH Forgiveness model – Recall the hurt; - Depending on the EFT markers emerging, begin therapeutic work on self-forgiveness through the following, optional work on: Focusing (shift to clearing a space if the client shows difficulties), UFB Markers and about the Empty Chair task; Deepen experiential formulation on EFT perspective on emotional injuries: • Therapists search for clues on: • Issues concerning the need to self-forgive and work with secondary emotions, according to EFT; • The will of the client to work with self-forgiveness (Step 1 and Step 2 of REACH Forgiveness: if the client shows will to work with self-forgiveness - Recall the hurt and empathize with ourselves).
Phase III	- Overview of the experiential process in the 2 first sessions and during the time between; - Carry on Empathic Exploration on the emotional injury and associated emotional reactions: Work through to address the markers emerging in therapeutic work on self-forgiveness; - During Empty Chair Task (work with secondary and primary emotions) and shift to Imaginary Confession (according to REACH Forgiveness) if the client shows difficulty in the empty chair task and deepen experiential process (e.g., express the guilt, self-criticism, sadness): • Therapist help client hold on and process the vulnerability of the client by empathic validation and fostering self-compassion: Step 2 – REACH Forgiveness – Empathize with ourselves; • Therapists guide client through Two Chair Dialogue for emerging conflict splits markers in the self (e.g., listening to markers of self-criticism) and/or Two Chair Work for self-interruption processes (e.g., clue regarding a high intensity of emotions call for empathic affirmation and/or clearing a space). • Focusing can be used, as well, if the client needs further work on consolidating emerging transformational process (e.g., self-compassion); - Focus on self-forgiveness and/or the letting go process: • Therapists look for opportunity/openness to work with these processes and listening to the markers present in the here and now. - Working through imaginary confession/REACH Forgiveness, switch to Step 3 – REACH Forgiveness – Altruistic gift of forgiveness (by allowing the client to work on forgiving herself or himself) and Step 4 – REACH Forgiveness – Commitment to self-forgive by, for example, writing a note to ourselves) combined with Empathic Validation.
Phase IV	- Overview of the experiential process in previous sessions and during the time between; - Empathic exploration/EFT about the of the current needs and issues; - Depending on the EFT markers emerging, proceed to consolidate the previous therapeutic work on self-forgiveness, following the pace of the client, namely: • Empty Chair task and work with secondary and primary emotions (e.g., clues of shame and sadness); • Work on self-interruption and self-critical processes (e.g., clues of hopelessness, shame and guilt) – work with these emotions with Two chair enactments and give meaning to those processes (vulnerable self and critical self); • If needed, switch to Step 2 – REACH Forgiveness – Empathize with ourselves (work through to reinforce client empowerment). - Proceed to Step 5 – REACH Forgiveness – Hold onto Forgiveness by reading the (negative and positive) notes about themselves/ self-care activities that the client did as homework (combined with Therapist empathic validation): • Therapists foster client engagement in further self-care activities and written notes about the self (e.g., writing new ones), in order to not to forget as the person progresses in self-forgiveness forgave); • Therapists support client empowerment and new meanings about positive emotions (e.g., searching for clues for as self-compassion, self-generosity, self-love), and commitment to holding on to self-forgiveness and letting go.
Phase V	- Overview of the experiential process in previous sessions and during the time between; - Keep working through to consolidate client change regarding new meanings and new experiences (e.g., empowerment of the positive emotions and attitudes towards the self, such as empathy and compassion), related with Step 5 – REACH Forgiveness – Hold onto Forgiveness; - Explore other sets besides the clinical set and empower to use the new skills in future situations; - Consolidation of the change process, preparing treatment termination and client autonomy; - Work through personal or relational issues regarding termination of the clinical intervention.
Follow-Up (1, 2 & 3)	- Overview of the experiential process in the clinical intervention and client evolution since termination and during the time between; - Empathic exploration of difficulties, challenges and gains during and after the overall clinical intervention; - End of the session.

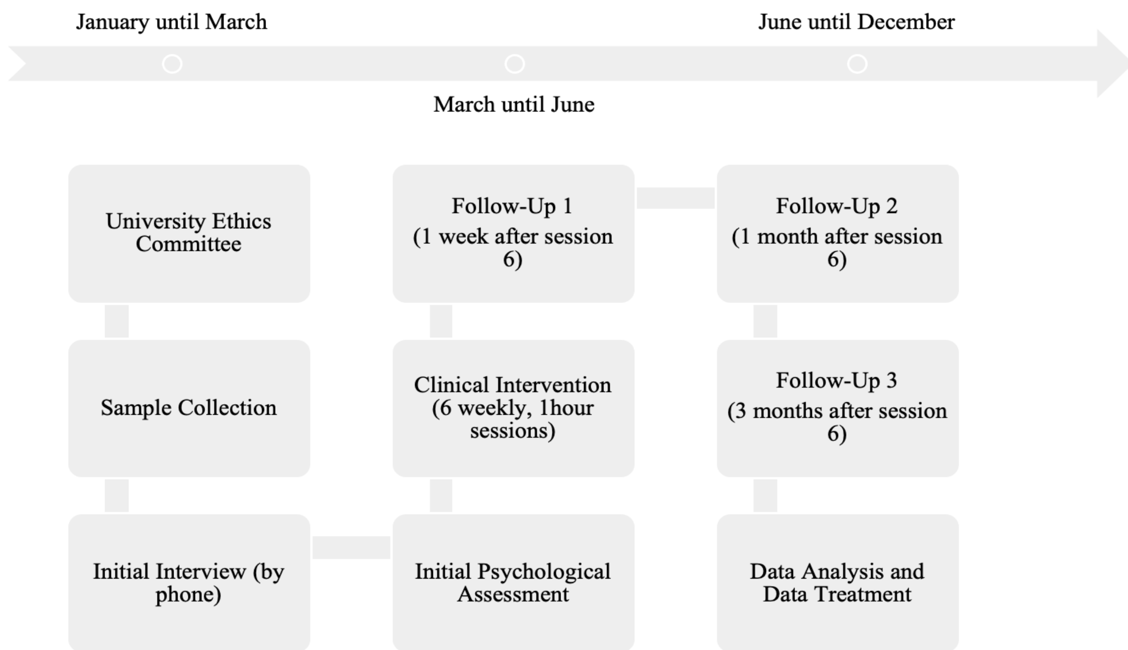
Note. EFT (Emotion-Focused Therapy).

Post-Treatment and Follow-Up Assessments. At the end of the process, all the measures were filled out by the clients. In addition, three follow-up sessions (1 week, 1 month and three months) were carried out in order to monitor the evolution of the client outside the clinical context (Figure I).

*Data Analysis***.** Statistical analysis will be performed in order to assess the outcome of the clinical intervention, treating the data in a quantitative format, using for example the program SPSS (Figure I).

Data Protection and Management. Data protection has the main goal to guarantee the confidentiality of the participants. In this sense, all the information retrieved from this study will be saved on an institutional server, and only the therapist (first author) has authorization to access this data. All clinical psychologists involved in the study and directly or indirectly contacting with participants (during assessment, clinical intervention and supervision) and participants' data comply with the ethical principles to guarantee their confidentiality. Moreover, participant data and results will be described anonymously on scientific articles, to guarantee participants' confidentiality. In addition, if participants require some information regarding their process or research results, the first author will provide the data related to each participant.

Figure I. Procedures of the Intervention



Assessment Protocol. The assessment protocol integrates several measures (previously referred on the *Measures* section) in order to monitor the evolution of participants' symptomatology throughout the clinical intervention. The initial assessment occurred on a pre-treatment (intake/initial assessment) during 90 minutes, to allow the application of the SCID-V-CV (First et al., 2015) in order to diagnose the client according to DSM-5 (excluding participants that fill out the exclusion criteria). The previously mentioned measures were also applied to monitor symptoms at the initial phase of the process on the main and secondary variables (self-forgiveness; psychological well-being; general symptoms and depressive symptoms). The clients included on the study needed to fill in the inclusion criteria of the present study (see inclusion and exclusion criteria on the section *Participants and Procedures*). At the beginning of the intervention the main goals of the study were explained to clients, as well as guaranteed the confidentiality issues in order to preserve the identity of the

clients (e.g., an informed consent was given to the clients). The key points of the initial, intermediate and final phase of the intervention were explained and also the aspects regarding the clinical assessment during the clinical sessions and the follow-up sessions (Figure II).

Figure II. Assessment Protocol of the Clinical Sessions

Initial Assessment (Pre-Treatment)	•Scid-5-CV •DSFPS; SSFS; Self-Forgiveness Specific Scale •Self-Compassion S.; FSCRS; *Letting Go M.*; PWBS; BSI; PHQ-9; Core-10; URICA
Session 1 Session 2	•DSFPS; SSFS; PWBS; FSCRS; PHQ-9; Core-10; Wai-T; Wai-C
Session 3	•DSFPS; SSFS; Self-Forgiveness Specific Scale •Self-Compassion S.; FSCRS; *Letting Go M.*; PWBS; BSI; PHQ-9; Core-10; Wai-T; Wai-C
Session 4 Session 5	•DSFPS; SSFS; PWBS; FSCRS; PHQ-9; Core-10; Wai-T; Wai-C
Session 6	• DSFPS; SSFS; Self-Forgiveness Specific Scale • Self-Compassion S.; FSCRS; *Letting Go M.*; PWBS; BSI; PHQ-9; Core-10; Wai-T; Wai-C
3 Follow-Up Sessions (Post-Treatment)	• DSFPS; SSFS; Self-Forgiveness Specific Scale • Self-Compassion S.; FSCRS; *Letting Go M.*; PWBS; BSI; PHQ-9; Core-10; URICA

Note. DSFPS (Differentiated Self-Forgiveness Process Scale), SSFS (State Self-Forgiveness Scale), FSCRS (Forms of Self-Criticism Reassuring Scale), PWBS (Psychological Well-Being Scale), PHQ-9 (Personal Health Questionnaire - 9), Core-10 (The Clinical Outcome Routine Evaluation – Outcome Measure 10), URICA (University of Rhode Island Change Assessment Scale), WAI-T (The Working Alliance Inventory – Therapist), WAI-C (The Working Alliance Inventory – Client).

STUDY 2. Illustration of a Good Outcome Case: The case of "Christina"

The second study follows a case-study design (Cornish & Wade, 2015b; Meneses & Greenberg, 2019) describing the evolution of a self-forgiveness process, illustrated by a good outcome case study and by the Theory-building case studies (Stiles, 2010, 2021). The present study aims to describe the case of "Christina", a good outcome case study, where the focus was the resolution of an emotional injury resulting from a non-severe interpersonal offense. Specifically, we intend to analyze the changes in self-forgiveness process, psychological well-being and clinical symptomatology (depressive and general), monitored throughout the clinical intervention. The reliable change index (Jacobson & Truax, 1991) applied to PHQ-9 scores (following McMillan et al., 2010) and to CORE-10 scores (following Barkham et al., 2013), in "Christina's" case classify her as a good outcome case (see Table II).

Table II. Outcome Measures in "Christina's" Case

Outcome Measures	Pre-Treatment (Initial Assessment)	Post-Treatment (S6)	Final Assessment (FUP 3)	Outcome
PHQ-9	11	0	0	**Depression cut-off score = 9 RCI (90% CI) = 5**
CORE-10	14	1	1	**General symptoms cut-off score = 13 RCI (90% CI) = 6**

Note. See McMillan et al. (2010) for RCI criteria applied to PHQ-9; See Barkham et al. (2013) for RCI criteria applied to CORE-10; PHQ-9 – Personal Health Questionnaire – 9; CORE-10 The Clinical Outcome Routine Evaluation – Outcome Measure 10; S6 – Session 6; FUP 3 – Follow-Up 3; RCI – Reliable Change Index; CI – Change Index.

METHOD

Participants

Client. "Christina" is a twenty-year-old girl who reported oneself as the offender/author of a non-severe emotional injury as a consequence of a negative interpersonal event which happened for at least one year but maintains an enduring quality of an unfinished business (something that is still unresolved), and which experiences suffering and self-condemnation, such as guilt, regret, sadness and self-criticism. "Christina" asked for help to overcome the negative experience that still remained in her life, enhancing pain and negative feelings. Thus, "Christina" was focus on decrease her symptoms of anxiety, self-criticism and overall symptomatology. Her main motive to enroll in this study concerns an offense that she reported committed towards her ex-boyfriend. She described the offense in a written format (on the Specific Self-Forgiveness Scale), where she explained "I said very bad things to him. I was unfair and he didn't deserve to hear all of that. Today we maintain our friendship and he told me to crossover, because he already forgot. But it's still here and I can't forget. I need help to resolve this.". She described a specific, negative interpersonal situation where she criticized him in a harsh way and currently blamed herself and over criticized herself due to being very unfair with the victim.

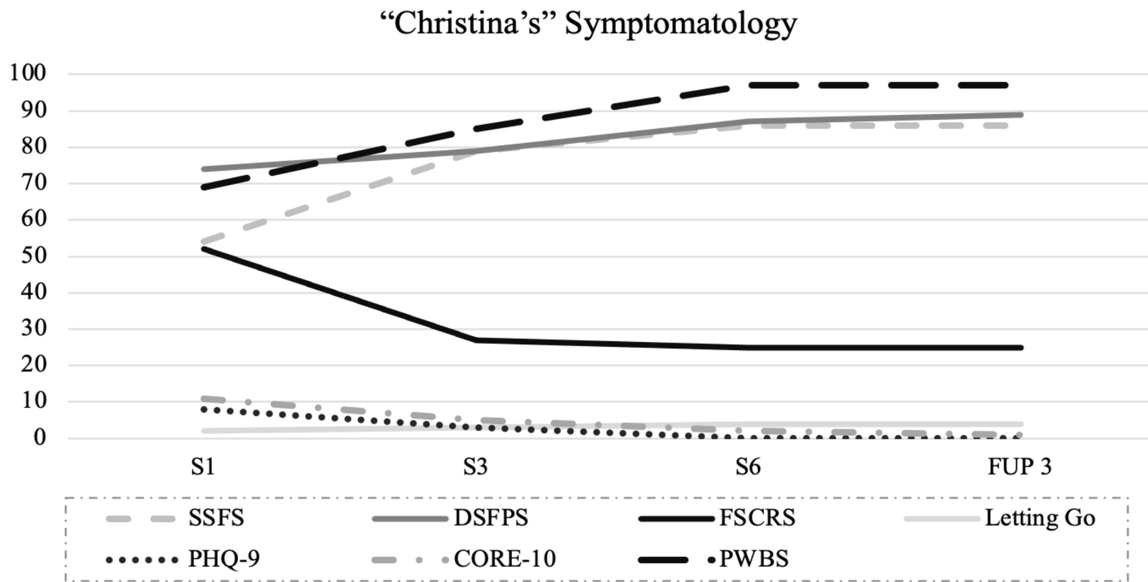
Therapist and Researchers. The therapists are described on topic Study 1, on the section Method/Participants/Therapists.

Measures

The measures were applied as described previously on Study 1 (section Measures – Figure II). “Christina” filled in the measures and the results demonstrated that she had higher levels of anxiety, stress, some criteria of depressive symptoms (e.g., difficult in sleeping, which were a consequence of her anxiety), higher levels of perfectionism, self-blame and self-condemning, lower levels of psychological well-being, lower levels of responses of self-forgiveness towards herself; see Table II and Figure III).

We consider for “Christina’s” case to monitored and analyze her symptomatology trough the following measures: SSFS (State Self-Forgiveness Scale), DSFPS (Differentiated Self-Forgiveness Process Scale), FSCRS (Forms of Self-Criticism Reassuring Scale), Letting Go Measure, PHQ-9 (Personal Health Questionnaire - 9), Core-10 (The Clinical Outcome Routine Evaluation – Outcome Measure 10), PWBS (Psychological Well-Being Scale), and consider the S1 (Session 1), S3 (Session 3), S6 (Session 6), and FUP 3 (Follow-Up 3) (see Figure III).

Figure III. "Christina's" Symptomatology



Note. SSFS (State Self-Forgiveness Scale), DSFPS (Differentiated Self-Forgiveness Process Scale), FSCRS (Forms of Self-Criticism Reassuring Scale), Letting Go Measure, PHQ-9 (Personal Health Questionnaire - 9), Core-10 (The Clinical Outcome Routine Evaluation – Outcome Measure 10), PWBS (Psychological Well-Being Scale), S1 (Session 1), S3 (Session 3), S6 (Session 6), FUP 3 (Follow-Up 3).

Procedures

The procedures followed the guidelines described on Study 1, on the Procedures section. "Christina" was included in the study since she fit the overall main purpose of the investigation and filled in the inclusion criteria. Furthermore, at an initial phase, the overall project was explained in order to guarantee that all the procedures were comprehend by the client. Also, it was explained to "Christina" that her participation was voluntary and that she had the possibility to quit the research at any time, without no consequences involved. After an overall explanation about the rationale of the clinical intervention, "Christina" signed an informed consent in order to guarantee the confidentiality of the data and in order to follow the ethical principles of the Portuguese Psychologists' Association (which are similar to the ones prescribed by the American

Psychological Association), and also guarantee the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

RESULTS

Phase I

The phase I of the intervention includes the session 1, which has the purpose of establishing the therapeutic alliance and goals/focus for the clinical intervention, as well as the empathic exploration of the problematic experiences. Moreover, it was important for "Christina" to receive some information regarding EFT in emotional injuries and self-forgiveness, and about the intervention in order to comprehend the main goals of the study, the therapeutic models that were used, as well as the establishment of the personal goals on the clinical intervention.

The bonds that were created on the first and second sessions were crucial towards the continuum of the clinical intervention, where a compromise between "Christina" and the clinical intervention was promoted, which was also productive to the dyad between "Christina" and the therapist. The following is an excerpt of session 1:

> *Therapist: "Christina", what do you think about those personal goals that we have established?*
>
> *"Christina": I think it will be helpful for me in order to… at least become more in peace regarding this situation with my ex-boyfriend, which currently is actually my friend. He already told me to forget and to move on, but I just can't because I feel regret and guilt about it. I need to overcome these and move on… He is right, but I don't know how.*

Therapist: mmhmm… this situation brought and brings you a lot of pain, sadness maybe, and can you give me some examples of what it does to your body/physically?

[The therapist followed the experience of "Christina" by guiding her through the task of Focusing, addressing EFT]

"Christina": Yes. I feel very anxious and I am too much hard with myself as well. Sometimes I cry, but at those moments I try to calm my mind by doing other stuff. I feel ashamed and very guilty about what happened.

Therapist: "So, where do you feel this anxiety, this guilt… is it on your shoulders maybe? Or on your neck?

"Christina": Well, I think I feel very stressed in my muscles, and my chest, a weight on my chest, as well as in my mind… Sometimes I overthink about it.

Therapist: And right now, how do you feel talking about this?

"Christina": If we go further, I think I'm going to be stressed and more anxious, but right now I feel less symptoms, a little bit anxious but I'm am ok to talk about it.

Therapist: Ok, let's breathe a little bit… (silence). How do you feel right now?

"Christina": I'm ok. I just need to overcome this, like he said. This pain, it makes no sense, I just need to find the way out of it like I said, because… (silence) I just need.

[The experience of "Christina's" pain allowed the therapist to validate and work through empathic affirmation, and to access to her needs (addressing was well the Step 1 and 2, REACH Forgiveness, Recall the hurt and empathize with herself, her own emotions). This part of the session was intense and also permitted to search for clues, regarding the integrative work with self-forgiveness]

Therapist: mmhhmm… it must be very painful and very hard to deal with this pain, even though you have your friend telling you that you need to let go. But if you allow me to express my perspective, it's like you need to feel it, you need to find the way through it by yourself. Does this make sense to you?

"Christina": Totally. I need to do this by myself and to find the answer by myself.

Therapist: Do you think it makes sense for you to talk about forgiveness, and specifically in this situation about self-forgiveness, and work as well with that critical voice that makes you feel anxious at the same time?

"Christina": Yes. It makes total sense to me, since I'm very curious about what this can bring to me, and especially what I can find inside.

Therapist: Ok, so, in the next sessions we will start to work with this topic, about the anxiety and the critical voice, and see what comes up, in order to see what happens inside. Is that ok to you?

"Christina": Yes, that makes total sense.

In the transcript above of a segment of the first session, it is possible to understand the pain that "Christina" was feeling, and her anxiety about the offense with her ex-

boyfriend. Moreover, “Christina” established her goals for the clinical intervention, namely resolve her unfinished business with her ex-boyfriend, try to forgive herself, decrease her self-criticism in order to enhance positive emotions and new meanings. “Christina” demonstrated positive expectations regarding the treatment.

Her clinical symptoms at an initial phase were higher, regarding her anxiety and her critical self, showing values such as 52 for the Self-Criticism and Reassuring Scale, as well as lower self-forgiveness, regarding specifically the emotions of self-acceptance and self-compassion, assessed on the scale State Self-Forgiveness Scale. Thus, the values of psychological well-being were lower, indicating the existence of worrying and unhappiness about her course of life, and specifically about the described situation (see Table II and Figure III).

Phase II

The second phase of the clinical intervention regards to Evocative and Exploration work, specifically on EFT model, where it was possible to understand the emotions and pain that “Christina” was struggling with. As can be read in session 1, it was possible to implement the task of Focusing on “Christina”, where she described to feel anxiety on her body, creating an insight about what this anxiety used to do to herself. Moreover, “Christina” described her overthinking when she was very stressed, concerning those precise moments where she thought about the offense committed to her hex-boyfriend.

In this sense, the phase II of the intervention included the session 2, where was possible to comprehend how “Christina” react to the work with self-forgiveness. Surprisingly, “Christina” expressed to the therapist about her will to work with self-forgiveness, on session 1.

Session 2 focused on the need to work with the conflict split that "Christina" presented. After trying to make the Imaginary Confession/REACH Forgiveness, similar to the Empty Chair task/EFT, "Christina" started to cry. During this moment, the therapist did some empathic affirmation/EFT, in order to tranquilize "Christina".

After some exercises of breathing and after some empathic affirmation/EFT, the therapist implemented the task of Two Chair Dialogue/EFT in order to give voice to "Christina's" conflict split and in order to understand the self-interrupted process. The following excerpt represents the self-interruption process:

Therapist: How is this side feeling, this side that represents your needs?".

"Christina": Its scared. I'm scared about what the other side is going to tell me.

Therapist: Ok, so I need you to say to him directly, if you can, about what you are feeling.

"Christina": I'm scared of you… (silence)… ("Christina" started to cry and self-interrupted the dialogue).

At that moment, the therapist continued the session by doing some empathic affirmation work and by validating the difficulty that "Christina" was struggling with at that moment and with the power of the critical voice. Moreover, it was possible for the therapist to talk with "Christina" about the benefits of self-forgiveness (enhancing the steps 1 and 2 of the REACH Forgiveness model), telling her that she had the right to feel sad and scared, but also, that she had the right to understand what all of that means

and to overcome it. "Christina" went home and thought about it, which leaded us to session 3.

Phase III & Phase IV

Phases III and IV focuses on self-interruption work. As previously said, session 3 started precisely with the process that self-interrupt "Christina" on the Two Chair Dialogue task/EFT. By guiding "Christina" on the Two Chair Dialogue/EFT task, it was possible to give some empowerment to her vulnerable self and give voice to her basic needs that were represented by the need of feeling some peace regarding the offense with her ex-boyfriend. By telling the therapist, it was a clue and a key to enhance the step 2 and 3 of REACH Forgiveness, which focused on the work to "Christina" empathize with herself and to give her an altruistic gift, i.e., to forgive herself. At that precise moment, "Christina" verbalize that she had value and that she needed to overcome the problem. Moreover, it was possible to see some peace in "Christina's" eyes and in her corporal language, which was much more relaxed, comparing to the first session. It is important to relate the data of the main measures: self-forgiveness started to increase, especially the "Christina's" self-acceptance and self-compassion. Thus, her psychological well-being enhanced, as well as her skills to tranquilize herself (measured by the Self-Criticism and Reassuring scale). The depressive symptoms decreased, comparing to the beginning of the treatment (see Table II and Figure III).

Session 4, which is integrated in phase III and IV, focused on the continuum of working with primary emotions, and the perception if there were new meanings of the intervention. "Christina" started to share her positive perspective about the clinical intervention, by saying that it had been helpful by understanding some issues that, on her own, she would never think about (e.g., the power of her critical voice; the scariness

that she felt; the courage by believing that she can overcome and that she can forgive herself). In this sense, session 4 focused on empower the role of forgiveness in the process (step 4/Reach Forgiveness, Commitment to Forgive herself), as well as the need to understand what would happen if she talked to her ex-boyfriend, on the Empty Chair task/EFT.

The next transcription related "Christina" on her Two Chair Dialogue/EFT and on the Empty Chair task/EFT, as well as the therapist empowering the process of self-forgiveness and validating new meanings:

"Christina": You need to be aware about what you are doing. You need to be more responsible. You are an adult now.

["Christina" switched to the other chair]

Therapist: *Ok, so what do you have to say to that critical voice?*

"Christina": I need some space. I understand that I need you, however you need to calm down. I am a responsible girl. I know I make a mistake, but I've apologized and I know that I've changed. I do have responsibility about that episode; however, you don't need to criticize me all the time. I have value and I do things right.

Therapist: How are you feeling saying this?

"Christina": I feel lighter. It's good to feel understood and feel that I have value.

Therapist: "mmhhmm… It feels lighter, doesn't it?

"Christina": Yes. I feel more relaxed… (silence). I feel I can do it. I know I deserve this.

[After "Christina" talked with her critical voice, the therapist switch to "Christina's" self-experiential/EFT in order to understand her basic needs and addressing STEP 2 and 3 of REACH Forgiveness, empathize with herself and with her experience and make a commitment to self-forgive]

Therapist: What do you have to say to her, sitting there on that chair? What does she need at this point?

"Christina": She needs to forgive herself for what she did. She needs to feel beloved and that its ok. Its already in the past, and she is very much self-worth. She is very brave. ("Christina" started to cry").

Therapist: (silence)… What is the meaning of those tears?

"Christina": Tears of happiness. (silence).

[The therapist validates that precise moment of the therapy, empowering "Christina's meaning, which was an open door to the Empty Chair Task, EFT, and to Step 4, giving "Christina's" an altruistic gift, addressing the Step 4, REACH Forgiveness]

Therapist: (silence)... Do you think you are ready to talk to "Peter"? (ex-boyfriend of "Christina").

"Christina": I can try. Yes.

Therapist: mmhhmm… Imagine that "Peter" is sitting on that chair. What do you like to say to him? Try to talk to him directly, if you can.

"Christina": Ok, so. (silence)… I know I've made a mistake and that you already told me several times to move on, and that was a long time ago, but you know… I was never capable of doing so. But it feels good to feel that you forgave me, and it feels good to have your friendship. It also feels good that I'm am capable to forgive myself. I think that is what I need. That is my answer. Starting to look for myself and see that I'm am brave and capable, and that everyone makes mistakes. I'm sorry for what I did.

Therapist: How he is reacting to your confession?

Christina: "He's laughing at me and wants to hug me, like he always does when we talk.

Therapist: How does it make you feel?

"Christina": (silence)… ("Christina" cries) … (silence)… I mean… So much time and finally, I know it will always be here, but I did it.

Therapist: That must be a warm feeling.

"Christina": And a happy one too (smile).

Therapist: You are very brave "Christina". Using your words, you are very brave.

"Christina": I think I am. Thank you.

At the end of session 4, the therapist asked "Christina" to think about the process of self-forgiveness, and to write some notes (on the paper or just mentally) about its meaning to her. Also, "Christina" verbalized her fear to lose the sense of happiness that she was feeling on that moment. The therapist asked her if that could be a self-interrupt

process and “Christina” respond that could be. The therapist asked “Christina” to think about that issue until the next session.

Phase V

Phases V represents the empowerment on self-forgiveness and the end of the clinical intervention.

Integrating session 5 and 6, the next steps of the treatment focused on talking about the needs of “Christina”, as well as enhancing the step 5 of REACH Forgiveness which regards to Hold onto Forgiveness. Moreover, it was possible to work the empowerment regarding the critical voice by mediating their conflict and achieving an understanding between the two sides. These achievements contributed to “Christina’s” self-criticism reduction, as well as to her balance in terms of mental well-being and positive emotions. Moreover, “Christina’s”, by herself, told to the therapist that she was scared on the final of session 4 because she was afraid of not feeling happy again and that the negativity at a certain moment take control of her life again. After exploring this issue, “Christina” normalize her feeling of anxiety. What she needed was to understand that she was capable to understand that critical voice, balance with her needs and overcome with the confidence that every human being can commit mistakes. The therapist validated “Christina’s” reflection and empowered all the gains and these powerful new meanings.

The end of the clinical intervention was represented by the empowerment of the change process of “Christina”, combining with step 5/REACH Forgiveness. Moreover, it was highlighted the work on the exploration of future situations, empowering her to use the new skills.

At the end of the clinical intervention, “Christina” showed lower levels of self-criticism and self-condemning, absence of depression symptoms, lower levels of overall

symptomatology, and at last, higher levels of self-forgiveness and psychological well-being (see Table II and Figure III).

DISCUSSION

The present study combined two studies in order to present a feasibility protocol study which aimed to comprehend the effects of a brief clinical intervention, combining the models of EFT and REACH Forgiveness, for the resolution of a non-several emotional injuries, in a clinical sample with university students (Greenberg et al., 2008; Cornish & Wade, 2015a, 2015b; Fox et al., 2021; Hoddinott, 2015; Lancaster, 2015; Yardley et al., 2015). Thus, the study also included the description of "Christina's" case, a good outcome case study as a result of the clinical intervention proposed on study 1 and enhancing the novelty of the two described studies.

"Christina's" case was a good outcome case, not only in terms of the reduction of her symptoms and the increase of her psychological well-being, but as well as an illustrative case that shows that EFT and REACH Forgiveness model can combine in a positive way in the clinical context.

"Christina" showed some self-dysregulation at the initial phase of the clinical intervention, by saying that her anxiety was causing her pain, physically and mentally, as a consequence of the negative episode that she experienced. While EFT combines empathic exploration with directive techniques of enactment and emotion exploration and where is important for the emotional regulation of the person (Elliott et al., 2004; Greenberg & Goldman, 2018), it was important for "Christina" to guide her with the assumption that emotions are important to work with in a clinical set. Moreover, her negative experience was causing maladaptive feelings, which increase her anxiety as

well as her episodic memories was enhancing during time, causing even more pain, anxiety, shame and guilt. Shahar (2013) says that emotions can be maladaptive when the person experience traumatic events in their life, conducting in this sense to the development of affective and cognitive memories, which causes maladaptive function to the normal function of those emotions when activated.

"Christina's" case showed not only the importance of resolving unfinished businesses/EFT, as well as showed the importance of work on maladaptive emotions and its healing process. Moreover, in this particular case, "Christina" showed since the beginning the will to work on self-forgiveness. As Wohl (2008) defines, self-forgiveness is the release of negative emotions which involves the abandonment of negative beliefs, feelings and behaviors related to the self (e.g., guilt; shame; self-criticism) in order to promote positive emotions such as self-compassion, generosity and self-love. "Christina" showed a greater improvement regarding her positive affective towards herself, by working on the core issue which was the guilt and shame by the offense that she committed. The clinical intervention allowed "Christina" to work in her self-forgiveness (REACH Forgiveness; Wade et al, 2014; Worthington, 2006), promoting her a better sense of well-being and positive emotions, such as self-acceptance and self-compassion.

As some authors suggests, the key process in self-forgiveness tends to be linked with the awareness of the change process (e.g., Greenberg et al., 2008; Worthington, 2006; Woodyatt et al., 2017). Moreover, this awareness regards on how the client feels about the process of letting go the negative emotions (e.g., self-criticism, shame, anger) and allow to feel positive emotions, such as self-compassion, self-generosity and/or self-acceptance (Toussaint et al., 2020; Woodyatt et al., 2017; Worthington et al., 2018).

In the case of “Christina”, her awareness about her offense, as well as her since of responsibility, allowed her to take a new perspective of the situation. Moreover, it was possible to work with her higher self-criticism by implementing the task of Two Chair Dialogue/EFT, which was something that was blocking her in moving on. The clinical intervention promoted the balance between these two sides (conflict split/EFT) and allowed her to self-forgive, by steps. By make a commitment to forgive herself, by empathize with herself and by giving her an altruistic gift which regarded positive notes of herself, and at last by holding on to her forgiveness, which was very much worth it by her effort and will during all the clinical intervention.

CONCLUSION, LIMITATIONS, AND IMPLICATIONS FOR FUTURE RESEARCH

More research needs to be conducted in order to study the protocol presented in the current study. Moreover, it is important to test the current protocol with other samples (e.g., general community). Thus, it would be encouraging to test the same protocol in a larger sample.

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CHAPTER IV

THE CASE OF “CHLOE”: A POOR OUTCOME CASE STUDY IN EMOTION-FOCUSED THERAPY AND REACH FORGIVENESS MODEL

ABSTRACT[4]

Previous studies linking self-forgiveness, well-being and other positive clinical and health outcomes have supported therapies that aim to, directly or indirectly, promote the self-forgiveness process in face of interpersonal offenses and emotional injuries (such as, Emotion-Focused Therapy – EFT and REACH Forgiveness model). Aim: Describe the case of "Chloe", a poor outcome case in a brief, integrative clinical intervention in EFT and the REACH Forgiveness model to address difficulties related to a (non-severe) interpersonal offense. Method: We present the evolution of "Chloe" during a six-sessions, brief intervention (combining EFT and the REACH Forgiveness model), and contrast the evolution of her symptoms with a description of the main variables of her clinical process (self-forgiveness, psychological well-being, self-criticism, depressive and overall symptomatology). Results: The Letting Go measure indicated that "Chloe" did not forgive herself, besides other improvements during the clinical intervention. At the end of the treatment, the levels of self-forgiveness (measured by the State Self-Forgiveness Scale and the Differentiated Self-Forgiveness Process Scale) were still low, as well as her levels of psychological well-being (measured by the Psychological Well-Being Scale). Discussion: "Chloe" showed some improvements, for example, the decrease of self-criticism; yet, she may have needed a few more sessions to work with this core issue to evidence further gains in her symptoms and main process variables. The case of "Chloe" shows that poor outcome cases challenge the current research in this domain and should be encouraged as theory-building opportunities.

[4] *Note.* The present study has been submitted in a peer-review international journal and is currently under review.

INTRODUCTION

Studies that involve self-forgiveness processes showed evidences of positive outcomes related to the increasement of mental health and well-being of the clients (e.g., Woodyatt et al., 2017; Worthington et al., 2018). These results support therapies and clinical interventions that aim to promote, directly or indirectly, positive effects in these self-forgiveness processes (e.g., REACH Forgiveness model – Worthington, 2006; Wade et al., 2014). In the clinical field, interventions such as Emotion-Focused Therapy and the REACH Forgiveness model have been developed for the resolution of interpersonal offenses and emotional injuries (Greenberg et al., 2008; Meneses & Greenberg, 2019; Woodyatt et al., 2017; Worthington, 2006), demonstrating positive clinical outcomes as they facilitate forgiveness processes (e.g., Massengale et al., 2017; Meneses & Greenberg, 2019; Wade et al., 2014). Yet, most of the previous clinical studies put their focus on the experience of the "victims" and if they forgive (or not) the author of an offense. In this study, we expand the current framework to focus on the experience of the offender, i.e., the person who feels responsible for an interpersonal offense or emotional injury directed to a significant other.

When someone has committed/authored an offense towards a significant other, one tends to experience negative affect, such as guilt, shame, and/or blame (Leach, 2017; Tangney et al, 1996; Lazarus & Shahar, 2018; Shahar, 2015). This process is usually associated to maladaptive beliefs, feelings and behaviors (Tangney et al., 2005), leading to rumination and depression (Graham et al, 2017; Whelton, 2000; Woodyatt et al., 2017). Previous research shows direct and indirect positive effects between self-forgiveness, self-criticism, and psychological responses, such as depression, general

symptoms, and psychological well-being (e.g., Costa et al., 2021; Graham et al., 2017; Griffin et al., 2015; Massengale et al., 2017).

Yet, further research is needed especially regarding clinical cases that fail to evidence progress in self-forgiveness or exhibit the positive benefits of clinical interventions (in terms of clinical symptoms) that were expected given previous studies (Toussaint et al., 2020). For example, Costa et al., 2021 have found that depressive symptoms can be reduced if the client overcome an emotional injury (see CHAPTER III, Study 2).

Studying specific cases, such as poor outcome cases, can also provide directions towards adjustments that the theories may require (Stiles, 2010), including the clinical theories underlying specific psychological interventions. The case study of "Chloe" was especially chosen here to illustrate a poor outcome case-study of a feasibility study to explore the effects of a brief clinical intervention to promote self-forgiveness in offenders (who authored of a non-severe emotional injury to a significant other). Besides describing the evolution of the case of "Chloe" in terms of self-forgiveness, self-criticism, psychological well-being, depressive and overall symptomatology, we aim to discuss the implications of this poor outcome case to the literature in the field, adopting a theory-building stance (Stiles, 2010, 2015).

Contrasting Self-forgiveness in Emotion-Focused Therapy and the REACH Forgiveness model

Self-forgiveness is defined as a transformation of negative emotions and feelings, negative beliefs and behaviors directed to the self (e.g., guilt, shame, blame, self-criticism, self-punishment) in order to be replaced by more positive affect, beliefs, feelings and behaviors towards the self, such as self-compassion, generosity and self-

love (e.g., Wohl et al, 2008; Woodyatt et al., 2017; Tangney et al., 1996). From the several proposals to work with forgiveness in the clinical context, two very important ones are Emotion-Focused Therapy (EFT) and the REACH Forgiveness model, which we will elaborate below.

Forgiveness and Self-forgiveness in Emotion-Focused Therapy. Emotion-Focused Therapy (EFT) has been one of the therapies that has placed a stronger emphasis (theoretical and empirical) on understanding the process of resolving emotional injuries, with several empirical studies on this topic (see Greenberg et al., 2008; Meneses & Greenberg, 2019). According to EFT, emotions are interconnected with the person's basic needs, and accessing them – as an important source of information regarding our experience as human beings – allows the person to regulate and use their emotions more properly (Elliott et al., 2004; Greenberg & Goldman, 2018). However, it should be noted that emotional reactions could become maladaptive in present as a function of early traumatic experiences. These experiences, may lead to the development of cognitive-affective memories that, when activated, shape what we feel in reactions to others and the world, and may limit or disrupt adaptive functioning (Paivio & Pascual-Leone, 2010). Moreover, it seeks to increase clients' awareness and adequate expression of emotions, facilitate emotional regulation and reflection on their emotional reactions.

Combining humanistic and constructivist influences and expanding the notion of Carl Rogers regarding client-centered empathy (Pos & Greenberg, 2007; Greenberg & Goldman, 2018), EFT focuses on emotions and, as an experiential therapy, aims to provide opportunities to foster emotion transformation (Greenberg & Goldman, 2019). In EFT, emotional processing is seen as essential to provide awareness on the experiential process and foster therapeutic change: this therapy explores and guides the

client by accessing emotional experiences in order to promote self-reflection and contribute to a deeper comprehension of problems, emotional reactions and the experiential process (Cunha et al., 2017). In parallel, decreasing the intensity of emotional distress and enhancing emotion regulation and reflection allows the person to change maladaptive emotional reactions into more adaptive ones (Greenberg & Goldman, 2018). To achieve these results, EFT combines empathic exploration with more directive, enactment techniques that further pursue emotional arousal and emotional deepening, promoting emotion regulation (especially of overwhelming, unregulated emotional reactions) and the transformation of maladaptive emotional reactions, which are usually associated to clinical problems and underlying core issues/vulnerabilities (Greenberg & Goldman, 2018). This allows for emotion transformation, the elaboration of the new meanings and ultimately facilitates self-narrative reconstruction (Angus & Greenberg, 2011; Cunha et al., 2017).

Through a thorough theoretical and empirical review on the process of forgiveness and letting go of emotional injury, Meneses and Greenberg (2019) focus on the experience of the injured person and explain that the process of overcoming emotional injuries is non-linear and grows over time. The authors state that in the therapeutic context, the phases of the intervention tend to become a step-by-step, recursive process instead of a linear one, compared with alternative prescriptive treatments. In the same rationale, Meneses and Greenberg (2019) emphasize the importance of exploring the meanings clients assign to the negative experiences and feelings that they hold against the other leading, therefore, to focus on the meaning of the emotional injury for the client (e.g., negative images about the others and/or oneself; difficulties in trusting others and/or oneself). In this sense, time is an important factor to

the process of forgiveness, highlighting that each client needs to work at their own pace, in a proper time (Meneses & Greenberg, 2019).

Greenberg and colleagues (2008) conducted an important study on the resolution of negative experiences related to emotional injuries. The authors devised a clinical protocol to study the effectiveness of EFT compared with a Psychoeducation treatment (where participants were provided with information and suggestions regarding the topic of forgiveness). In specific, Greenberg and colleagues (2008) studied the effects of forgiveness and letting go regarding the (initial) negative feelings in both treatment conditions. The two conditions also differed in how they address the process of forgiveness: EFT adopts an indirect focus on forgiveness, since the emphasis is on unfinished business resolution (whichever route it may take, depending on the client) while the Psychoeducation treatment adopted a direct, prescriptive focus toward forgiveness. Results evidenced more improvement in the clients in the EFT condition, when compared to the clients in the Psychoeducation treatment: most EFT clients improved in forgiveness and letting go measures evidencing, pre-post changes in negative feelings (e.g., anger; shame; guilt), and showing more positive feelings (e.g., self-love; self-confidence). These results extended to the general clinical symptomatology (e.g., lower depressive symptoms). The EFT clients who did not forgive and did not let go (according to the measure Letting Go), showed more negative affect, and especially negative feelings (e.g., lower self-punishment).

Meneses and Greenberg (2019) also published two case studies to illustrate how EFT may help clients to deal with emotional injuries and, especially, with unfinished business. Both of these clients were emotionally injured. For example, client A demonstrated vulnerability at the begging of the treatment. According to the author, the vulnerability appeared when the client tried to express some sadness. However, when

the client was in contact with the sadness, he/she self-interrupted the process by expressing anger. Concerning client B, who was the opposite of client A, demonstrated a reciprocal response to the vulnerable self, leading therefore to other responses (e.g., compassion) leading to an opening process of forgiveness.

In sum and besides the differences between the two clients, both cases illustrated improvement, regarding the forgiveness process, by accessing to the pain and to the core issue, leading to the ability of feel and express empathy. These positive emotions and reciprocal responses allowed the clients to become more engaged with themselves and with others (Meneses & Greenberg, 2019).

Forgiveness and Self-forgiveness in the REACH Forgiveness model. In the case of forgiveness, through focusing on the underlying negative emotional reactions (e.g., such as guilt, shame, blame, self-criticism, self-punishment), this therapy can be particularly suited to enhance emotion transformation, especially promoting emotional forgiveness and the process of letting go of emotional injuries (Meneses & Greenberg, 2019). Another benchmarking clinical intervention in this field of studies is the REACH Forgiveness model, conceptualized by Worthington (2006). In contrast to EFT, this model adopts an explicit, direct approach on the process of forgiveness and self-forgiveness, having been applied both with victims and offenders (see Griffin et al, 2015; Toousaint et al., 2020; Woodyatt et al., 2017).

The REACH Forgiveness model enhances five steps, namely: I) *Recall The Hurt*, where the focus is to process the personal emotions associated to the negative interpersonal experience; II) *Empathize With The Offending Part*, where the focus is allowing for new and positive perspectives from the negative experience; III) *Altruistic Gift of Forgiveness*, which encourages the person to take in the perspective of

forgiveness by an act of altruism (e.g., self-care behaviors, attitudes, and feelings); IV) *Commitment to Forgive*, where the focus is to enhance the commitment to forgiveness and its meaning (implying decisional forgiveness); V) *Hold Onto Forgiveness*, which conducts the person to maintain their achievements in the process of forgiveness, especially if negative emotions recur (Wade et al., 2014; Worthington, 2006).

Griffin et al. (2015) studied the effect of a self-forgiveness workbook, based on the REACH Forgiveness model. The 204 participants were randomly assigned to either an immediate treatment or a wait-list control condition. The results showed evidences of less self-condemnation and higher levels of self-forgiveness. Moreover, there were stronger treatment effects associated to lower levels of predisposition to self-forgive and higher levels of transgression severity, which can be read as a sign of responsibility of the committed offense.

Using the REACH Forgiveness model, Kazoun (2018) studied the effects of this intervention in nine participants who suffered from emotional injuries. Results indicated that all of the participants decreased their negative feelings after the clinical intervention; however, this author also found out that the intensity of the negative experience and the nature of the emotional injury was a predictor of the forgiveness process. Thus, the meaning and importance of the relationship with the offender was a mediator of the process. The overall results indicated the benefits of forgiveness for the resolution of an emotional injury; more specifically, those who forgave evidenced more positive results (such as acceptance), than those who did not forgive. The later also experienced the negative effects of unforgiveness and its individual impact in terms of psychological, physical, and social symptoms.

Also using the REACH Forgiveness model, Toussaint et al. (2020) studied a group of 124 Indian university students engaged in overcoming emotional injuries through the

process of forgiveness. This study analyzed the efficacy of the REACH Forgiveness model and also studied the importance of spirituality for forgiveness and its role as a predictor in the process of forgiveness. The results evidenced the efficacy of the REACH Forgiveness model, with students demonstrating higher levels of empathy and positive affect by the end of treatment. The authors also confirmed that spirituality was a predictor of forgiveness and was beneficial in terms of motivation to engage the students with the forgiveness process (Toussaint et al., 2020).

Setting the stage for Self-forgiveness: A clinical proposal integrating EFT and REACH

With strongest evidences in the work of forgiveness and in changes in the experience of the injured victims, EFT has demonstrated before its effectiveness and positive impact concerning the resolution of emotional injuries (e.g., Greenberg et al., 2008; Meneses & Greenberg, 2019). The innovation of the present proposal concerns the expansion of the scope of EFT for the resolution of emotional injuries, by focusing on the experience of the offender – i.e., the person who authored an offense – and broadening the scope, more explicitly, from forgiveness to self-forgiveness (or forgiving the self). Thus, the present clinical proposal departs from the foundation of EFT and integrates the steps of the REACH Forgiveness model to achieve self-forgiveness (Worthington, 2006; Wade et al., 2014). As stated before, the REACH Forgiveness model is also a benchmarking model to achieve forgiveness and has demonstrated prior empirical evidence regarding its usefulness and effectiveness in the work with offenders.

In the clinical context, the process of self-forgiveness integrates strategies for the decrease of self-criticism, blame and/or shame, in order to promote positive emotions

and responses towards the self, such as self-acceptance (Woodyatt et al., 2017). This leads to the promotion of positive values and attitudes towards the self of the offender (Wenzel et al., 2012; Wohl & McLauhglin, 2014). Thus, the literature has shown that this process is associated to the responsibility of the offense and tends to often motivate the person to deal productively with the offense, by doing acts that promote positive interpersonal and personal effects (Tangney et al., 2005; Woodyatt & Wenzel, 2013).

The experience of self-condemnation and self-criticism after an offender commit an emotional injury is extremely intense (Tangney, 2005). Shahar defines self-criticism as the predisposition to set idealistically high standards for oneself. Thus, the author also states that the person tends to adopt and inflexibility position regarding life (e.g., higher levels of self-condemnation when the person doesn't achieve his or her goals) (Shahar, 2015). In this sense, evidences regarding negative effects for the person with higher indexes of self-criticism tends to be linked with negative affect (e.g., shame; guilt; anger), anxiety, psychosomatic disorders, and negative behaviors, compromising the well-being of the person. There is a complexity around this process which is imperative for therapist to work when they recognize that the client may have these higher maladaptive standards, in order to assess and guide the client to work with this issue (Shahar, 2015).

Conflict identities is as a specific form of self-criticism that is implicated in the responsibility of the offense (Woodyatt et al., 2017). Through the lens of the offender, the self-forgiveness process restores and repairs these conflict identities in the self, involving the acceptance of the moral social values (Enright & Fitzgibbons, 2000; Woodyatt et al., 2017). In this sense, it becomes important for the therapist to be alert and to verbalize these parts of the self in conflict (as conflict identities) and which emotional reactions this process trigger (usually some form of negative treatment of the

self), in order to promote client awareness, and prepare the way to reestablish a reconciliation, negotiation and integrations between those two parts (Woodyatt et al., 2017; Sahar, 2015). For more details, see Table I.

Emotional Injuries and the Role of the Empty-chair Task

Emotional injuries usually involve markers of unfinished business, which call for the use of the Empty Chair task, one of the hallmark tasks in EFT, with extensive research associated to it (e.g., Meneses & Greenberg, 2019). Yet, as stated before, previous research has been focused mostly on the experience of the injured person (i.e., the victim), not on the injurer – i.e., the offender or author of these emotional injuries to a significant other.

Meneses and Greenberg (2019) theorize that empathy is primordial to the facilitation of forgiveness, and to face the emotional injury. This primordial step conducts the client to access core pain and core vulnerabilities in a safe, interpersonal context, which allow them to feel it, and to give meaning to it. Through this process, there is frequently an activation of the enduring pain/hurt and a persistent sense of unfairness, resentment or resignation that the person has not let go and which indicates unresolved issues termed, according to EFT, unfinished business (e.g., Greenberg & Goldman, 2018).

In this sense, unfinished business calls for the Empty Chair task as therapeutic strategy. This task involves invoking, through imagination, the presence of the significant other and acknowledging and stating (to the imagined other in the empty chair) how this enduring pain feels and was formed. Through this enactment task, episodic memories are activated in the here and now and the central pain regarding the injury is aroused. This aims to facilitate emotional processing and identifying unmet

needs regarding the experience with the significant other. This sets the path to allow access to interrupted emotions, regulate negative feelings or overcome the sense of being stuck in the injury and allowing to work towards letting go of this negative experience, its enduring impact and affect and/or forgive the other (Meneses & Greenberg, 2019). The access to and transformation of the pain related to the injury tends to change previous maladaptive, stuck emotional reactions and activate the capability of reconstruct the narrative, by giving new meanings and more positive affect, thus contributing to the process of forgiveness/self-forgiveness.

The Importance of Working with Self-criticism

In EFT, this specific type of self-criticism or negative maltreatment of the self can be addressed through the Two Chair Dialogue (Greenberg & Goldman, 2018). This task involves working with two distinct sides of the self – the vulnerable self and the critical self – as conflict splits. As the experience of an offender who committed an emotional injury involves some form of self-criticism, in a majority of cases (according to Wade et al, 2014; Tangney, 2015; Woodyatt et al, 2017), this dialogue becomes an important task in order to address negative maltreatment of the self and understand the impact of the critical self (Greenberg & Goldman, 2018).

Regarding the REACH Forgiveness model, it is important to recall the hurt and empathize with their own emotions and negative feelings, which in the most of the cases the clients demonstrate shame and culpability, adopting maladaptive behaviors through life (Woodyatt et all., 2017). In the therapeutic set, the therapist can work through the Two Chair Dialogue, addressing EFT (Goldman & Greenberg, 2018), and by guide the client to empathize with him or herself, in order to access the pain and promote self-forgiveness.

Purposes and Aims of the Present Study: What Can We Learn from a Theory-building Case Study?

The *Theory-Building Case Study* method, is defined as a specific form of knowledge construction that researchers and practitioners can use to build, construct or refine models or theories, based on intensive observations and rich descriptions about a particular case or a series of cases (Stiles, 2010; Stiles 2015; Stiles, 2021). With several previous examples applied to the clinical field or to psychotherapy process, independently of the model that is used by the therapist (e.g., Stiles 2015), as specific cases are contrasted among each other or contrasted with the theories that they depart from, this form of theory-building allows the researcher to expand and, sometimes, challenge the assumptions of the models and guidelines previously established in a clinical intervention. In this sense, the crucial point of a proper description of a Theory-Building Case Study is the links between the case and the theory, in order to achieve rich descriptions regarding detailed observations of the case that can inform the theory (Stiles, 2007; Stiles, 2015; Stiles, 2021). One of the situations where individual cases can be more useful to refine theories, is when cases do not follow the expected outcome; hence, poor outcome cases can present a challenge to theories and provide feedback toward the points where theories need refinement (Felice, 2020; Stiles, 2021).

The present study focuses on a poor outcome case study, since it is important to describe what therapists can miss or where the therapeutic process can go wrong in a particular case (Stiles, 2021). This enriches the preexistent theory and adds clinically meaningful new knowledge to assist practitioners. The present study describes the case of "Chloe", a poor outcome case study in a clinical intervention to promote self-forgiveness, integrating EFT and REACH Forgiveness model. Specifically, it will be

used: i) to show the evolution of clinical variables during a brief clinical intervention to resolve an emotional injury resulting from a non-severe interpersonal offense, ii) to discuss how this case did not confirm the expected evolution prescribed by the underlying clinical model/theories and iii) to raise possible hypoThesis concerning its poor outcome. For this, we analyze the evolution of "Chloe" during the treatment, comparing the pre- and post-treatment changes in the following clinical variables: self-forgiveness, self-criticism, letting go, and psychological measures, such as psychological well-being, depressive and general symptoms.

Overall, we intended to enhance the contribution of poor outcome cases to the refinement of clinically robust theories, to place an emphasis on the care that must be taken by clinicians with brief interventions, and to raise important issues so that robust clinical models can prevent therapeutic failure. The description of the case follows the guidelines of a *Theory-Building Case Study* proposed by Stiles (2010, 2015) and the assumptions of this clinical intervention, which follows EFT guidelines (Greenberg & Goldman, 2018; Meseses & Greenberg, 2019) integrated with the REACH Forgiveness model (Worthington, 2006; Wade et al., 2014).

METHOD

Participants

Client. "Chloe" was a twenty-five-year-old girl, single, and a full-time worker and university student. She enrolled in a clinical study developed on campus (see Costa et al., 2021, in CHAPTER III for further details) who asked for help in order to increase well-being in her daily functioning. In the enrollment interview assessment, she described that her current distress was due to an emotional injury and an interpersonal

offense that she committed towards her younger sisters. "Chloe" was asked to describe this moment, in a written, narrative form, and she described the offense as follows (henceforth, designated as emotional injury):

"*I did not have the right to abandon my sisters in an extreme situation. My mother never cared about us and I was the one who took care of them. I realize that I abandoned them* [when she decided, at 16 years old, to leave her household where she lived with her younger sisters and an abusive mother with an alcohol addiction]. *They don't feel that way, but I do and I will never forgive myself. My mother is addictive to alcohol and now she is sick and she needs us to take care of her. I will never forgive her, but I do my best to take care of them all, but in a distant way. It was because of her* [the mother] *that I had to abandon the house. Currently, things are better, but this situation stresses me out and I feel that will never overcome this. That is why I asked for help. Maybe here I can find a way*."

She recognized this interpersonal offense as a negative situation, she argued that she had been being unfair with her younger sisters, and this triggered intense self-blame and self-criticism, as well as symptoms of anxiety, sadness, irritability, and other general symptomatology. At the initial assessment, the measures indicated (see Table II). In the phase of pre-treatment, "Chloe" exhibited clinically significant depressive and global symptoms in the measures used (see Table II below), which were maintained at post-treatment (see Table III). Given these results, "Chloe" was considered a poor outcome case. She presented higher levels of self-criticism and depression at the pre-treatment, and a higher negative affect concerning the Letting Go measure. Moreover, her predisposition and traits to self-forgive were lower, concerning the measures SSFS and DSFPS. At the phase of pos-treatment, "Chloe" improved her self-condemnation symptoms, addressing the measure of self-criticism, FSCRS (see Figure I). "Chloe"

presented a small change in her depressive and overall symptomatology. The other main change processes regarding self-criticism, psychological well-being, and self-forgiveness were a non-linear process (Meneses & Greenberg, 2019) and its evolution is represented by “Chloe’s” difficult in letting go the negative feelings (see Table III; see Figure II and III).

Therapist and Researchers. The therapist was the first author of the present study, a female clinical psychologist (with 34 years old), with a Masters’ degree in Clinical and Health Psychology, with prior training in EFT and more than six years of clinical experience. During the treatment phase, she was supervised by her main scientific advisor, a female clinical psychologist (with 40 years old), with a Ph.D. in Clinical Psychology, specialized in EFT, and with more than 15 years of clinical practice. The initial and the follow up assessments, were carried out by two other female psychologists in her thirties (who were not involved in the therapeutic process in order to safeguard the reliability of the results), also with a Masters’ degree in Clinical and Health Psychology, and more than five years of clinical experience.

Measures

Diagnostic Measure

Structured Clinical Interview for DSM-5® Disorders: Clinician Version (SCID-V-CV; First et al., 2015). The SCID-V-CV is a semi-structured interview that allows to conduct a systematic diagnostic assessment of the client, according to criteria of the Diagnostic and Statistical Manual of Mental Disorders - 5th Edition (*DSM-5*; APA, 2013). The SCID-V-CV was used in the initial assessment to collect general

information about the mental health symptoms and psychopathology in the present and throughout the life cycle, to arrive at a possible clinical diagnosis.

Process and Outcome Measures

State Self-forgiveness Scale (SSFS; Wohl et al., 2008; Portuguese version by Costa et al., 2021). The State Self-Forgiveness Scale is a self-report measure that evaluates self-forgiveness. It consists of 17 items, with response options from 1 to 6, where 1 = *Strongly Disagree* to 6 - *Strongly Agree*. The SSFS integrates two subscales, namely the (a) Self-forgiveness Feelings and Actions (SSFA; e.g., Self-forgiveness Feelings - *"Considering what I did wrong, I feel acceptance of myself*"; e.g., Self-forgiveness Actions - *"Considering what I did wrong, I punish myself"*); and (b) Self-forgiveness Beliefs (SFB; e.g., *"Considering what I did wrong, I believe I am decent"*). This measure also contains a final, single response item (*"Considering what I did wrong, I forgive myself..."*), with response options from 0 = *"Not at all"* to 3 = *"Completely"* Wohl and colleagues (2008) reported Cronbach's alpha for both subscales: for SFFA, α = .74; for SFB, α = .89. In the present study, the SFFA had α = .77 and the SFB had α = .84. The α for the total SSFS was .85.

Differentiated Self-forgiveness Process Scale (DSFPS; Woodyatt & Wenzel, 2013; Portuguese version by Costa et al., 2021). The DSFPS is a self-report measure that evaluates self-forgiveness, initiated by a question to define the type of offense committed, in a narrative form (e.g., infidelity; betrayal of trust). It then assesses the degree of severity of that offense through three subscales, namely: Pseudo Self-Forgiveness (PSF; e.g., *"I think the other person was guilty of what I did*"); Self Punitive (SP; e.g., "*What I did is unforgivable"*); and Genuine Self-Forgiveness (GSF;

e.g., "*I'm trying to learn with my mistake"*). The subscales comprised a total of 20 items, rated on a seven-point Likert scale from 1 = *Strongly Disagree* and 7 = *Strongly Agree*. The original results obtained by Woodyatt and Wenzel (2013) report Cronbach's alphas as Pseudo Self-Forgiveness (α = .81); Self Punitive (α = .85); Genuine Self-Forgiveness (α = .85). In the present study, the Differentiated Self-Forgiveness Process Scale had Cronbach's alphas for the three weakly related subscales – Pseudo Self-Forgiveness (α = .64); Self Punitive (α = .80); Genuine Self-Forgiveness (α = .82). We considered for the present study only the subscale Self-Punitive.

Forms of Self-criticism and Reassuring Scale (FSCRS; Gilbert et al., 2004; Portuguese version by Castilho & Gouveia, 2011). The FSCRS is a self-report measure that evaluates self-criticism and self-reassurance in situations of failure. It is composed of 22 items constituting three subscales (e.g., *"I cannot accept failures without feeling inadequate"*; "*I have a feeling of disgust for myself*"). The subscales are Inadequate Self, Self-reassurance, and Hated Self. Responses options are from 0 = *Not at all like me* to 4 = *Extremely like me.* Gilbert and colleagues (2004) reported Cronbach's alphas for all subscales – Inadequate Self (α = .90); Self-reassurance (α = .86); Hated Self (α = .86). Castilho and Gouveia (2011) also had similarly strong Cronbach alphas – Inadequate Self (α = .89); Self-Reassurance (α = .87); Hated Self (α = .62). In the present study, Cronbach's alphas for the subscales were - Inadequate Self (α = .89), Self-reassurance (α = .87), and Hated Self (α = .79). In the present study, we only consider the subscale (total) Self-criticism, constituted by Inadequate Self and Hated Self and with an α = .89.

Letting Go Measure (Greenberg et al., 2008). Assesses the existence of negative feelings against the offender of the offense (the self or the other). The *Likert* scale ranges between 1 = *Strongly Disagree* and 5 = *Strongly Agree*. Greenberg et al. (2008) had strong Cronbach's alpha (α = .94). In the present study, the α was .91.

Psychological Well-being Scale (PWBS; Ryff, 1989; Portuguese version by Novo et al., 1997). The PWBS is a self-report measure to evaluate psychological well-being. This brief version contains 18 items (e.g., *"I gave up trying to make big improvements or changes in my life a long time ago*"; "*I like most aspects of my personality"*), distributed across the following six dimensions: Self-Acceptance; Personal Growth; Purpose in Life; Positive Relations; Environmental Mastery and Autonomy. Response options were from 1 = *Strongly Disagree* to 6 = *Strongly Agree*. Ryff (1989) reported Cronbach's alpha ranging from .83 (Self-Acceptance) to .68 (Personal Growth). The results obtained by Novo and colleagues (1997) showed evidences of a low estimated internal consistency for all subscales - Self-Acceptance (α = .52), Personal Growth (α = .40), Purpose in Life (α = .33), Positive Relations (α = .56), Environmental Mastery (α = .49), Autonomy (α = .37). In the present study, the Psychological Well-Being Scale (total) had a strong Cronbach's alpha (α = .93) and we consider the total PWBS as one of the main clinical variables to monitor the evolution of the treatment.

Personal Health Questionnaire (PHQ-9; Kroenke et al., 2001; Portuguese version by Ferreira et al., 2019). The PHQ-9 is a self-report measure that evaluates the severity of symptoms of depression according to the criteria of the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013). This measure has 9 items (e.g., *"I feel little interest or pleasure in doing things*"; "*I feel that I don't like myself or feel disappointed*

about myself or others") that use a four-point response options from 0 = *Not at all* to 3 = *Nearly every day*. Kroenke and colleagues (2001) found strong Cronbach's alphas from α = .86 to .89. The Portuguese version by Ferreira and colleagues (2019) also had alphas from α = .61 to .77. In the present study, the PHQ-9 has α = .75.

The Clinical Outcome Routine Evaluation – Outcome Measure 10 (CORE-10; Barkham et al., 2013; Portuguese version of Sales et al., 2012). This questionnaire assesses the frequency of general symptomatology experienced in the last week (e.g., "*I've been feeling anxious or nervous*"; "*I've been feeling sad*"). The Likert scale varies from 1 = *Never* to 4 = *Always*. Barkham et al. (2013) found a strong Cronbach alpha (α = .93) and Sales et al. (2012) also found an α = .95. In the present study, the CORE-10 has α = .93.

Procedures

Recruitment of the participant. "Chloe" was recruited through a university study for the validation and adaptation of self-forgiveness measures in a prior study (Costa et al., 2021). Participants willing to participate in a clinical study on self-forgiveness, receiving free therapeutic sessions, contacted the research team. An informed consent was provided with the explanation of the study and its goals. Confidentiality of the participant was guaranteed, in adherence to the 1964 Helsinki declaration and its later amendments or comparable ethical standards, as well as to the ethical principles of the Portuguese Psychologists' Association (which are similar to the ones prescribed by the American Psychological Association) and to the General Data Protection Regulation, adopted by the European Union (Directive 95/46/EC), in the context of scientific

research (Chassang, 2017). This study also received approval from the Ethics Committee of the university.

Inclusion Criteria. Participants were adults with age superior to 18 years old, who reported having committed a (non-severe) interpersonal offense or emotional injury to a (significant) other, and who suffered as a consequence from it, for at least one year (adapted from Greenberg et al., 2008). Participants volunteering to participate in a clinical study on self-forgiveness, had to be willing to disclose and work on a specific interpersonal offense that they had committed, receiving free therapeutic sessions.

Exclusion Criteria. Following Greenberg and colleagues (2008), experiences of sexual abuse, incest or domestic violence were excluded, considering these experiences as severe emotional injuries. Other specific situations were also excluded due to shifting the clinical focus for these issues, and requiring specific interventions (such as suicide attempts, loss of a loved one in the last year, substance abuse and/or personality disorders).

Assessment Protocol. The assessment protocol involved the use of several clinical measures (previously referred on *Measures*) in order to monitor clinical symptoms and other important clinical variables throughout the clinical intervention. The pre-treatment, initial assessment involved the use of the SCID-V-CV (First et al., 2015) to explore clinical diagnosis according to DSM-5 (taking usually 90 minutes for this assessment procedure) and the use of the self-report measures indicated above. The intervention started with the explanation of the main goals of the clinical intervention and confidentiality issues in order to preserve the identity of the participant (an

informed consent was signed by the client). All therapeutic sessions were recorded for supervision and research and monitored with the psychometric measures previously referred.

Initial Assessment and Pre-Treatment. "Chloe" was involved in an individual assessment interview in order to meet the main goals of the study, to provide information regarding this clinical study and to assure that her participation was voluntary. After this assessment, she was considered eligible to participate in the present study (regarding the inclusion/exclusion criteria) and, therefore, she signed an informed consent of the research.

Clinical Intervention. The manual for the clinical intervention was based on the principles of EFT (Greenberg & Goldman, 2018; Meneses & Greenberg, 2019) and the integrative steps of the REACH Forgiveness model for self-forgiveness (Griffin et al., 2015; Woodyatt et al., 2017; Worthington, 2006; Wade et al., 2014). The treatment was conducted during six weeks (one session per week, during one hour). She was given some experiential formulation and information about the clinical model in the pre-treatment phase, in order to approach the needs of "Chloe" to the main goals of the study. Thus, it was clarified that besides the intervention was brief, it would be beneficial in order to learn and enhance some skills to deal with future situations. "Chloe" confess the committed offense in order to promote self-responsibility and positive affect, such as empath. The intervention integrated five phases. The first phase focused on the empathic exploration of the problems and the EFT empathic stance. The second phase integrated the continuum of the work of phase I, and in addition the experiential formulation of the problem, in the case of "Cloe", her committed offenses

towards her sister and her need to decrease the critical self. Phase III was focused on the work with “Chloe’s” self-criticism. The two-chair dialogue was the main task during this phase and during the therapy. Thus, the imaginary confession (REACH Forgiveness) was conducted, since “Chloe” manifest some will to self-forgive, but she self-interrupt the process. Phase IV and V were conducted to consolidate “Chloe’s” achievements and new meanings.

Table I. Outline of the Clinical Intervention

Phase I	- Establish the therapeutic alliance and the EFT empathic stance; - Empathic Exploration of the problematic experiences/EFT with a focus on the emotional injury; - Information regarding EFT in emotional injuries, self-forgiveness, intervention, and this clinical intervention (e.g., Emotion-Focused Therapy and REACH Forgiveness model), to allow for the establishment of personal goals on the clinical intervention.
Phase II	- Empathic Exploration of emotional injury and experiential formulation of the problem: • Exploring the emotional injury that the offender committed: Step 1 –REACH Forgiveness model – Recall the hurt; - Depending on the EFT markers emerging, begin therapeutic work on self-forgiveness through the following, optional work on: Focusing (shift to clearing a space if the client shows difficulties), UFB Markers and about the Empty Chair task; Deepen experiential formulation on EFT perspective on emotional injuries: • Therapists search for clues on: • Issues concerning the need to self-forgive and work with secondary emotions, according to EFT; • The will of the client to work with self-forgiveness (Step 1 and Step 2 of REACH Forgiveness: if the client shows will to work with self-forgiveness - Recall the hurt and empathize with ourselves).
Phase III	- Overview of the experiential process in the 2 first sessions and during the time between; - Carry on Empathic Exploration on the emotional injury and associated emotional reactions: Work through to address the markers emerging in therapeutic work on self-forgiveness; - During Empty Chair Task (work with secondary and primary emotions) and shift to Imaginary Confession (according to REACH Forgiveness) if the client shows difficulty in the empty chair task and deepen experiential process (e.g., express the guilt, self-criticism, sadness): • Therapist help client hold on and process the vulnerability of the client by empathic validation and fostering self-compassion: Step 2 – REACH Forgiveness – Empathize with ourselves; • Therapists guide client through Two Chair Dialogue for emerging conflict splits markers in the self (e.g., listening to markers of self-criticism) and/or Two Chair Work for self-interruption processes (e.g., clue regarding a high intensity of emotions call for empathic affirmation and/or clearing a space). • Focusing can be used, as well, if the client needs further work on consolidating emerging transformational process (e.g., self-compassion); - Focus on self-forgiveness and/or the letting go process: • Therapists look for opportunity/openness to work with these processes and listening to the markers present in the here and now. - Working through imaginary confession/REACH Forgiveness, switch to Step 3 – REACH Forgiveness – Altruistic gift of forgiveness (by allowing the client to work on forgiving herself or himself) and Step 4 – REACH Forgiveness – Commitment to self-forgive by, for example, writing a note to ourselves) combined with Empathic Validation.
Phase IV	- Overview of the experiential process in previous sessions and during the time between; - Empathic exploration/EFT about the of the current needs and issues; - Depending on the EFT markers emerging, proceed to consolidate the previous therapeutic work on self-forgiveness, following the pace of the client, namely: • Empty Chair task and work with secondary and primary emotions (e.g., clues of shame and sadness); • Work on self-interruption and self-critical processes (e.g., clues of hopelessness, shame and guilt) – work with these emotions with Two chair enactments and give meaning to those processes (vulnerable self and critical self); • If needed, switch to Step 2 – REACH Forgiveness – Empathize with ourselves (work through to reinforce client empowerment). - Proceed to Step 5 – REACH Forgiveness – Hold onto Forgiveness by reading the (negative and positive) notes about themselves/ self-care activities that the client did as homework (combined with Therapist empathic validation): • Therapists foster client engagement in further self-care activities and written notes about the self (e.g., writing new ones), in order to not to forget as the person progresses in self-forgiveness forgave); • Therapists support client empowerment and new meanings about positive emotions (e.g., searching for clues for as self-compassion, self-generosity, self-love), and commitment to holding on to self-forgiveness and letting go.
Phase V	- Overview of the experiential process in previous sessions and during the time between; - Keep working through to consolidate client change regarding new meanings and new experiences (e.g., empowerment of the positive emotions and attitudes towards the self, such as empathy and compassion), related with Step 5 – REACH Forgiveness – Hold onto Forgiveness; - Explore other sets besides the clinical set and empower to use the new skills in future situations; - Consolidation of the change process, preparing treatment termination and client autonomy; - Work through personal or relational issues regarding termination of the clinical intervention.
Follow-Up (1, 2 & 3)	- Overview of the experiential process in the clinical intervention and client evolution since termination and during the time between; - Empathic exploration of difficulties, challenges and gains during and after the overall clinical intervention; - End of the session.

Note. EFT (Emotion-Focused Therapy).

Post-Treatment and Follow-Up. The assessment schedule was applied as planned (one session per week, during one hour). In addition, three follow-up sessions (one week, one month and three months after the end of the treatment) were carried out in order to monitor the evolution of "Chloe" outside the therapeutic context.

Data Analyses. All the data retrieved from this study was protected and stored on computer servers of the psychotherapy lab of the university. According to the research procedures and data management plan, approved by the Ethics Committee, only the main researchers have authorization and are able to access the data. The qualitative data were analyzed according to procedures that guarantee confidentiality (case studies use a fictional name and mask identification issues). The Reliable Change Index of the main outcome/change measures was also performed using the *R Program* (Morley & Dowzer, 2014), to categorize the treatment outcome in the case of "Chloe". The case of "Chloe" was analyzed according to the main principles of Theory-building case studies, proposed by Stiles (2010, 2021).

RESULTS

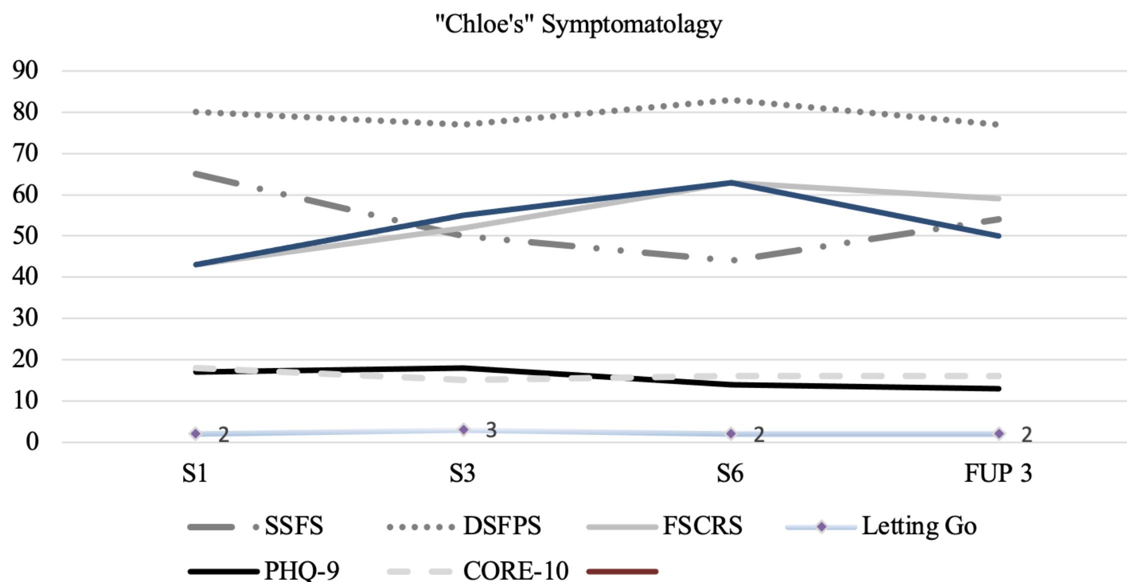
First, the evolution of "Chloe" symptomatology will be presented. Second, a clinical formulation of the problematic experience of "Chloe" will be stated based on the models EFT and REACH Forgiveness model (see Table I). After the clinical formulation, the results will be subdivided in topics to enhance "Chloe's" evolution during the treatment.

Evolution of "Chloe's" Symptomatology

Self-forgiveness process was avoided by "Chloe" at the initial phase; however, she was willing to try to work with it. Her critical side was very powerful, and her self-punishment was a negative behavior and feeling, which self-interrupted her process to access the core issue (to overcome the pain regardless to her offense). "Chloe" felt very anxious, with a high emotional arousal, feeling very sad at the same time (see Figure I and Table II).

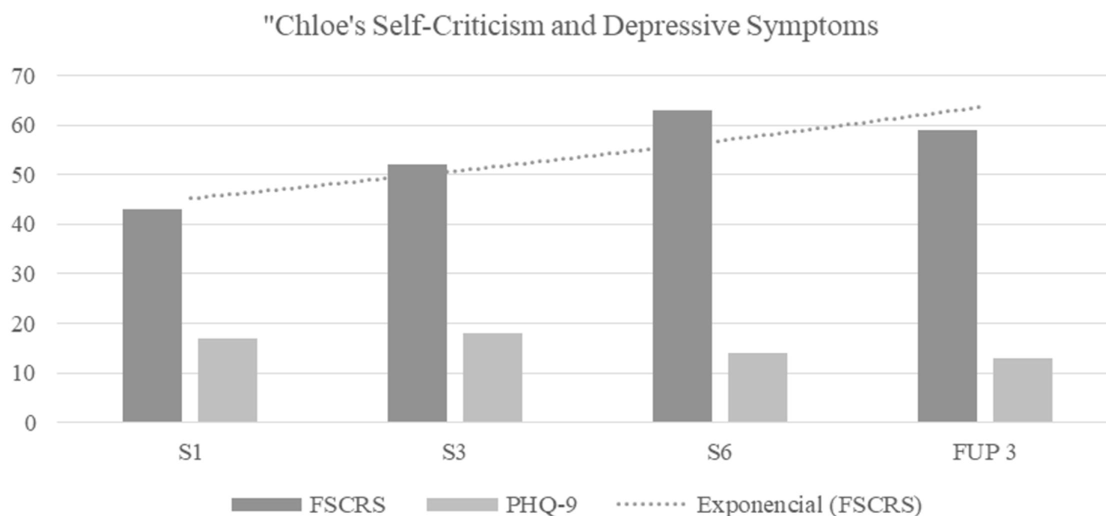
"Chloe's" self-criticism remained in higher standards, and her symptoms of depression decreased very slightly (see Figure II).

Figure I. "Chloe's" Symptomatology



Note. SSFS (State Self-Forgiveness Scale), DSFPS (Differentiated Self-Forgiveness Process Scale), FSCRS (Forms of Self-Criticism Reassuring Scale), Letting Go Measure, PHQ-9 (Personal Health Questionnaire - 9), Core-10 (The Clinical Outcome Routine Evaluation – Outcome Measure 10), PWBS (Psychological Well-Being Scale), S1 (Session 1), S3 (Session 3), S6 (Session 6), FUP 3 (Follow-Up 3).

Figure II. “Chloe's” Self-Criticism and Depressive Symptoms



Note. PHQ-9 (Personal Health Questionnaire – 9, FSCRS (Forms of Self-Criticism Reassuring Scale), S1 (Session 1), S3 (Session 3), S6 (Session 6), FUP 3 (Follow-Up 3).

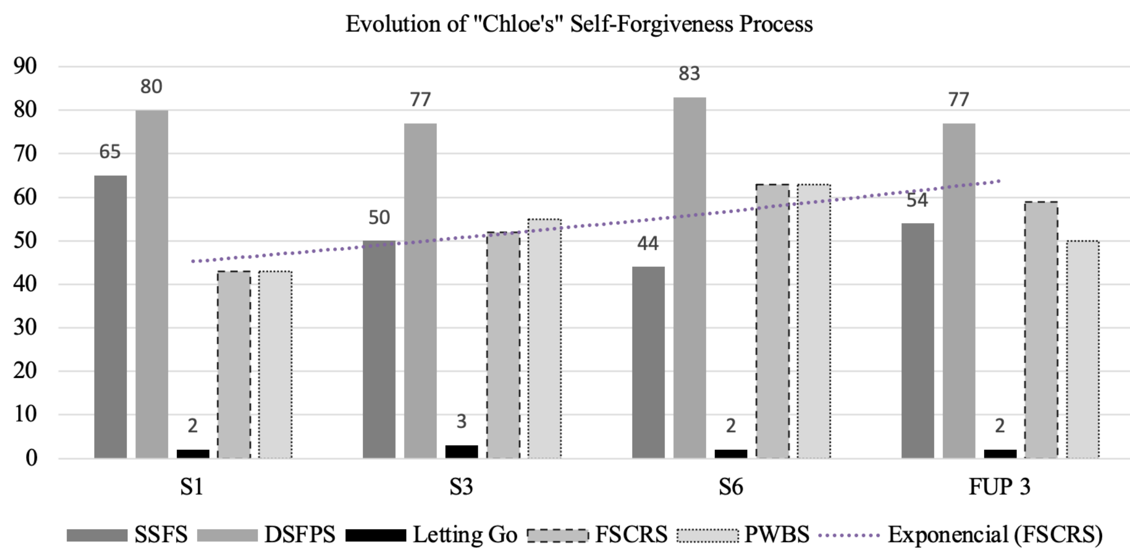
Table II. Outcome Measures in “Chloe’s” Case

Outcome Measures	Pre-Treatment (Initial Assessment)	Post-Treatment (S6)	Final Assessment (FUP 3)	Outcome
PHQ-9	17	14	13	**Depression cut-off score = 9** **RCI (90% CI) = 5**
CORE-10	18	16	16	**General symptoms cut-off score = 13** **RCI (90% CI) = 6**

Note. See McMillan et al. (2010) for RCI criteria applied to PHQ-9; See Barkham et al. (2013) for RCI criteria applied to CORE-10; PHQ-9 – Personal Health Questionnaire – 9; CORE-10 The Clinical Outcome Routine Evaluation – Outcome Measure 10; S6 – Session 6; FUP 3 – Follow-Up 3; RCI – Reliable Change Index; CI – Change Index

"Chloe's" levels of psychological well-being slightly increased (see Figure III and Table III). Self-forgiveness started to mildly increase, especially about "Chloe's" self-acceptance and self-empathy. Her psychological well-being maintained, and her levels of self-criticism slightly decreased, but were still in higher indexes. Her depressive symptoms slightly decreased as well (see Figure III and Table III).

Figure III. Evolution of "Chloe's" Self-Forgiveness Process



Note. SSFS (State Self-Forgiveness Scale), DSFPS (Differentiated Self-Forgiveness Process Scale), Letting Go Measure, FSCRS (Forms of Self-Criticism Reassuring Scale), PWBS (Psychological Well-Being Scale), S1 (Session 1), S3 (Session 3), S6 (Session 6), FUP 3 (Follow-Up 3).

Table III. Letting Go Measure in "Chloe's" Case

Measure	Pre-Treatment (Initial Assessment)	Post-Treatment (S6)	Final Assessment (FUP 3)	Outcome
Letting Go Measure	2	3	2	**Negative feelings cut-off score = 4** **RCI (90% CI) = 3**

Note. See Greenberg et al. (2008) for RCI criteria applied to Letting Go Measure-; S6 – Session 6; FUP 3 – Follow-Up 3; RCI – Reliable Change Index; CI – Change Index.

A Brief Experiential Formulation in the case of "Chloe"

"Chloe" had been struggling with feelings of shame, hopelessness, sadness and guilt in the last years. She presented feelings of self-condemnation concerning an emotional injury that implicated herself, her sisters and her mother. Specifically, "Chloe" blamed herself by leaving her home when she was sixteen, and leaving her younger sisters with their mother, an abusive person with an alcohol addiction. Even though she felt she had no way out but to leave their household, she felt she had abandoned her sisters then and could not forgive herself for not being able to protect them and take care of them anymore at such a young age.

Although she was away for several years, currently, she lives with her mother, who depends on "Chloe's" daily caretaking, as her sisters are currently living with their respective boyfriends. "Chloe" also struggled with her feelings about her mother, who neglected her three daughters. She felt that her mother's addiction to alcohol was a health problem that her mother never really cared about. "Chloe" never forgave her mother by neglecting her daughters. At the same time, she expressed high levels of self-criticism, self-punishment, self-condemnation, guilt, sadness and shame by leaving her sisters with her mother. She never forgave herself as well, and her of negative feelings and punishment toward herself were very present in her life.

The trauma associated to "Chloe's" story and the neglect of her mother who during several years appeared to trigger some of the experiences and emotions that "Chloe" presented. The feelings of abandonment and insecurity, and at the same time, the maladaptive behavior of self-criticism and self-punishment were strong evidences that "Chloe" was disengaged with her basic needs and was stuck in a deep pain. She tended to walk away when she felt sadness, and adopted a pattern of self-neglect (e.g., working during several hours in order to not to think about the negative experience and staying

out of the house to avoid facing her mother). A critical inner voice was formed during her life, enhanced in extreme situations, and provoked high levels of anxiety (measured by FSCRS), self-punishment (measured by DSFPS) and negative affect (measured by the Letting Go Measure).

"Chloe" took responsibly for her actions by currently assuming a role of a caretaker in her family (mother and sisters). However, the negative affect remained, causing intense pain and negative self-treatment and depriving "Chloe" of feelings of self-worth and empathy toward herself (REACH Forgiveness).

"Chloe's" cognitive-affective memories were associated to experiences of abandonment and negative feelings, which culminated with the need to leave the house and survive independently at an extremely severe situation for a child/adolescent (of 16 years old). The need to survive in an environment deprived of affection and love in her early life activated the need for autonomy and also established a pattern of strength through the experiential avoidance of her own needs and vulnerabilities which, later on, also prevented her from experiencing positive affect and accessing her emotions and basic needs.

Setting the stage of "Chloe's" Clinical Context for Self-forgiveness

The clinical intervention of "Chloe" was subdivided in five phases and was described in Table I. Phase I included the establishment of the therapeutic alliance, combined with empathic exploration in order to recall the hurt (REACH Forgiveness, Step 1). In addition, it was important to provide "Chloe" an understanding of her problems under this particular clinical proposal, through experiential formulations and in order to establish the personal goals for her therapeutic process (overcome the emotional injury and decrease the negative feelings about herself). The first and second

sessions were vital to create the therapeutic bond and explore empathically the specificity and history of this emotional injury, which became crucial aspects in the continuum of the treatment (EFT). The following excerpt is an illustration of the first session:

Therapist: "Chloe", how are you feeling today and what brings you here?

"Chloe": Well… (silence), as I said in the assessment session and in the questionnaires, I think it will be helpful for me to talk about my feelings, although being very difficult for me. All the situation with my sisters (…) causes me too much pain and I can't overcome. In the last few days, at work, for example, I feel very anxious and nervous, and I don't know why.

[The therapist explored this experience by Focusing on her body - EFT]

Therapist: mmhmm… and right now, as we talk about it, do you feel these same feelings? Anxiety for example?

"Chloe": Yes. More or less. I think I feel anxious every time that I remember it, but I don't know where this anxiety comes from, regarding my work for example.

Therapist: So, where do you feel this anxiety in your body… Can you specify if feel it especially in any part of your body? Is it on your shoulders, maybe? Or on your neck?

"Chloe": Well, I think I feel very stressed in my muscles, and my chest.

Therapist: mmhmm…And right now, how do you feel talking about this?

"Chloe": I'm starting to feel it more intensely, in my shoulders, all my muscles are contracted.

Therapist: mmhhmm... Do you want to give a name for what's happening right now?

"Chloe": Yes… well, I know this comes up because I have my issue with my sisters, my self-blame, I criticize myself all the time, and I get sleeping difficulties. I just work, come to college, go home, take care of my mom and boyfriend, but I'm not happy. And I don't know… It's everything.

[The therapist validated her experience and tried to lead the client through an increasing access in her negative experience – Recall the Hurt, Step 1, REACH Forgiveness; and feelings on "Chloe's" body – Focusing, EFT]

In the previous excerpt it was possible for the therapist to recognize how "Chloe" was struggling with her self-punishment and sadness, causing severe pain, regarding her issue with her sisters and her mother.

The next excerpt is an illustration of Phase II. It addresses the previous session, where it was possible for "Chloe" to access the emotions and experience regarding the emotional injury. Here, the therapist searches for clues regarding issues concerning the work with secondary emotions, according to EFT, and trying to understand "Chloe's" will to work with self-forgiveness (Step 1 and Step 2 of REACH Forgiveness: Recall the hurt and empathize with herself).

Therapist: That must be very painful, living with so many worries, and especially this situation with your family, because your body language also tells me that you really feel anxious when you talk about it. We are meeting each other, but

what do you think if we could talk about this self-blame and this criticism that affects you so much? Do you think it would help?

"Chloe": Yes… It's helpful… I know that this concerns the guilt that I feel, but I want you to know that my sisters don't blame me for nothing. They are awesome, and we are very close to each other. But, in my head, there are no excuses for what I did, for abandoning them…

Therapist: mmhhmm… it must be so hard to feel that way. Even when you know that it was needed for you to be allright, because, if it wasn't that, maybe you would not have the closest relationship that you have with them. This must be very painful, to feel it every day.

"Chloe": Yes… because in the bottom I feel I needed that, but this guilt that I feel... I liked when I left because I felt happier. But at the same time, I feel too much guilt, and the sense of being selfish, and that's hard… (silence… "Chloe" cries…).

[The therapist followed "Chloe" with empathic validation and empathic affirmation responses, in order to respond properly to the vulnerability felt by "Chloe" at that precise moment of the session]

Therapist: Yes… so much pain that I see in you… do you think those tears have some meaning?

"Chloe": Yes… I guess they do, but I don't know what… (silence)

Therapist: mmhhmm… how are you feeling right now? I know that you wrote your story, and I read it, but it's different when we talk with someone, right?

"Chloe": Yes… It's good to talk to someone that does not judge us. I mean, I don't have anyone to judge me, but I feel ashamed with all of this.

It was possible to comprehend the pain that "Chloe" was feeling. Her struggles concerned mainly about her offense with her sisters, and her sadness regarding the issues with her mother.

"Chloe's" Emotional Injuries, the Role of the Empty-Chair Task, and the Work with Self-Criticism

Phase III provided an overview of the experiential process in the first sessions.

The therapist carried on with the empathic exploration on the emotional injury associated to emotional reactions. The work with "Chloe" continued in terms of searching for clues and openness to work with self-forgiveness. Thus, as "Chloe" showed some difficulties and exhibited markers of negative treatment of the self, as the critical voice appeared, the therapist guided "Chloe" through the Two Chair Dialogue (EFT) for emerging conflict splits in the self.

The next excerpt is a brief illustration of "Chloe's" critical voice and her vulnerability to inner criticism:

> *"Chloe": The critical voice always says to me "You don't deserve to feel happiness because of the things you have done (...) You cannot be selfish anymore."*
>
> *Therapist: It's scary, right? That side wants you to be always aware about the past... that's why you're shaking... that must be hard to deal with, and painful... Does that make sense?*
>
> *"Chloe": Why does she always do that? It's hard (silence... "Chloe's cries...).*

Therapist: Those tears are the reason of such a hard situation, and a hard voice that you always listen. It's not fair, because you deserve to feel some peace, am I right?

"Chloe": Yes, I feel tired. I mean, I don't deserve to live like this, but I'll never forget what I've done to them, to my sisters. In part that side is right. [vulnerable self agrees with the critic, collapsing]

[After this, the therapist followed "Chloe" with the work on empathic affirmation, in order to respond properly to her vulnerability and pain]

Therapist: It's still difficult to look at that side and say this to her, am I right?

"Chloe": Today it is difficult, but one day I'll have the courage. I need to be more relaxed.

Therapist: mmhhmm… and how do you feel right now?

"Chloe": Still scared, but now that I'm talking to you, I feel more relaxed, but still scared and anxious.

Her negative emotions of shame and guilt, as well as some sadness regarding all of these issues came into full expression when "Chloe" revealed in the session that she would never be capable to forget or forgive herself.

In the middle of the process and concerning Phase IV, "Chloe" showed some improvement regarding her critical side and the access to her needs. Her anxiety was triggered by higher levels of self-condemning, as well as coping strategies to avoid resolving the issues with her sisters. Moreover, her sadness was the core pain, which regarded her basic need of being cared by her mother.

“Chloe” told to her therapist that she blamed her mother by not taking care of her daughters and that she was now feeling obligated to play the role of a mother with her younger sisters.

That precise moment was a representation of a marker concerning “Chloe’s” unfinished businesses and the therapist invited “Chloe” to experiment the Empty-chair task (EFT; and addressing Step 3 and 4, Altruistic Gift and Commitment to forgive/self-forgive). It is important to state that in this particular case, two situations were focused on the intervention: a) the issue with her sisters, where “Chloe” blamed herself for abandoning them in a particular time of her life; b) the issue with “Chloe’s” mother whom she blamed for not taking care of her daughters.

The next excerpt is an illustration of the moment of “Chloe” with her mother in the Empty-chair Task:

“Chloe”: Why didn’t you take care of us? I like you, you are my mother, but why? Why were you so neglectful with me and my sisters? Why? I was too young to care for them, and that’s why I went through bad moments and needed to leave. I will never forgive myself because they needed me at that time. (“Chloe” cries)

Therapist: I feel so much pain and sadness in your words. You were so young, and needed to be an adult to take responsibility for everything…

“Chloe”: It’s so unfair. You didn’t have that right. I like you; I don’t want you to be sick, I just wanted to have a mom.

Therapist: How is your mother reacting to your words?

“Chloe”: She doesn’t say anything because I know she regrets. (silence)

Therapist: And how are you feeling by saying this to her?

"Chloe": I don't know. It's so unfair because I like her, but it was because of her that I abandoned them. I blame the two of us. We were the older. I don't deserve to be happy, because when I feel happy, I feel that I'm being selfish.

[The therapist immediately directs attention to the critical voice of "Chloe", appearing in the last sentence]

Therapist: mmhhmm… do you think that your critical voice is appearing again?

"Chloe": Yes. This voice is always here. I just want to soften this side.

Therapist: mmhhmm… go to the other chair and be that critical voice.

"Chloe": I understand you but you have done bad things in your life and you need to remember.

After "Chloe" talked to her mother in the Empty-chair Task, the therapist notices markers of self-criticism and invites the client to address this process through the task to the Two-chair Dialogue in order to understand what her critical side wanted to say to her in that moment.

Therapist: What do you want to say to your critical side?

"Chloe": Just be aware that I will never forgive myself, but you need to soften your voice. I need some peace in my life. (silence)

Therapist: Ok, so say that again, that you need more peace and that you know that that side exists and you don't need to struggle with that side all over the time. Look at yourself in the eyes and say it again. [facing the critic]

"Chloe": Just be aware that I will never forgive myself, but you need to soften your voice. I need some peace in my life. (silence)

Therapist: How are you feeling by saying this? How does it make you feel? Do you think that side agrees with you?

"Chloe": Yes. I feel good, talking to my mom, and to my critical side. It's like I am throwing away a lot of weight, and that's good.

Therapist: And this is new for you, right? This sense of lightness. You need to feel this more times, right?

"Chloe": It's a good feeling. I work hard. I need to calm down. But concerning my sisters, I maintain my thoughts, namely that I don't deserve forgiveness. They always tell me to forget, but I can't.

Therapist: mmhhmm… Do you still feel that warm feeling, regarding the lightness?

"Chloe": Yes. I wish it lasts forever.

Therapist: So, let's stay in silence a little bit and just feel this good feeling. Just feel it and then try to give it a meaning. (silence)

"Chloe": (silence) I think it's a warning, regarding that I deserve to live a life more slowly, because now things are ok. Sometimes my mom needs some medical care, but besides that, everything is ok.

At the end of the session, the therapist asked "Chloe" to think about the process of self-forgiveness, and to write some notes (on the paper or just mentally) about its meaning to her (integrating Step 3, REACH Forgiveness).

The therapist focused the intervention on the continuum of working with "Chloe's" primary emotions, and the perception if there were new meanings.

Phase V represented consolidation of the achievements and preparing treatment termination.

"Chloe" shared her positive perspective about the treatment, by saying that it had been helpful by understanding some issues that, by her own, she would never think about it, namely: the power of her critical voice; the power by talking to a psychologist; the new meanings about herself, regarding an improvement in her positive value towards herself.

However, "Chloe" also addressed some concerns about the end of the treatment, and that normally, when she feels that way, she tends to closed herself (addressing her experience of sadness). The therapist normalized this concern and told "Chloe" that she could always continue with the treatment in more sessions, if she needed so. After this sharing, "Chloe" felt relief, but at the same time the therapist observed that "Chloe" became more introvert during the last sessions.

As "Chloe" showed difficulties on progressing in the direction of self-forgiveness, the clinical protocol was adapted to the needs of "Chloe". In the last sessions, the therapist gave empower in the new meanings of "Chloe's", for example by enhancing her progress in soothing her critical self. Moreover, the therapist validates her positive value towards herself. These processes were the core issues of "Chloe", besides her emotions of sadness, shame, and guilt still remained.

The therapist worked in the last session by validating "Chloe's" achievements, in order to consolidate the sense of happiness, self-empathy, and value toward herself.

Besides these improvements, "Chloe" still had some symptoms of depression, anxiety, and self-criticism, which was consider not enough to consider a good outcome case.

What can we learn from the case of “Chloe”?

Addressing the theory of Stiles (2010, 2015) about the Theory-building Case Studies, we consider that “Chloe” needed more time to overcome the several issues that she presented in the clinical intervention. Thus, if there were more sessions to deal with the issues related with her mother, this could possibly lead toward reconciliation and forgiveness, because at a certain point of the intervention “Chloe” stated and expressed her sadness about her mother. Thus, she reported that she missed her mother’s affection. Furthermore, the situation with her sisters was a consequence of the problematic relationship between “Chloe” and their mother. “Chloe” felt that she left her sisters in a moment of need. If this intervention had been extended for more sessions (a possibility which the client declined), maybe this would a positive indicator for the process of self-forgiveness.

The nature of “Chloe’s” offense regarding her past. Her problematic situation with her mother was a negative factor to the process of self-forgiveness. Furthermore, “Chloe” grew in a bad environment, with lack of affection. For a child and a teenager, this is a negative experience, and possibly traumatic also, which can damage her personality development, and the need to survive in such a hostile environment. In this sense, “Chloe” needed to overcome her situation with her mother, and after, to overcome her struggles within herself.

Another important note is that “Chloe” only recognizes this problematic situation with her mother during the middle of her therapy process, specifically in session 3, and this could be an explanation for the less improvement in the change process and an obstacle to the process of self-forgiveness.

DISCUSSION

"Chloe" presented lower improvement regarding the processes of self-forgiveness, self-criticism, and psychological responses (psychological well-being, depressive, and overall symptoms), which evidenced that she was not successful in the process of change achieved during these six sessions, comparing the pre-treatment and post-treatment.

When a person has committed an offense, towards the other or towards themself, one tends to experience negative affect, such as guilt, shame, and/or blame (Leach, 2017; Tangney, et al, 1996), leading to maladaptive beliefs, feelings and behaviors (Tangney et al., 2005), which can promote rumination and depression (Graham et al, 2017; Whelton, 2000; Woodyatt et al., 2017).

"Chloe's" statements are in accordance with the previous authors; however, she did not reach forgiveness. A possible hypothesis concerns her negative feelings that she felt about herself regarding her committed offense towards her sisters, as well as her relationship with her mother, which was stated as difficult regarding their past.

Different types of clinical interventions (e.g., Emotion-Focused Therapy/ Greenberg & Goldman, 2018; REACH Forgiveness model/Worthington, 2006; Wade et al., 2014) are developed for the resolution of an emotional injury (Greenberg et al., 2008; Woodyatt et al., 2017), demonstrating benefits on the self-forgiveness process for the person (e.g., Massengale et al., 2017; Wade et al., 2014).

Thus, several researchers indicate that self-forgiveness tends to be associated with motivation and consciousness of the change process (e.g., Meneses & Greenberg, 2018; Woodyatt et al., 2017). Therefore, it regards on person's feelings about letting go the

negative emotions, giving space for new meanings and positive affect (Woodyatt et al., 2017).

It is important to highlight some improvements, namely the softning of “Chloe’s” critical side, which helped her to slightly decrease her indexes of self-punishment, self-condemning, and negative affect, with this process being important to regulate her self-criticism and, consequently, her emotional arousal (Shahar, 2015).

“Chloe” was probably not prepared to self-forgive, or hypothetically, maybe she only needed to regulate even more her self-criticism, her sadness, and her conflict splits. However, she ended the treatment still presenting with clinical levels of symptomatology (addressing PHQ-9, CORE-10, and Letting Go Measure as the measures that indicated that her improvement was not enough to consider her a good outcome, regarding the reliable change index), which is an indicator that she needed a few more sessions to address her needs and overcome unresolved situations.

“Chloe’s” conflict splits regarding her critical responses towards herself occurred with less frequency. The conflict splits can also be read in the perspective of conflict identities, according to the author Woodyatt and colleagues (2017), where conflict identities tend to be associated with the responsibility of the offense, as well as with the self-forgiveness responses. Through the lens of the transgressor, these are restorer and repair processes of the self, that involve the acceptance of the moral social values (Enright & Fitzgibbons, 2000; Woodyatt et al., 2017).

In this sense, it becomes important for the therapist to be alert and to verbalize these in order to promote a higher consciousness for the client, in order to reestablish a reconciliation between those two parts (Woodyatt et al., 2017).

“Chloe” showed improvement regarding her psychological well-being, however with not sufficient indexes to consider a change in the therapeutic process. These are in

accordance with the theory that the client needs to be predisposed to forgive and be prepared for the process, as well as the therapist (Holmgren, 2002).

CONCLUSION, LIMITATIONS, AND IMPLICATIONS FOR FUTURE RESEARCH

"Chloe's" case did not support the theorizing regarding previous research that showed direct and indirect effects between self-forgiveness, self-criticism, and psychological responses, such as in depression and overall symptoms, and psychological well-being.

A limitation of the present study concerns to the brief clinical intervention, specifically in the case of "Chloe", with more severe symptomatology addressing, for example, her higher levels of self-criticism. More sessions were needed in order to work more deeply with some concerns and issues that appeared during the sessions.

More research needs to be conducted in order to study the protocol presented in the current study. Thus, it is important to replicate the protocol with other samples (e.g., general community).

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CHAPTER V

CLINICAL OUTCOMES OF A SELF-FORGIVENESS INTERVENTION INTEGRATING EMOTION-FOCUSED THERAPY AND REACH FORGIVENESS MODEL

ABSTRACT[5]

Recognizing oneself as the author of an interpersonal offense which caused emotional injury to a significant other tends to trigger experiences of self-criticism, blame and self-condemnation. Studies have shown that self-forgiveness can repair conflicts within the self and decrease self-criticism and depressive symptoms related to interpersonal offenses, as well as increase psychological well-being. Aims: The present study focuses on offenders and how they deal with emotional injuries they have caused in the past, expanding prior clinical studies in Emotion-Focused Therapy (which have mainly focused on helping victims deal with emotional injuries). Method: We recruited a sample of undergraduate students (who recognized themselves as authors of a non-severe emotional injury to significant others) for a feasibility study to analyze the outcomes of a brief clinical intervention integrating EFT for emotional injuries and the REACH model (related to self-forgiveness). We analyze here pre and post-treatment clinical outcomes in terms of self-forgiveness, self-criticism, psychological well-being, depressive and overall symptomatology. Results: The results confirmed the differences between good and poor outcome cases, and the majority of cases showed evidence of improvement regarding the main variables: lower self-criticism, higher self-forgiveness, and improvement in several psychological responses, evidencing higher psychological well-being, and lower depressive and overall symptomatology. Conclusion: This clinical protocol appears to be feasible and effective in this sample (i.e. university students, who are non-severe offenders). This integrative clinical intervention, in EFT and REACH Forgiveness, tends to be beneficial for the healing of non-severe emotional injuries through the process of self-forgiveness.

[5] *Note.* The present study has been submitted in a peer-review international journal and is currently under review.

INTRODUCTION

Self-forgiveness has been studied during the last few years by several authors (e.g., Woodyatt et al, 2017; Worthington, 2006; Worthington et al., 2018; Toussaint et al., 2020). Previous empirical studies show evidences regarding the benefits of self-forgiveness for the person, namely by improving overall well-being, reduction of negative affect, and/or increasing positive attitudes and values towards the self (see the *Handbook of Self-Forgiveness* by Woodyatt et al, 2017).

Authors such as Costa et al. (2021; see CHAPTER II) have found that self-forgiveness acts directly or indirectly on depressive symptoms and psychological well-being, through lessening self-criticism and self-condemnation experienced by offenders after an interpersonal offense. Moreover, prior studies have shown positive well-being indicators, through the access to positive emotions and positive psychological responses (e.g., Toussaint et al., 2020; Woodyatt & Wenzel, 2013; Worthington et al., 2018).

Emotion-Focused Therapy (EFT) has been studying emotional injuries across several studies in the last decades, highlighting the positive role of forgiveness and letting go (e.g., Greenberg et al., 2008; Meneses & Greenberg, 2019; Paivio & Pascual-Leone, 2010). Yet, the focus has been placed mostly of the victims' experience of emotional injuries. The present study expands this focus to address the self-criticism, self-condemnation and suffering experienced by (non-severe) interpersonal offenders (i.e., individuals who recognize themselves as authors of a non-severe emotional injury to a significant other), and aims to present the outcomes of a clinical intervention protocol combining EFT with steps from the REACH Forgiveness model (for self-forgiveness).

Self-forgiveness and Its Role in the Work with Emotional Injuries

When people have committed an interpersonal offense, apart from the interpersonal consequences of the offense, they often experience self-criticism or self-condemnation (Peterson et al., 2017; Thompson et al., 2005). We focus here on the internal experience of offenders and especially consider how self-forgiveness can repair and overcome self-criticism related to the offense and increase psychological well-being (Griffin et al., 2015; Woodyatt et al., 2017; Woodyatt & Wenzel, 2013).

Cornish and Wade (2015), as well as Costa and colleagues (2021), have studied self-forgiveness, self-criticism, and psychological responses, and their relationships between them. For example, severe emotions of blame or guilt tend to stimulate adaptive changes in the behavior of the perpetrator of the offense by promoting the sense of responsibility (Woodyatt & Wenzel, 2013). Nevertheless, when those negative emotions become too intense, chronic or pervasive, they usually enhance negative coping responses (e.g., rumination and interpersonal avoidance that perpetuates conflicts; Gilbert & Andrews, 1998; Whelton, 2000; Wohl et al., 2010). Consequently, internal rumination can, therefore, lead to negative health outcomes, such as self-criticism associated to negative emotions, enhancement of depressive symptoms (see Costa et al., 2021; addressing CHAPTER II and CHAPTER IV) and also higher emotional arousal and cardiac responses from offenders (e.g., Da Silva et al., 2017).

Self-forgiveness has an important role in the reduction of self-criticism (Gilbert & Woodyatt, 2017), leading to the reduction of rumination and acute negative emotions (Da Silva, Witvliet, & Riek, 2017; Wohl et al., 2010). Under this psychological framework, self-forgiveness tends to be beneficial for the person, promoting their skills to tolerate and regulate negative emotions and using them more productively (in terms

of social and intrapersonal functioning). In this sense, self-forgiveness is a process through which the person relieves one's negative feelings, behaviors and emotions, in order to balance them with more positive emotions, feelings and behaviors (Woodyatt & Wenzel, 2013; Worthington, 2006), leading to a better psychological well-being (Massengale et al., 2017; Woodyatt et al., 2017). Thus, it can lead to positive attitudes towards the self, restoring personal sense of value and the moral reintegration of the self (Peterson et al., 2017; Thompson et al., 2005).

A Brief Clinical Intervention in Emotion-Focused Therapy and REACH Forgiveness model for Self-forgiveness

Emotion-Focused Therapy (EFT) is a well-known therapeutic model, with several studies conducted within the scope of the resolution of emotional injuries (see Greenberg et al., 2008; Meneses & Greenberg, 2008). More specifically, Meneses and Greenberg (2019) review the empirical evidences regarding the positive benefits of this type of clinical work with emotional injuries, showing that this model of intervention promotes direct and indirect effects in the forgiveness process.

EFT focuses on the dialectics that occur between emotions and its comprehension (Greenberg & Goldman, 2018) and, therefore, combines empathic exploration with more process-guiding techniques (related to enactment tasks, for example) to facilitate emotional arousal, exploration, and regulation, with the final aim to foster emotion transformation. Globally, EFT tends to contribute to facilitate several change processes in the person, and increasing overall well-being (Meneses and Greenberg, 2019). Hence, using a famous quote in this model – EFT *changes emotions with emotions* (Pos & Greenberg, 2007; Greenberg & Goldman, 2018) — meaning that the therapeutic process leads the client to enter experiential work, which incites the access to the more

painful/core issue, allowing its transformation (Greenberg & Goldman, 2018; Pos & Greenberg, 2007). Ultimately, this facilitates self-transformation and self-narrative reconstruction (Angus & Greenberg, 2011; Cunha et al., 2017).

In the case of forgiveness, Meneses and Greenberg (2019) state that EFT is a non-prescriptive treatment of forgiveness (given that achieving forgiveness is seen as an optional therapeutic goal, which may not apply to all cases). Nevertheless, previous studies in EFT evidence positive results regarding the resolution of emotional injuries resulting from interpersonal offenses, through the process of forgiveness and letting go (Greenberg et al., 2008; Meneses & Greenberg, 2019).

In contrast, the REACH Forgiveness model (Worthington, 2006; Wade et al., 2014) focuses the clinical work directly on helping clients achieve forgiveness and/or self-forgiveness (e.g., Toussaint et al., 2020; Worthington et al., 2018). The REACH Forgiveness model has also been studied in the last few years within the scope of the resolution of emotional injuries (Worthington, 2006; Worthington et al., 2018), with several empirical evidences regarding its effectiveness (see the meta-analysis by Davis et al., 2015, and Wade et al., 2014). Focusing on the resolution of emotional injuries related to interpersonal offenses, as well as its consequences to a person's life, the REACH Forgiveness model adopts a different stance towards (self-)forgiveness, making this an explicit therapeutic goal for the clinical work. In the case of working towards self-forgiveness with offenders, the REACH model adopts directive techniques to facilitate awareness of responsibilities/accountability for the offense, confrontation with the situation, soothing tasks, and empowerment of the reached new skills and achievements regarding forgiveness (Toussaint et al., 2020).

Previous studies demonstrate positive results with the REACH Forgiveness model (Davis et al., 2015, & Wade et al., 2014). For example, Toussaint et al. (2020) used the

REACH intervention with a sample of university students wanting to overcome emotional injuries through the process of forgiveness. The author identified the connection between spirituality and less unforgiveness (i.e., higher spirituality leads to a higher forgiveness), and as a consequence, improve the person's empathy, positive affect, and emotional forgiveness. Kazoun (2018) also stated the importance of overcoming emotional injuries through forgiveness, since it enhanced the positive benefits associated to it, such as acceptance. This author also highlights the negative effects of unforgiveness and its individual impact, in terms of psychological, physical, and social symptoms regarding a clinical sample (namely, higher negative affect such as guilt or remorse).

The Present Study

The present study analyses the outcomes of a brief clinical intervention in Emotion-Focused Therapy (Greenberg & Goldman, 2018; Meneses & Greenberg, 2019), combined with the REACH Forgiveness model (Worthington, 2006; Wade et al., 2014), in a sample of 11 university students. As we have seen before, both models have independently shown positive benefits of forgiveness concerning the resolution of unresolved emotional injuries and unfinished business (Costa et al., 2021; Greenberg & Goldman, 2018; Menenes & Greenberg, 2019; Pos & Greenberg, 2007; Wade et al., 2014, Worthington, 2006). Yet, clinical studies which focus on self-forgiveness are still scarce.

Following previous studies in this field (e.g., Toussaint et al., 2020; Worthington et al., 2020), this study will analyze pre-treatment and post-treatment changes in the clinical variables of self-forgiveness, self-criticism, psychological well-being, depression, and overall symptomatology, as outcomes of this feasibility study. The

novelty of this feasibility study concerns addressing the negative experiences of non-severe offenders (such as self-condemnation, blame and self-criticism, due to perpetrating an interpersonal offense or emotional injury to a significant other) and assessing the clinical outcomes of this new, brief and integrative clinical protocol to facilitate self-forgiveness (presented in CHAPTER III).

The present study analyzes one hypothesis:

Hypothesis. We hypothesize that a person with individual brief intervention in EFT and REACH Forgiveness model would accomplish the following: (a) decrease the presence of general symptomatology from the pre- to post-treatment; (b) reduce the negative affect towards the self (as measured by the Letting Go Measure); (c) show improvement in self-forgiveness and its correlation with other constructs (self-criticism, negative affect, and depression).

METHOD

Participants

Clients. From the 55 participants recruited at an initial phase, 11 fulfilled the inclusion criteria and were enrolled in this clinical study (as mentioned above; see CHAPTER III). Thus, the present sample is constituted by 11 participants, with ages superior to 18 years, who committed a non-severe emotional injury, occurring at least one year prior to enrollment. The participants were all female university students from the same major (e.g., social sciences) and had a mean age of 24.18 years (*SD* = 7.10).

These participants were considered suitable concerning the purposes of this clinical study (see Table I) and its inclusion criteria: recognizing oneself as the author of an interpersonal offense (an emotional injury) committed to a significant other, and experiencing symptoms of depression and high levels of self-criticism (such as

rumination on the interpersonal offense), as a consequence of it. Given that we wanted to consider only non-severe emotional injuries, we excluded situations of sexual abuse, domestic violence or incest, among others (following the inclusion criteria by Greenberg et al., 2008). Also, crisis situations or severe mental health problems, like suicide attempts, loss of a loved one in the last year, personality disorders and/or substances abuse, were exclusion criteria given the specificity and briefness of the present clinical protocol (also according to Greenberg et al., 2008). The majority of the clients presented higher levels of general symptomatology and negative affect towards the self (see Table II).

Therapist and Researchers. The therapist (first author) was the same for all 11 clients, a female researcher with a Masters' Degree in Clinical and Health Psychology, with 35 years old and more than 7 years of professional experience. At the time of this study, she had received training in Emotion-Focused Therapy. She was supervised by her PhD advisor, a Clinical and Health Psychologist with 40 years old, with a PhD in Clinical Psychology, and specialized in Emotion-Focused Therapy with more than 15 years of experience in clinical practice. Two other female researchers were responsible for the initial assessments and follow up sessions (they were not involved in the therapeutic process in order to safeguard the reliability of the assessment results). These two researchers (with 30 and 34 years old), both had a Masters' Degree in Health and Clinical Psychology and more than 7 years of experience in clinical practice.

Measures

Diagnostic Measure

Structured Clinical Interview for DSM-5® Disorders: Clinician Version (SCID-V-CV; First et al., 2015). According to criteria of the Diagnostic and Statistical Manual of

Mental Disorders - 5th Edition (DSM-5), the SCID-V-CV is a semi-structured interview that allows to conduct a systematic diagnostic assessment of the client. The SCID-V-CV was used here in the initial assessment of clients to collect general information about the existence of psychopathology in the present and throughout the life cycle.

Clinical Outcome Measure

The Clinical Outcome Routine Evaluation – Outcome Measure 10 (CORE-10; Barkham et al., 2013; Portuguese version of Sales et al., 2012). The CORE-10 evaluates the general symptomatology (e.g., *"I've been feeling anxious or nervous"; "I've been feeling sad"*). The Likert scale ranges from 1 = *Never* to 4 = *Always*. Barkham et al. (2013) evidence strong psychometric properties concerning the Cronbach alpha (α = .93) of the original version. In the Portuguese version, Sales et al. (2012) also found strong psychometric properties in the Portuguese version (α = .95), similar to the results for the CORE-10 in the present study (α = .93 and ω = .95). See Barkham et al. (2013) for RCI criteria applied to CORE-10: General symptoms cut-off score = 13 and RCI (90% CI) = 6.

Symptoms Measures

State Self-forgiveness Scale (SSFS; Wohl et al., 2008; Portuguese version by Costa et al., 2020). The SSFS is a self-report measure to evaluate self-forgiveness, with 17 response items (options range from 1 to 6, where 1 = *Strongly Disagree* to 6 = *Strongly Agree*). The SSFS incorporates two subscales: (a) Self-Forgiveness Feelings and Actions (SSFA; e.g., Self-forgiveness Feelings - *"Considering what I did wrong, I feel acceptance of myself"*; e.g., Self-Forgiveness Actions - *"Considering what I did wrong, I punish myself "*); and (b) Self-forgiveness Beliefs (SFB; e.g., *"Considering what I did*

wrong, I believe I am decent"). The SSFS contains a final item *("Considering what I did wrong, I forgive myself..."*), with response options from 0 = *"Not at all"* to 3 = *"Completely"*. Wohl and colleagues (2008) reported good psychometric properties regarding the Cronbach's alpha for both subscales: for SFFA, α = .74; for SFB, α = .89. The present study also found the good psychometric properties in the Portuguese version of this scale, considering the subsequent Cronbach's alpha: SFFA had α = .77 and SFB had α = .84. The α for the total SSFS was .85 and ω = .88.

Differentiated Self-forgiveness Process Scale (DSFPS; Woodyatt & Wenzel, 2013; Portuguese version by Costa et al., 2020). The DSFPS is a self-report measure that assesses self-forgiveness, initiated by a question to define the type of offense committed (e.g., infidelity; betrayal of trust) and then assessing the degree of severity of that offense through three subscales, namely: Pseudo Self-Forgiveness (PSF; e.g., *"I think the other person was guilty of what I did"*); Self-Punitive (SP; e.g., "What I did is unforgivable"); and Genuine Self-Forgiveness (GSF; e.g., "I'm trying to learn with my mistake"). The subscales contained a total of 20 items, rated on seven-point response options from 1 = *Strongly Disagree* and 7 = *Strongly Agree*. The results obtained by Woodyatt and Wenzel (2013) evidenced good psychometric properties concerning the Cronbach's alphas for Pseudo Self-Forgiveness (α = .81); Self Punitive (α = .85); Genuine Self-Forgiveness (α = .85). The present study also evidenced adequate to good psychometric properties concerning the Cronbach's alphas for the three weakly related subscales: Pseudo Self-Forgiveness (α = .64), Self-Punitive (α = .80), and Genuine Self-Forgiveness (α = .82). We considered for the present study only the subscale Self-Punitive.

Letting Go Measure (Greenberg et al., 2008). The Letting Go Measure evaluates the existence of negative feelings against the offender of an interpersonal offense (to the self or the other). It is constituted by one single item. The *Likert* scale varies between 1 = *Strongly Disagree* and 5 = *Strongly Agree*. Greenberg and colleagues (2008) found strong psychometric properties on the original version of this scale, considering Cronbach's alpha (α = .94). Similar results were also found in the present study: the α was .91 and ω = .93.

Forms of Self-criticism and Reassuring Scale (FSCRS; Gilbert et al., 2004; Portuguese version by Castilho & Gouveia, 2011). The FSCRS measures self-criticism and self-reassurance in situations of failure in the format of a self-report measure. It is constituted by 22 items, integrating three subscales: Inadequate Self, Self-Reassurance, and Hated Self. Responses options range from 0 = *Not at all like me* to 4 = *Extremely like me* (e.g., *"I cannot accept failures without feeling inadequate"*; "*I* have a feeling of disgust for myself"). Gilbert and colleagues (2004) reported good to strong psychometric properties in this scale, with Cronbach's alphas ranging from .86 to .90 – Inadequate Self (α = .90); Self-reassurance (α = .86); Hated Self (α = .86). Castilho and Gouveia (2011) also found good to strong Cronbach alphas: Inadequate Self (α = .89); Self-reassurance (α = .87); Hated Self (α = .62). In the present study, Cronbach's alphas also evidence good psychometric properties, ranging from .79 to .89: Inadequate Self (α = .89), Self-reassurance (α = .87), and Hated Self (α = .79). For our present purposes, we only considered the subscale (total) Self-criticism, integrated by Inadequate Self and Hated Self and with an α = .89 and ω = .90.

Personal Health Questionnaire (PHQ-9; Kroenke et al., 2001; Portuguese version by Ferreira et al., 2019). The PHQ-9 evaluates the severity of symptoms of depression according to the criteria of the Diagnostic and Statistical Manual of Mental Disorders in the format of a self-report measure. This measure has 9 items (e.g., *"I feel little interest or pleasure in doing things"; "I feel that I don't like myself or feel disappointed about myself or others"*) that use a four-point response options ranging from 0 = *Not at all* to 3 = *Nearly every day*. Kroenke and colleagues (2001) stated strong Cronbach's alphas from α = .86 to .89. The Portuguese version by Ferreira and colleagues (2019) also stated adequate alphas, ranging from α = .61 to .77. In the present study, the PHQ-9 showed good psychometric properties, with Cronbach alpha α = .75 and ω = .85.

Psychological Well-being Scale (PWBS; Ryff, 1989; Portuguese version by Novo et al., 1997). The PWBS is a self-report measure to assess psychological well-being. This brief version contains 18 items (e.g., *"I gave up trying to make big improvements or changes in my life a long time ago"; "I like most aspects of my personality"*), distributed across the following six dimensions: Self-acceptance; Personal Growth; Purpose in Life; Positive Relations; Environmental Mastery; and, Autonomy. Response options range from 1 = *Strongly Disagree* to 6 = *Strongly Agree*. Ryff (1989) reported adequate to good psychometric properties on the original version of this scale, with Cronbach's alpha ranging from .83 (Self-Acceptance) to .68 (Personal Growth). For the Portuguese version, the results achieved by Novo and colleagues (1997) evidenced a low estimated internal consistency for all subscales: Self-Acceptance (α = .52), Personal Growth (α = .40), Purpose in Life (α = .33), Positive Relations (α = .56), Environmental Mastery (α = .49), Autonomy (α = .37). Yet, in the present study, the Psychological Well-being Scale (total) showed strong psychometric properties concerning the

Cronbach's alpha (α = .93) and ω = .94. We, therefore, considered the total PWBS as one of the main clinical variables to monitor the evolution of the treatment.

Procedures

Study Dissemination and Recruitment of Participants. This study was approved by the Ethics Committee of the University. The recruitment of the participants started with the explanation and dissemination of the project at the university campus. Voluntary participants interested in joining this clinical study contacted the research team (through e-mail) and were then contacted over the phone. This specific phone call contact by the research team provided the opportunity to carry out a pre-assessment procedure, involving a few questions concerning the type of emotional injury, the motives for participating, and an initial assessment regarding inclusion/exclusion criteria (e.g., to understand if participants were not medicated, as an example). Thus, participants were asked to provide information and fill in a set of measures regarding to main goals of the project. If they met the inclusion criteria and were eligible for enrollment, they were contacted by phone or email one week later by a researcher of the project (first author) to schedule an initial assessment interview.

Initial Assessment and Pre-Treatment. All clients had an individual assessment interview. The initial assessment interview was organized to verify eligibility, confirm inclusion/exclusion criteria and voluntary participation conditions in order to meet the main goals of the study. At this point of the study, the participants were informed, in more detail, about the project goals, issues regarding confidentiality and (sociodemographic or personal) data management/protection, in adherence to the current legislation and ethical guidelines, namely: i) the 1964 Helsinki declaration and

its later amendments or comparable ethical standards; ii) the ethical principles of the Portuguese Psychologists' Association (which are similar to the ones prescribed by the American Psychological Association); and iii) adherence to the General Data Protection Regulation, implemented by the European Union (Directive 95/46/EC), in the context of scientific research (Chassang, 2017). An email contact was also provided to allow participants to request (if desired) further information from the research team or referral to psychological help.

At this pre-treatment stage, all clients were monitored with the clinical interview and measures proposed in the clinical protocol (see above and CHAPTER III). After this assessment, if it was concluded that clients were suitable to participate in the present study (regarding eligibility, assessment information and inclusion/exclusion criteria), clients and researchers signed an informed consent. Then, the participants were informed that they would begin the intervention one week later.

Clinical Intervention. Following the assumptions of Emotion-Focused Therapy (Greenberg et al., 2008; Meneses & Greenberg, 2019) and REACH Forgiveness model (Worthington, 2006; Wade et al., 2014), this clinical protocol (see CHAPTER III for detailed information) has five phases, according to Table I. The clinical intervention (involving these 11 clients) was completed during one year, with initial assessments, six intervention sessions (one session per week), and three follow up sessions (one week, one month and three months after the end of the treatment). During the treatment and immediately before the beginning of the sessions, the participants adhered to an assessment schedule providing data concerning the clinical variables (see section *Measures* above).

Table I. Outline of the Clinical Intervention

Phase I	- Establish the therapeutic alliance and the EFT empathic stance; - Empathic Exploration of the problematic experiences/EFT with a focus on the emotional injury; - Information regarding EFT in emotional injuries, self-forgiveness, intervention, and this clinical intervention (e.g., Emotion-Focused Therapy and REACH Forgiveness model), to allow for the establishment of personal goals on the clinical intervention.
Phase II	- Empathic Exploration of emotional injury and experiential formulation of the problem: • Exploring the emotional injury that the offender committed: Step 1 –REACH Forgiveness model – Recall the hurt; - Depending on the EFT markers emerging, begin therapeutic work on self-forgiveness through the following, optional work on: Focusing (shift to clearing a space if the client shows difficulties), UFB Markers and about the Empty Chair task; Deepen experiential formulation on EFT perspective on emotional injuries: • Therapists search for clues on: • Issues concerning the need to self-forgive and work with secondary emotions, according to EFT; • The will of the client to work with self-forgiveness (Step 1 and Step 2 of REACH Forgiveness: if the client shows will to work with self-forgiveness - Recall the hurt and empathize with ourselves).
Phase III	- Overview of the experiential process in the 2 first sessions and during the time between; - Carry on Empathic Exploration on the emotional injury and associated emotional reactions: Work through to address the markers emerging in therapeutic work on self-forgiveness; - During Empty Chair Task (work with secondary and primary emotions) and shift to Imaginary Confession (according to REACH Forgiveness) if the client shows difficulty in the empty chair task and deepen experiential process (e.g., express the guilt, self-criticism, sadness): • Therapist help client hold on and process the vulnerability of the client by empathic validation and fostering self-compassion: Step 2 – REACH Forgiveness – Empathize with ourselves; • Therapists guide client through Two Chair Dialogue for emerging conflict splits markers in the self (e.g., listening to markers of self-criticism) and/or Two Chair Work for self-interruption processes (e.g., clue regarding a high intensity of emotions call for empathic affirmation and/or clearing a space). • Focusing can be used, as well, if the client needs further work on consolidating emerging transformational process (e.g., self-compassion); - Focus on self-forgiveness and/or the letting go process: • Therapists look for opportunity/openness to work with these processes and listening to the markers present in the here and now. - Working through imaginary confession/REACH Forgiveness, switch to Step 3 – REACH Forgiveness – Altruistic gift of forgiveness (by allowing the client to work on forgiving herself or himself) and Step 4 – REACH Forgiveness – Commitment to self-forgive by, for example, writing a note to ourselves) combined with Empathic Validation.
Phase IV	- Overview of the experiential process in previous sessions and during the time between; - Empathic exploration/EFT about the of the current needs and issues; - Depending on the EFT markers emerging, proceed to consolidate the previous therapeutic work on self-forgiveness, following the pace of the client, namely: • Empty Chair task and work with secondary and primary emotions (e.g., clues of shame and sadness); • Work on self-interruption and self-critical processes (e.g., clues of hopelessness, shame and guilt) – work with these emotions with Two chair enactments and give meaning to those processes (vulnerable self and critical self); • If needed, switch to Step 2 – REACH Forgiveness – Empathize with ourselves (work through to reinforce client empowerment). - Proceed to Step 5 – REACH Forgiveness – Hold onto Forgiveness by reading the (negative and positive) notes about themselves/ self-care activities that the client did as homework (combined with Therapist empathic validation): • Therapists foster client engagement in further self-care activities and written notes about the self (e.g., writing new ones), in order to not to forget as the person progresses in self-forgiveness forgave); • Therapists support client empowerment and new meanings about positive emotions (e.g., searching for clues for as self-compassion, self-generosity, self-love), and commitment to holding on to self-forgiveness and letting go.
Phase V	- Overview of the experiential process in previous sessions and during the time between; - Keep working through to consolidate client change regarding new meanings and new experiences (e.g., empowerment of the positive emotions and attitudes towards the self, such as empathy and compassion), related with Step 5 – REACH Forgiveness – Hold onto Forgiveness; - Explore other sets besides the clinical set and empower to use the new skills in future situations; - Consolidation of the change process, preparing treatment termination and client autonomy; - Work through personal or relational issues regarding termination of the clinical intervention.
Follow-Up (1, 2 & 3)	- Overview of the experiential process in the clinical intervention and client evolution since termination and during the time between; - Empathic exploration of difficulties, challenges and gains during and after the overall clinical intervention; - End of the session.

Post-Treatment and Follow-Up Assessments. The assessment schedule was applied as planned (one session per week, during one hour). In addition, three follow-up sessions (one week, one month and three months after the end of the treatment) were also conducted in order to monitor the evolution of clients outside the therapeutic setting. At post-treatment, the majority of the clients showed improvement (see Table II and III).

Data Management. All the information retrieved from this study was protected and stored on computer servers of the psychotherapy lab of the university. The main researchers were the only persons who have authorization to access the data. The results were analyzed anonymously (case studies use a fictional name and mask identification issues), to safeguard that data and results preserve the confidentiality of the clients.

Data Analysis. The authors used the SPSS and the *R* program to conduct the non-parametric Wilcoxon analyses signed ranks testing. These analyses were conducted in the outcome measures, specifically in CORE-10, in order to compare the pre-treatment ranks at 0 weeks to post-treatment ranks at 6 weeks. Moreover, we conducted Pearson correlation coefficients, in order to analyze if there were intercorrelations between the measures. Clinical change in the outcome measure was assessed according to Reliable Clinical Index criteria (Jacobson & Truax, 1992). The RCI is the value that any pre-post change has to exceed in order for the change to be considered more than random error of measurement (Morley & Dowzer, 2014). For symptom's analysis, the variables of interest for this study (following Barkham et al., 2013, and Graham et al., 2017) were: self-forgiveness (measured by SSFS), self-punishment (DSFPS), depressive (assessed

by PHQ-9), negative affect (assessed by Letting Go Measure), self-criticism (measured by FSCRS), and psychological well-being (measured by PWBS).

A value of 0.1 is considered a small effect, 0.3 a medium effect, and 0.5 a large effect (Waddell, Nassar, & Gustafson, 2011).

RESULTS

This section will first show the main descriptive results obtained by participants in this feasibility study. Second, analysis of the reliable change indexes of the participants will allow the comparison between good and poor outcome cases. Then, we will report the differences found between pre- and post-treatment and correlations between the constructs.

Overall Descriptive Results During the Clinical Intervention

The clients were university students, all females, from the same major (e.g., psychology), and had a mean age of 24.18 years (*SD* = 7.10). All the 11 clients participated in all phases of the intervention, with 0 dropouts. During the clinical intervention, the majority of the participants showed improvement regarding the main variables (see Table II).

Table II. Outcome Measure

Outcome Measure	Participants	Pre-Treatment (Initial Assessment)	Post-Treatment (S6)	Final Assessment (FUP 3)	Outcome
CORE-10	P1	18	16	16	PO (Improved)
	P2	10	2	2	GO (Recovered)
	P3	9	0	0	GO (Recovered)
	P4	13	2	0	GO (Recovered)
	P5	9	1	0	GO (Recovered)
	P6	14	2	3	GO (Recovered)
	P7	13	2	2	GO (Recovered)
	P8	8	1	0	GO (Recovered)
	P9	14	4	3	GO (Recovered)
	P10	12	0	0	GO (Recovered)
	P11	14	1	1	GO (Recovered)

Note. Outcome status was analyzed according to Barkham et al. (2013), who ascertained RCI criteria applied to the CORE-10 - General symptoms cut-off score = 13 and RCI (90% CI) = 6; CORE-10 The Clinical Outcome Routine Evaluation – Outcome Measure 10; S6 – Session 6; FUP 3 – Follow-Up 3; RCI – Reliable Change Index; CI – Change Index; PO – Poor Outcome; GO – Good Outcome.

The pre-treatment phase was marked by higher levels of self-criticism (*M* = 47.5, *SD* = 8.74), self-punishment (*M* = 83.0, *SD* = 3.87), and depressive symptomatology (*M* = 10.9, *SD* = 3.48), which were found in all participants. These indexes were parallel to lower values of psychological well-being (*M* = 46.2, *SD* = 4.96) and lower self-forgiveness (*M* = 64.3, *SD* = 10.9), also evidenced by all participants.

The post-treatment and the follow-up session assessments show improvement on the majority of the clients, as can be seen in Tables II and III.

Table III. Letting Go Measure

Outcome Measure	Participants	Pre-Treatment (Initial Assessment)	Post-Treatment (S6)	Final Assessment (FUP 3)	Outcome
Letting Go Measure	P1	2	3	2	PO (Improved)
	P2	2	5	5	GO (Recovered)
	P3	1	5	5	GO (Recovered)
	P4	1	4	4	GO (Recovered)
	P5	2	5	5	GO (Recovered)
	P6	1	4	5	GO (Recovered)
	P7	2	5	5	GO (Recovered)
	P8	1	5	5	GO (Recovered)
	P9	1	4	4	GO (Recovered)
	P10	2	5	5	GO (Recovered)
	P11	2	5	5	GO (Recovered)

Note. See Greenberg et al. (2008) for RCI criteria applied Letting Go Measure-; S6 – Session 6; FUP 3 – Follow-Up 3; RCI – Reliable Change Index; CI – Change Index.

Clients improve in the overall measures, evidencing lower self-punishment (*M* = 48.0, *SD* = 13.3) and self-criticism (*M* = 22.9, *SD* = 13.5), lower depressive symptomatology (*M* = 2.91, *SD* = 3.94), higher indexes of psychological well-being (*M* = 88.5, *SD* = 9.59), and self-forgiveness beliefs, attitudes, and behaviors (*M* = 91.3, *SD* = 17.1). Ten of 11 participants achieve reliable clinical change, as assessed by the measure CORE-10 (Barkham et al., 2013). Regarding the 10 participants classified as good outcomes, they show improvements regarding the main variables; especially

relevant is their scores related to the letting go of the emotional injury (as assessed by the Letting Go Measure), comparing with the poor outcome case (see Table III).

Differences between Pre- and Post-Treatment

We conducted the Wilcoxon test to observe the differences between pre- and post-treatment (at 0 and 6 weeks, measured by CORE-10). The results show evidences of clinically significant change. One of eleven (9%) improved and one of eleven (91%) recovered. Median post-treatment score ranks were statistically significantly lower than pre-treatment (Wilcoxon, $Z = 11.0$, $p < 0.001$, *Cohen's* $d = 0.865$, 95% *CI* [8.23; 12.9]) (see Table IV).

Table IV. CORE-10

	CORE-10		Reliable Change Index (RCI)			
Participants	0 week	6 weeks	Worse	No change	Improved	Recovered
P1	18	16			✓	
P2	10	2				✓
P3	9	0				✓
P4	13	2				✓
P5	9	1				✓
P6	14	2				✓
P7	13	2				✓
P8	8	1				✓
P9	14	4				✓
P10	12	0				✓
P11	14	1				✓

Note. See Barkham et al. (2013) for RCI criteria applied to CORE-10 - General symptoms cut-off score = 13 and RCI (90% CI) = 6; CORE-10 The Clinical Outcome Routine Evaluation – Outcome Measure 10; RCI – Reliable Change Index; CI – Change Index; P - Participant

The reliable change index (RCI) for the CORE-10 indicates that the intervention was positive and successful for most participants, with only 1 participant being classified as a poor outcome case (P1). P1 showed lower levels of self-forgiveness and maintained higher levels of self-criticism by the end of the treatment. Besides its

decrease, and some improvement during therapy, this case did not show enough symptom change to be considered a good outcome case study, given that the degree of distress (measured through CORE-10) did not fall under the cut-off point. P1 is considered a poor outcome case regarding the presence of negative affect at the end of the treatment.

Correlation Between the Constructs

The results showed evidence of improvement for self-forgiveness, parallel with the improvement of psychological well-being and by the decrease of self-criticism, depression symptomatology and overall symptomatology. Self-forgiveness was negatively correlated with depression (r = -.689) and positively correlated with psychological well-being (r = .560). Thus, self-forgiveness was negatively correlated with self-criticism (r = - .812). Self-criticism was positively correlated with depression (r = .721).

DISCUSSION

Emotion-Focused Therapy (EFT) has been studying emotional injuries across several studies in the last decades, highlighting the positive role of forgiveness and letting go (e.g., Greenberg et al., 2008; Meneses & Greenberg, 2019; Paivio & Pascual-Leone, 2010). According to the literature, Emotion-Focused Therapy enhances the work with emotions, guiding the client to a deeper experiential work (Pos & Greenberg, 2007; Meneses & Greenberg, 2019), enhancing the awareness upon emotions and needs that, in a first instance, may not being accessible to the client (Elliott et al., 2004; Greenberg & Goldman, 2018). Most of the previous studies on the resolution of emotional injuries

have focused on the experience of victims – i.e., the injured person –, leaving open for future inquiry what would happen in the experience of offenders (i.e., the injurer). Here, the REACH Forgiveness model takes the lead by placing the focus on offenders as shown in previous clinical studies (such as Toussaint et al., 2020; Worthington et al., 2018), and helping them deal with their negative experiences due to the emotional injuries they have committed (characterized by negative affect, self-condemnation and self-criticism). The REACH Forgiveness intervention under this scope uses directive techniques to promote owning responsibility towards the offense, to allow opportunities to confront (not avoid) the situation, combined with soothing tasks, and empowerment of new skills and achievements regarding self-forgiveness.

This feasibility study analyzed the outcomes of an innovative clinical intervention to facilitate self-forgiveness, by integrating EFT and the REACH models, in a sample of (non-severe) offenders, recognizing themselves as the authors of an emotional injury to a significant other. In the present study, we tested one hypothesis which was supported by the current data. We tested for differences between pre- and post-treatment, as assessed by the main clinical outcome measure used in this study (CORE-10).

Results showed that the majority of cases (10 in 11) were considered good outcome cases given the comparison between pre- and post-treatment scores in their global symptoms, according to CORE-10. The outcome status of these cases was also maintained at the follow-up assessment, carried out six months after the end of the clinical intervention. The recovery of clinical symptoms measured by CORE-10 was also confirmed by other measures used here, namely to assess the evolution of depressive symptoms (PHQ-9) and the letting go of the injury (Letting Go Measure). Only one case in this sample was considered a poor outcome case (P1), although this participant showed reliable improvement in global symptoms (according to CORE-10).

The overall results reported here support the usefulness of this innovative clinical intervention, and suggest the effectiveness of EFT for resolving emotional injuries may be expanded from focusing on the experience of victims as in previous studies (see Meneses & Greenberg, 2019) towards helping offenders overcome their negative experiences in the aftermath of these interpersonal offenses.

Some authors argue that self-forgiveness has an important role in the reduction of self-criticism (e.g., Gilbert & Woodyatt, 2017), leading to the reduction of rumination and acute negative emotions (Wohl et al., 2010). For example, Costa et al. (2021; addressing our second study in CHAPTER II), showed that self-forgiveness tends to act directly or indirectly on depression and psychological well-being, through decreasing self-criticism, after an interpersonal offense. The results of the present study are consistent with the idea that offenders who experience guilt, regret, and remorse, can reduce self-criticism through forgiving oneself (Woodyatt et al., 2017; Costa et al., 2021). More specifically, this clinical intervention focused on facilitating self-forgiveness allowed (the majority of) participants to progress towards increasing levels of self-forgiveness and psychological well-being, and this evolution was accompanied by decreasing levels of self-punishment, self-criticism, negative affect and depressive and overall symptomatology.

Regarding to psychological well-being, results indicated that self-forgiveness was positively associated with psychological well-being. According to the literature, self-forgiveness is the process where the person relieves one's negative feelings, behaviors and emotions, in order to balance them with positive responses (Woodyatt & Wenzel, 2013; Worthington, 2006). These processes tend to increase psychological well-being (Massengale et al., 2017; Woodyatt et al., 2017), and lead to positive attitudes towards

the self, reaching the sense of the value and moral reintegration of the self (Peterson et al., 2017; Thompson et al., 2005).

Concerning the participant who showed less improvement during therapy, this may relate to the briefness of this treatment (in only six sessions). Moreover, this can as well can be related to internal characteristics of that client concerning the higher levels of self-criticism and self-punishment that was presented in the beginning. Thus, the trauma caused by the emotional injury can also be an influence on the clinical results (Pascual-Leone & Paivio, 2010), as well as on the relationship within the client-therapist dyad (Woodyatt et al., 2017). Thus, when a client commits an interpersonal offense, apart from the interpersonal consequences of the offense, they often experience higher self-criticism and/or self-condemnation (Pascual-Leone & Paivio, 2010; Peterson et al., 2017; Thompson et al., 2005).

CONCLUSION, LIMITATIONS AND IMPLICATIONS FOR FUTURE RESEARCH

The present study focused on assessing if an intervention combining EFT and the REACH Forgiveness model had clinical impact in the experience of self-forgiveness and psychological well-being of offenders after having committed an interpersonal offense to a significant other. The results are consistent with the theory, contributing to positive changes in the majority of the participants. Thus, this clinical protocol appears to be feasible and effective in our clinical sample of university students, suggesting that EFT and REACH Forgiveness may be beneficial regarding the healing of negative experiences reported by non-severe offenders of emotional injuries, through the process of self-forgiveness.

Focusing now on the limitations of this study, we have to acknowledge that the proposed protocol has only six sessions, which may be a limitation concerning participants who present more severe symptomatology at the beginning of treatment. More specifically, for the poor outcome case study in this sample, which presented a higher level of self-criticism, six sessions may have been too brief for this client to improve further. This is important for taking into account in the inclusion criteria of future clinical studies in this domain.

Furthermore, the small sample with 11 female participants, all university students within the same field of studies (social sciences), was a second limitation. The participants within this homogenous sample may have had other resources (e.g., due to their vocational path, educational level) that may have benefited the outcomes of such a brief intervention. Thus, it can be difficult to generalize the results to other samples. Hence, it is extremely important to test this protocol in a larger sample and with a different community (e.g., general community), by checking, for example, if the intervention needs to be longer with other clients or other presenting issues (concerning the type of interpersonal offense).

Other limitations concern the design of the present study. First, in the present study, it was not possible to compare the results with, for example, a waiting list control condition group. It would be interesting to assess the evolution of participants in these two different conditions (intervention vs. wait-list), and see if external factors contribute for participant changes. Second, it is worth highlighting that only one therapist conducted the therapy (although the assessments and follow-up sessions were conducted by two other researchers). This is also a limitation of the present study. Therefore, it is not possible to ascertain if the results obtained here are due to the

clinical intervention *per se* or if specific therapist effects are also playing an important part.

In conclusion, we believe it is important to replicate the present study in different contexts and in different samples, in order to see what type of results can be found.

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CONCLUSION

CONCLUSION

The present Chapter will be subdivided in four topics, where the author aims to elaborate an integrative synthesis of the main constructs analyzed and results that were found and discussed throughout the Thesis, as well as to enhance a general discussion regarding its contributions. In addition, the present chapter will also be focusing upon the limitations and future directions regarding these studies, making a few suggestions for future research. At last, the final topic develops a brief and integrative reflection regarding the path that involved the overall process leading to the present PhD Thesis.

Theoretical Framework of the Main Results

The studies aggregated in the present PhD Thesis support the theory that self-forgiveness tends to benefit psychological well-being, leading the person to positive affect, resulting in restored and positive responses towards the self and preventing, as well, depressive and overall symptomatology. These main conclusions are based on the findings of the five studies presented, which were in congruence, not only with the theory (e.g., (Costa et al., 2021; Greenberg et al., 2008; Kazoun, 2018; Meneses & Greenberg, 2019; Woodyatt & Wenzel, 2013; Woodyatt et al, 2017), but also were connected between them.

The first study analyzed the psychometric properties of two self-forgiveness measures adapted for the Portuguese population, i.e., SSFS (Wohl et al., 2008) and DSFPS (Woodyatt & Wenzel, 2013). Their results show that the Portuguese versions of the SSFS and DSFPS exhibited good psychometric properties for use in this population. The measures also showed positive indicators regarding the association between self-forgiveness, self-criticism, psychological well-being, and depression.

The second study focused on the analysis of whether self-forgiveness acted directly or indirectly on depression and psychological well-being through self-criticism and self-reassurance after an interpersonal offense. The main results supported the theory concerning that self-criticism was expected to influence, directly and indirectly, the association between self-forgiveness and psychological well-being. In this sense, self-forgiveness could have an important role in the reduction of self-criticism (Gilbert & Woodyatt, 2017), leading therefore to the reduction of rumination and acute negative emotions (Wohl et al., 2010). Under this background, self-forgiveness tends to promote the capacity to tolerate negative emotions and the ability to use them appropriately (in terms of social and intrapersonal functioning). Therefore, the person can reconstruct a more positive attitude towards the self, promoting a moral reintegration and restoration without condoning their own negative behavior (Peterson et al., 2017; Thompson et al., 2005).

In the same study, the results indicated that self-forgiveness was positive to the person, increasing one's sense of psychological well-being, associated with positive emotions and responses to the self.

The third study enhances the novelty of the present PhD Thesis, by presenting an integrative and brief clinical protocol, planning the stages of a feasibility study. This takes into account the size of the sample and the necessity to adapt the intervention to the needs of the participants (e.g., Hoddinott, 2015). The clinical protocol was elaborated by combining the assumptions of Emotion-Focused Therapy – EFT (Greenberg & Goldman, 2018; Meneses & Greenberg, 2019) and the REACH Forgiveness model (Worthington, 2006; Wade et al., 2014). The novelty here was the attempt to expand EFT for the resolution of emotional injuries (with prior research well established on the experience of victims; i.e., the injured person) to a new set of clients,

namely by focusing on the experience of (non-severe) offenders. For this, the clinical protocol incorporated guidelines from the REACH Forgiveness model, given their prior studies with this type of clients (see Worthington, 2006; Wade et al., 2014). In this sense, the third study was subdivided in two studies:

Study 1. Presentation of a Clinical Protocol in Emotion-Focused Therapy and Reach Forgiveness model;

Study 2. Description of a good outcome case: The case of “Christina”.

The data of the third study – especially the evolution of this good outcome case – was in line with the theory, according to Greenberg and colleagues (2008), Greenberg and Goldman (2018), Meneses and Greenberg (2019), Worthington (2006), Wade and colleagues (2014). These authors suggest that the crucial process for facilitating self-forgiveness is related with the awareness upon the injury, the emotions related to it, which lead to the change process (e.g., Greenberg et al., 2008; Meneses & Greenberg, 2019; Wade et al., 2014; Worthington, 2006; Woodyatt et al., 2017). Most importantly, this awareness regards on how the client feels about the process of letting go the negative emotions (e.g., self-criticism, shame, anger) and allowing oneself to feel positive emotions, such as self-compassion, self-generosity and/or self-acceptance (Greenberg et al., 2008; Meneses & Greenberg, 2019; Woodyatt et al., 2017).

The main purpose of the clinical intervention regarded the Empty-Chair task to deal with the marker of unfinished business (related to the emotional injury), also focused by the authors Greenberg and colleagues (2008) on a prior clinical trial. In that study, the main purpose was to resolve unfinished business and facilitate the letting go of the emotional injury/injuries of the clients. Although forgiveness/self-forgiveness was not the main goal of the trial, this EFT intervention had positive, indirect effects on the process of forgiving the injurer (offender). The Empty-Chair is an experiential task,

which guides the client – through imagination – to put the author of the committed offense in an empty chair and to express the unresolved feelings related to the injury, accompanied by a caring, empathic therapist, who facilitates the resolution process (Greenberg et al., 2008; Meneses & Greenberg, 2019).

However, other tasks are used and have an important role in this type of EFT intervention, namely: the Two Chair Dialogue, where the client faces internal conflict splits concerning the presence of self-criticism. To adapt this intervention to a new sample of clients (non-severe offenders), we have incorporated the five steps of the REACH Forgiveness model, and especially the Imaginary Confession task, where clients confess the committed offense in order to promote adequate responsibility and foster new meanings to the situation of emotional injury they have authored (see CHAPTER III, Study 1).

Study 2 (also, see CHAPTER III) describes the case of "Christina", following the guidelines of Stiles (2010; 2015) regarding the Theory-Building Case Study. In line with the assumptions of EFT and REACH Forgiveness, the case of "Christina" highlights her awareness about her wrongdoing, as well as her sense of responsibility of the committed offense. This predisposition to self-forgive allowed "Christina" to take a new perspective of the situation. It was possible to work with her high self-criticism by implementing the task of Two Chair Dialogue from EFT, which was something that was blocking her in terms of overcoming the negative affect that she felt towards herself. The clinical intervention promoted in "Christina" the balance between two sides – the critical self and the vulnerable self (causing a conflict split, according to EFT) – which permitted her to self-forgive, step by step. According to the REACH Forgiveness model, "Christina" make a commitment to forgive herself, by empathizing with herself and by giving herself an altruistic gift, which implicated writing positive notes about

herself and adopting more self-care attitudes and behaviors. At last, “Christina” was able to hold on to her self-forgiveness, which was very much sustained by her involvement and effort and will to change, noticed during all the clinical intervention.

The fourth study (in CHAPTER IV) described a poor outcome case study (“Chloe’s case”), enhancing the importance to understand, as well, the evolution of poor outcome cases studies in the present PhD Thesis and in general psychotherapy research. Embracing the same theory of the previous studies, and giving a continuum to the clinical protocol, “Chloe’s” case was described under the assumptions of EFT (Meneses & Greenberg, 2019) and the REACH Forgiveness model (Worthington, 2006; Wade et al., 2014), and following the guidelines of a Theory-Building Case Study, drawn from Stiles (2010; 2015).

In contrast, “Chloe’s” case evolution did not confirm the evolution expected according to previous research that showed direct and indirect effects between self-forgiveness, self-criticism, self-reassurance, and psychological responses, such as in depression and general symptoms, and psychological well-being (e.g., Costa et al., 2021; see CHAPTER II).

According to the theory, some researchers (e.g., Greenberg et al., 2008; Kazoun, 2018; Meneses & Greenberg, 2019; Worthington, 2006; Woodyatt et al., 2017) indicate that self-forgiveness tends to be associated with a motivation and consciousness, during the change process, to develop a more positive, compassionate attitude toward oneself. Therefore, it focuses on the person’s feelings about letting go of the negative emotions, giving space for new meanings and positive affect to arrive (Woodyatt et al., 2017).

Even though she was able to benefit from these six sessions, “Chloe” presented lower improvement regarding the process of self-forgiveness, self-criticism, and psychological responses (psychological well-being, depressive, and overall

symptomatology). This guided to classifying her as a poor outcome case, when comparing the scores of the main outcome measures in the pre- and post-treatment phases. Her negative affect maintained until the end of the therapy and, focusing on the measure of Letting Go (Greenberg et al., 2008), we can understand that "Chloe's" belief that she did not deserve to be forgiven by herself remained mostly unchanged over the course of the intervention. However, it is important to highlight that there was some improvement regarding towards the softening of her critical side, which helped "Chloe" to regulate her levels of self-criticism and slightly decrease her indexes of self-punishment.

In our view, "Chloe" needed a few more sessions to increase the level of change. At the time, she was invited to continue therapy, outside of the present protocol, an aspect she declined at that moment.

The fifth study of the present PhD Thesis regards the implementation of a feasibility study to analyze whether this pioneering intervention in EFT and REACH Forgiveness model had an actual clinical impact in self-forgiveness and psychological well-being after an interpersonal offense. Therefore, its goals were addressing to one main hypothesis - We hypothesized that a person with individual brief intervention in EFT and REACH Forgiveness model would accomplish the following: (a) decrease the presence of general symptomatology from the pre- to post-treatment; (b) reduce the negative affect towards the self (as measured by the Letting Go Measure); (c) show improvement in self-forgiveness and its correlation with other constructs (self-criticism, negative affect, and depression).

The findings supported the hypothesis, pointing to the usefulness of this clinical protocol in the softening of the negative experiences of an offender who experiences guilt, regret, and remorse, and then forgives the self, tends to develop lessening self-

criticism (Woodyatt et al., 2017; Costa et al., 2021). The findings in this sample also suggest that this clinical intervention is capable of helping (non-severe) offenders reduce depressive and overall symptomatology, self-criticism, and negative affect. Moreover, the results evidence benefits in other psychological responses towards the self, such as psychological well-being. The results of this feasibility study were also consistent with the theory of the changes that occurred, leading to the reduction of depression, self-criticism, and to the increasing of psychological well-being (addressing CHAPTER II and III). Thus, the clinical protocol appears to be feasible and effective, at least for this sample of university students.

Overall, these findings encourage us to argue that an integration of EFT and the REACH Forgiveness model can be beneficial for expanding the applicability of EFT in the resolution of emotional injuries: i) by focusing on the experience (non-severe) offenders (authors of an emotional injury); and ii) transforming intense levels self-criticism and self-condemnation; through iii) steering the process towards self-forgiveness, as a way to heal the negative impact of emotional injuries.

General Discussion and Contributions

In our view, the present PhD Thesis represents an important contribution regarding the challenging nature of the theme. The majority of the conducted studies place their efforts in the perspective of the victim of an emotional injury or an interpersonal offense. Given that society usually expresses intense and negative views/expectations towards the benefits of adopting a more compassing and rehabilitating attitude towards offenders (e.g., Buen et al., 2020), choosing to study how to facilitate the healing – through self-forgiveness – of the negative experiences of offenders can become a defiant, controversial scientific topic. To study the perspective of an offender, even if it

concerns the authoring of a non-severe emotional injury, turned out to be challenging, in the sense that researchers may never know what to expect. This brief reflection addresses the importance of humanizing errors and leads to the notion that every human makes mistakes/offenses; however, it is vital to enhance the notion of responsibility for the committed offense, and the importance to emend such type of negative experiences and to adopt a more compassionate stance (for the victim and as well as for the offender).

The notion of self-forgiveness, as previously referred, is considered the stepchild of the Forgiveness research. However, step by step, more studies have been conducted in several areas and countries, and even in Portugal. In 2014, when I started this PhD program, very few researchers conducted this type of studies in Portugal. Notable exceptions come from the work of Félix Neto, who has developed studies and theoretical proposals upon the forgiveness process in several samples and countries, such as Africa, Asia, Southern Europe, and/or Latin America. In turn, comparing for example with our Spanish friends, there are more published studies on forgiveness and self-forgiveness conducted with Spanish teams, especially in the field of clinical psychology. From those, we can highlight, for example, the contributions made by María Prieto-Ursúa and Rafa Jódar Anchía (both from University of Pontifícia Comillas, Madrid, Spain), Yárnoz-Yaben (from University of the Basque Country, Spain) and Maria Fernández-Capo (Universitat Internacional de Catalunya, Spain).

Everett L. Worthington, Jr., one of the mentors of the present PhD and one of the most important researchers concerning his contribution to self-forgiveness and to forgiveness theme, has been conducting studies trough several years. In the United States, Forgiveness researchers are much more in advance, comparing with Europe. However, the science turned out to be just like that – a process that grows, replicates,

and consolidates over time, even in Latin Cultures such as Portugal, as recently argued by Rique et al. (2020).

The studies conducted by Worthington and Greenberg and their several colleagues, mentioned above, were very rich in terms of knowledge, different variables, and transversal processes that can be introduced in parallel to a second therapeutic model. The process of forgiveness and/or self-forgiveness for the resolution of emotional injuries and unfinished business, either from the perspective of Emotion-Focused Therapy or the REACH Forgiveness model, turned out to be very productive for inspiring this PhD Thesis, given their clinical results concerning the overall well-being of the person, and the literature extend these positive benefits to the improvement of specific (e.g., depression) and overall symptomatology.

Highlighting all of the above researchers, studies, and results, they contributed for the present project, integrated in the present PhD Thesis. The curiosity by this PhD candidate, and her main advisor, to study the perspective of the offender led to the series of studies presented above. In Portugal, in 2014, there were no measures that could assess self-forgiveness. In that sense, this process started with the validation of two measures, which in fact both of them assesses self-forgiveness, but in different dimensions. Then a question came up:

What if these two measures (SSFS and DSFPS) can be a complement in the clinical practice for the clients who have unresolved situations?

The mentioned study was a contribution for the research in Portugal, regarding the existence of two Portuguese measures, validated for the Portuguese population. Then, the results lead to the need to study the direct and indirect effects of self-forgiveness,

self-criticism, self-reassurance, psychological well-being, and depression. In this sense, this Thesis became a path in a continuum of theory, project, empirical studies, and a PhD story which led to the need to create a clinical protocol, based on the theory of Emotion-Focused Therapy and on the principles and techniques of the REACH Forgiveness model.

Greenberg and colleagues, who, in 2008, studied the effects of the resolution of emotional injuries trough the Empty-Chair Task and with indirect effects in forgiveness, inspired the elaboration of the present protocol. Their results encouraged us to go further, adapting and replicating their study by focusing in the perspective of the offenders, and adding the principles of the REACH Forgiveness model to the Emotion-Focused Therapy.

The spotlight of the present PhD Thesis regards the study with offenders, authors of non-severe offenses/emotional injuries to significant others. Studying the psychometric properties of the SSFS and DSFPS for the Portuguese population, and conducting a clinical intervention in the format of a feasibility study enhances the novelty of the theme and of the intervention itself. The subsequent studies intended to describe the results deriving from the previous studies, enhancing in this sense the importance of describing two case studies (good outcome vs. poor outcome), and finally to find out the impact that the clinical intervention had on the eleven participants, who were brave enough to self-disclose about their wrongdoings to their therapist and her research team.

The present PhD Thesis is a contribution with several names, regarding all the participants, researchers, and mentors that were involved.

Limitations and Future Directions

Several limitations can be highlighted in the present PhD Thesis, as well as the acknowledgment regarding some research that needs to be conducted in the near future. Science can be seen as the replication of the limitations of previous studies. In this sense, it is important to state the limitations of the five studies, combining with suggestions for futures studies.

The first study is addressed in CHAPTER I - *Construct Validity of Two Measures of Self-Forgiveness in Portugal: A Study of Self-forgiveness, Psychological Symptoms, and Well-being.* In this study, a specific sample of Portuguese university students was used, which in consequence, does not allow generalizing the results to other segments of the Portuguese population. However, other similar studies have been conducted throughout the years adopting the same method and contributing to the literature (e.g., Woodyatt & Wenzel, 2013; Castilho & Gouveia, 2011).

Similar to previous studies, the present study adopted a cross-sectional design, given the (a) difficulty to conduct a temporal stability computation, and (b) difficulty to demonstrate causal predictive validity of the scores. In this sense, further studies are required to deepen our knowledge upon the process of self-forgiveness in psychotherapy and in terms of its applicability in clinical and non-clinical populations. Thus, it would be useful for future studies to focus on other samples such as general population.

The second study is addressed in CHAPTER II - *Self-forgiveness Acts Directly and Indirectly to Affect Psychological Well-being and Depression through Self-criticism and Self-reassurance after an Interpersonal Offense.* This study focused on only one moment of assessment to study the direct and indirect effects of these variables, following previous published studies (e.g., Song et al, 2020; Juan et al, 2020). The

indirect effects obtained here suggest that a mediation process could possibly be occurring but that would require longitudinal design to adequately ascertain. In addition, we used university students, and it is conceivable that older adults who have had more life experiences might behave differently. Therefore, it is important to continue studying these constructs, and extend to other type of variables, contexts, and population.

The third study is addressed in CHAPTER III - *Self-Forgiveness and Psychological Well-Being: Clinical intervention protocol in Emotion-Focused Therapy and REACH Forgiveness model.* This study had a small sample, illustrating the difficulties for conducting larger clinical trials. However, the adopted format of a feasibility study (e.g., Hoddinott, 2015) allows researchers to approach the protocol to the needs of the sample, and even allow changing it in order to promote a better intervention regarding the needs of the participants. In this sense, future research needs to be conducted in order to replicate and expand the protocol presented here in other formats (e.g., clinical trial; older population; different therapeutic models; adapting the protocol to the needs of the sample, enhancing the need to conduct in more sessions).

The fourth study is addressed in CHAPTER IV - *The case of "Chloe": A poor outcome case study in Emotion-Focused Therapy and REACH Forgiveness model.* It is important to acknowledge the theory of Worthington regarding the Decision to Forgive and Emotional Forgiveness (Worthington, 2009). According to the theory, these two types of forgiveness are related to stages in the process, where the first one, Decision to Forgive, is associated to an immediate effect of the will to forgive; the second one, Emotional Forgiveness, is related to a deep process of forgiveness, involving a more profound work. Hypothetically, this could be one of the reasons for "Chloe's" poor results, regarding her process of self-forgiveness. Specifically in the case of "Chloe", it is important to state that this study concerned a very brief therapy, and this client

presented with more severe symptomatology evidenced, for example, in her higher levels of self-criticism. More sessions were possibly needed in order to work more deeply with some of the concerns and issues that appeared during the sessions. In this sense, it is important for future research to expand the knowledge about distinct forgiveness processes – namely the Decision to Forgive and Emotional Forgiveness – as important variables to take in account.

The fifth study is addressed in CHAPTER V - *Clinical outcomes of a self-forgiveness intervention integrating emotion-focused therapy and reach forgiveness model.* Following the previous studies, study 5 analyses the clinical results presented by a small sample. Small samples, although easier to obtain, represent some challenges at the analytical level, and it was difficult to conduct more robust statistical analyses. However, and according to other feasibility studies (e.g., Hoddinott, 2015), it was possible to see the positive results of this clinical intervention regarding the main variables of global and depressive symptoms, self-forgiveness and letting go and self-criticism and punitive self, even with only 11 participants. In this sense, it would be important to replicate the present study with a different team of therapists, in different contexts and with a different, larger sample (with offenders coming from the general community, for example), in order to check if the results obtained here can be confirmed, and extend to other type of statistical analyzes and other type of variables.

In conclusion, and according to the *Handbook of Forgiveness, 2nd ed.* (Worthington & Wade, 2020), numerous authors expressed more interest in seeing research in the future on the interpersonal context of offenses rather than what has been the case in the first 20 years of intensive research on forgiveness—a focus on the internal forgiveness processes of the victim.

The Path of the Present PhD Thesis

The present Ph.D. Thesis was a challenge that lasted for six, almost seven years. It was a privilege to study such an inspiring theme, as well as to work with such inspiring mentors, co-workers, and clients. Without them, it would not be possible to write this Thesis. I am trying to write the right words, but in confidence to whomever reads this, I am feeling that I have no words for the experience that I am feeling during the writing of these words. My gratefulness says it all, as I stated before.

In a brief synthesis, this conclusion highlights the main results and an overall perspective regarding the theme that was studied. As described before, self-forgiveness and psychological well-being were the constructs that are at the spotlight during this PhD Thesis. Two powerful constructs, and even so, still so much needs to be done.

Hopefully, I expect to see much more studies and data related to self-forgiveness and psychological well-being, all over the world, and especially, in Portugal. An open door, to study this theme in different contexts, and with different samples, is urgent, in order to comprehend how self-forgiveness is related and reacts to these different dimensions and approaches.

Self-forgiveness and psychological well-being tend to be associated, and are beneficial for those who struggle with unresolved situations and/or offenses, which sometimes tend to last for so many years. In a personal level, self-forgiveness is the liberation of the negative feelings that a negative situation may promote. In my opinion, offenders deserve to have a second chance, if they demonstrate regret. The power of the words goes beyond our imagination, and leaves so much scars that sometimes people do not recognize or notice.

So, and again, in my personal perspective, as a therapist, as a researcher, and as a human being, self-forgiveness is an open door for the reestablishment of our sense of

gratitude and liberation regarding a negative experience, leading therefore to more positive responses towards ourselves, such as self-compassion, self-acceptance, and/or self-giving love.

Like the way I started, I finish with a final note (the same one), from Mahatma Gandhi:

"Forgiveness is choosing to love.
It is the first skill of self-giving love."

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