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KERNBERGIAN PSYCHODYNAMICS AND RELIGIOUS ASPECTS OF THE FORGIVENESS PROCESS

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The concept of forgiveness is defined and placed in an object relations framework of Otto Kernberg and of John Gartner. The latter presents an interpretation involving the overcoming or splitting which is a kind of proto-forgiveness applicable for treating borderline patients. Given this context, a model of five stages in the forgiveness process is outlined. These stages are adapted from Linn and Linn (1978) and from Kernberg (1992). It is proposed that the crucial last stage requires more than self-acceptance. Specifically, recovery from genuine harm done to others or the self (real guilt) requires repentance and forgiveness, neither of which can be supplied by psychotherapy. Positive clinical signs of genuine forgiveness are briefly described, as are ways in which forgiveness is often put in the service of pathology, such as false forgiveness. Clinical procedures to facilitate forgiveness are noted.

In this article, the term *forgiveness* refers to a person's conscious decision to give up resentment and any claims for redress from someone who has hurt him or her. (For systematic discussion of definitional and psychological aspects of forgiveness, see Enright et al., 1991.) The psychological processes presumed to be involved in the act of forgiveness are a central focus here, since it is clear that the underlying dynamics of a patient can encumber, and may render impossible, genuine forgiveness.

In the early sessions, psychotherapeutic work commonly focuses on the depth or developmental level of tie patient's psychopathology. Otto Kernberg (1984) has made a major contribution in describing the phenomenology of severe personality disorders. As Gartner (1992) has noted, Kernberg takes, as his operational definition of character pathology, the use of primitive defenses in conjunction with the maintenance of reality testing. Kernberg has specified "that the dividing line between character pathology and higher level neurotic functioning lies in the integration of good and bad object representations" (Gartner, 1992, p. 23). To perceive and experience oneself and others as integrated, complex persons with needs, rights, etc., and with positive and negative qualities is the road to health. Extreme devalued or idealized internal representations of self and others are the mark of splitting and, therefore, of serious illness (Gartner 1992). Splitting involves the separation of both the positive and negative affect associated with a given person (object) and the separation of the supporting cognitive structures. Though Kernberg's scale is in some respects overly schematic, it is nonetheless useful for conceptualizing the general depth or developmental level of a patient's psychopathology.

An early task, then, of the therapist focusing on the forgiveness process is to determine the level of object-relatedness of the patient, that is, his or her location on the "vertical axis." One important goal of the therapy is to help the patient move up to a higher level of functioning. The therapist should pay particular attention to whether the patient has achieved object constancy (a lasting, integrated, internal representation of important others in their physical absence). Another question is whether the patient appears to be rejecting forgiveness due to neurotic characteristics or to higher level psychological processes such as conscious choice or an absence of positive motivation, or has a pre-object-constancy level of development where there is still much splitting. In these cases, the patient is more likely to be influenced by primitive psychological needs and anxieties.

GARTNER'S MODEL: IMPROVEMENT ON THE VERTICAL DIMENSION

Gartner (1992) pointed out that borderline personality disorder patients, who so vividly display the splitting defense, provide a dramatic challange for the therapist to show that he or she has not given up on the patient in spite of the patient's frequent expression of hostility. Examples of commitment include the fact that the therapist still comes to sessions, still focuses attentively on the patient's internal and external world, and, perhaps most importantly, still actively supports him or her. These are behavioral expressions of responsible love shown by the therapist, and often interpreted by the client as implicit forgiveness.

Gartner specified that such support allows the patient to reintroject the split-off negative self-representations without overwhelming or destroying the good self-representation. "I was hostile, envious, ungrateful, etc., and my therapist liked me, accepted me, valued me anyway." This gives hope to the patient. Splitting is no longer needed. The patient feels secure and safe, and the reality of self and others is more easily accepted. Gartner stated that it is an act of love and a corrective emotional experience to tolerate and to contain the borderline patient's aggression without retaliating or withdrawing.

As Waldinger and Gonderson (1987) wrote,

> Kernberg's view of treatment is most classical and least concerned with corrective experiences. Yet even he writes of the importance of the therapist's "holding" the patient, that is, tolerating the patient's expression of intense ambivalence. As the patient sees that the therapist does not crumble under the patient's aggressive onslaughts, the patient's fears about his or her own impulses diminish and the integrative ego-functions are strengthened. (p. 18)

This is true for all patients, with all diagnoses, even when the hostility is not transferred to the therapist but to someone else. Gartner has proposed that the ability of the therapeutic relationship to endure the transference of hatred and aggression serves as a living contradiction to the idea that either the patient or the therapist is "all bad." The therapist's persistent support thus constitutes an implicit behavioral expression of forgiveness, because the patient's bad behavior has been overlooked or set aside. Loving behavior has been shown in return. Such therapeutic support is "proto-" or "implicit" forgiveness, since the therapist normally does not actually decide to forgive; nor is forgiveness generally verbalized in any direct sense.

At times, however, the therapist may directly forgive a patient for expressing hostility; even more therapeutic may be the occasional times when the therapist may apologize to the patient for the therapist's mistakes or hurtful behavior which were perhaps not intentional, for example, having to be out of town for a particular session (see Gartner, 1992). In these instances, the oppertunity for forgiveness, even of minor wrongs, is offered to the patient.

In time the patient has examples - implicit and sometimes explicit - of forgiveness, and often the desire now to forgive others. But even here, as the authors have observed, the patient may decide not to forgive, out of fear, pride, selfishness, etc. Again, object-constance can facilitate real forgiveness, but the fact of one's ability to forgive does not mean that one will.

Often in psychotherapy with non-borderline patients, there is no hatred of the therapist but rather of others, such as parents, siblings, peers, co-workers, etc.; this hatred is frequently not transfered to the therapist. In this situation, the therapist uses the therapeutic alliance with the patient to facilitate forgiveness by mobilizing the cognitive, affective, and volitional ability of the patient (see later discussion).

In splitting, the perception of the other is caricatured; the other is simply "all bad." When this happens, the person also uses the defense mechanism of projection. The bad self-representation - the self who has been injured - in reality or fantasy - and feels hatred is almost certain to be projected onto persons and/or groups. "I hate, but that person (or group) is making me feel hateful feelings. The badness comes from that person (or group)."

The negative consequences of this process - the price paid - is the experience of being persecuted by the evil person(s) that one has created. This is the anxiety of the paranoid. Gartner (1992) wrote that apparently "the only author who has appreciated this aspect of forgiveness is Hunter (1978) who has stated that "... the development in the individual of the capacity for forgiveness should be seen in relation to its polar opposite, the fear of retaliation and paranoid anxiety" (p. 24).

Gartner (1992) has also noted that "experiences of catastrophic abuse later in life will also mobilize aggressive feelings that are too severe to be integrated" (p. 11), and splitting is reactivated to manage the

aggression. Victims of the Nazi concentration camps, victims of severe psychological and/or physical abuse in satanic cults are extreme examples of normals who often show the splitting process. (Keep in mind that all children presumably use splitting in the early years. We assume that under great stress even normal people can regress to splitting.)

Gartner (1992) proposed that authentic forgiveness is not the replacement of negative affect with positive loving feelings, as is commonly believed. Authentic, mature forgiveness requires, as a pre-condition, an integrated realistic perception of both the positive and negative aspects of self and others. This cognitive dimension of being convinced of one's own and of others' dual nature is essential.

Our proposed psychological explanation for why splitting prevents forgiveness is the following: When the patient is all good and his or her enemy is experienced as all bad, there is a complete qualitative distinction between the self and the other. This difference - this conceptual abyss - makes it impossible for the patient to empathize with the other. Only awareness of the other's good qualities and of the self's bad features allows recognition of the other as like the self. Otherwise the other is almost a different species - a demon. And human beings do not forgive demons.

People can genuinely have cognitive and affective empathy for "the enemy," for example, and still refuse to forgive since the benefits of hatred can be allowed to interfere (Vitz & Mango, 1997). Persons do not automatically forgive simply because they have been loved, or have achieved insight, or can empathize with others. (see Cunningham, 1985; Pingleton, 1989.) Even for good and normal people, forgiveness injures narcissism - it hurts.

The Kleinian concept of reparation is apparently a necessary psychological precondition of authentic, mature forgiveness. Reparation is a psychological process presumed by Klein (1964) to occur in the first year, whereby the infant tries to repair the negative effects which his or her destructive fantasies have had on the love-object (the mother). This mechanism is associated with anxiety, guilt, and depression. The fantasied reparation of the external and internal maternal object representation is said to permit the overcoming of the depressive position by guaranteeing the ego a stable identification with the beneficial object.

Infantile sadism is expressed in fantasies of destruction and fragmentation, of devouring, tearing, emptying, exhausting, etc. It is in response to the anxiety, guilt, and depression intrinsic to this position that the child during the first year of life tries to maintain or restore the wholeness of the maternal body. Various fantasies of the infant (according to Klein) represent repairing the damage done by the sadistic fantasies, such as preserving the mother's body from the attacks of "bad" objects.

Other reparative fantasies include putting the dispersed bits of the object back together again, bring what has ben killed back to life. By this restoring of wholeness to the love-object and negating all the evil that has been done to it, the child is said by Klein to be assured of the possession of a thoroughly "good" object, whose introjection will strengthen the self. These fantasies of reparation therefore have a structuring role in ego development.

The effort to undo the condition of disintegration to which the object has been reduced presupposes the necessity to make it beautiful and perfect. This unconscious reparative again described by Klein (1964) is the precursor to what can become true or mature forgiveness. Reparation is essentially a primitive drive for justice and union with the originally loved object.

THE FORGIVENESS PROCESS: MOVEMENT ON THE HORIZONTAL DIMENSION

Forgiveness is presumed to be the culmination of the stages shown in Table 1. *(See Table 1 at end of article. Ed.)* The last stage - Stage 5 - is rarely examined in detail in psychotherapy. It is the present thesis that pathological object-relations, trauma-related depression and severe hatred for example, are never really resolved without two normally religious processes: repentance and forgiveness. Therefore a more thorough clinical understanding of the stages in Table 1, especially the last stage, is needed.

The stages and their sequence shown in Table 1 should be understood as schematic simplifications. In actual psychotherapy aspects of later stages may occur at the same time as earlier stages. There is often backing and filling, as well as complex interaction among stages. But we, like others, have found the oerder shown in Table 1 to represent the logical therapeutic sequence.

THE LINN MODEL

A major contribution to the understanding of the psychology of forgiveness has been made by Matthew and Dennis Linn (1978) (see Table 1, top row). The Linn bothers observed that the five stages of the death and dying process described by Elizabeth Kubler-Ross (1969) can also be applied to understanding forgiveness. According to Bretherton (1992), Kubler-Ross appears to have been influenced by Bowlby's description (Robertson & Bowlby, 1952) of the psychological stages in a child's response to separation from his or her mother; these were elaborated into four phases of grief for adults by Bowlby and Parkes (1970): (a) numbness, (b) yearning and protest, (c) disorganization and despair, and (d) reorganization.

In working with persons who have experienced psychic injury, the Linns identify, first, the injuries, second, the stage of the forgiveness process at which the patient is currently located. They concurrently empathize with patients and help them continue the forgiveness process. We also propose that Kernberg's (1982) model of recovery in borderline patients can be interpreted as another example of the general model shown in Table 1.

Kernberg's Stages 1 and 2 rather nicely parallel those proposed by Linn and Linn (1978). The third stage, called "bargaining" by the Linns, is not explicitly found in Kernberg. However, Kernberg does acknowledge resistance as a kind of intervening clinical situation and therefore we propose that he recognizes something roughly equivalent to this stage. Stage 4, depression, is found in each model in relatively similar form. Stage 5, involving resolution, is similar in all models, but there are important distinctions.

In our model of this process, found on the bottom row of Table 1, we accept the first two stages as derived from the earlier theorists. Stage 3, we believe, is better described as "resistance," since bargaining is only one form of resistance, and this term is consistent with Kernberg's general understanding of borderline recovery. Resistance is triggered by subjects' growing awareness of their own responsibility for much of their hatred and their sense of the possible emergence of depression, as well as an unconscious understanding that they will have to let go of their hatred. The possibility of depression is resisted for obvious reasons, and the reasons for resisting the letting go of hatred are described in Vitz and Mango (1997). Resistance can express itself in silence, avoidance of sessions, in arguments with the therapist over the legitimacy of hatred, and in avoidance of further progress on the horizontal dimension by side-tracking the therapeutic session into irrelevant topics. In short, besides directly resisting and bargaining, it is through various forms of avoidance that this stage is often expressed. Stage 4 is more or less the same in each model, except that we make a distinction between normal grief and mourning and clinical depression.

There are commonly specific signs which accompany each stage. Denial is often accompanied by pain-killing, mood-altering activities and addictions such as alcohol, food, drugs, work, or sex. Addictions of all kinds are typically attempts to numb the pain at Stage 1. In Stage 2, where anger and rage are expressed, accompanying signs are pervasive self-pity, passivity about other aspects of life, and extreme devaluation of the other and of those similar to the hated person. Defenses such as splitting, fantasy, rationalization, reaction-formation, projection, idealization, devaluation, repression, and obsessive preoccupation with the hated other are also often observable at this stage.

Signs of Stage 3 resistance include ambivalence toward forgiveness, compulsive returning to expressions of hatred or to the scene of being hurt, resistance to empathy or compassion for the enemy, setting of preconditions, and a sense of entitlement. Stage 4 signs include sadness or tears over harm done to others and self, and depression over lost years and oppertunities; expressions of despair and clinical depression. The latter two are often associated with rejection of any self-responsibility for one's condition.

Crucial issues arise with respect to Stage 5. This stage is not developed in much detail be Kernberg, but one important process in recovery from the depression is acceptance of the self and of others. This acceptance involves the integration of both good and bad self aspects, and thus the overcoming of splitting. This will also create healthy guilt and mourning in the same way that overcoming splitting in infancy sets up a need for reparation. Certainly to accept oneself and others as flawed human beings is necessary for psychological health because it corresponds to a realistic understanding of oneself and others. Along with Gartner and the Linns, we consider this sort of acceptance to be one important component of the final stage, but we propose that another major process is also necessary in Stage 5, namely forgiveness, which involves much more than self-acceptance.

A DILEMMA OF SECULAR PSYCHOLOGY

A major problem arises when the patient must face genuine guilt. When one has, in fact, through one's own behavior, hurt other people or hurt oneself in a serious way, sefl-acceptance is a seriously inadequate response. Thus, an initial difficulty for a non-religious psychology is that self-acceptance is an unsatisfactory response to major harm that one has done to another or to oneself.

Some psychologists might suggest self-forgiveness. But people cannot forgive themselves for a crime or harm against another. A criminal who forgave himself for his deeds (such as murder, rage, or theft) would rightly be seen as self-indulgent, and perhaps even as psycopathic. The problem is a very basic one because we believe that the scriptural understanding that people have all sinned and that no one is just before God is an empirically accurate description of each person's condition. As humans we all have real guilt - and what are we to do with it? The prominent psychologist O. Hobart Mower (1960) put the problem clearly some years ago:

> For several decades, we psychologists looked upon the whole matter of sin and moral accountability as a great incubus and acclaimed our liberation from it as epoch-making. But at length we have discovered that to be "free" in this sense, i.e., to ahve the excuse of being "sick" rather than sinful, is to court the danger of also becoming lost... Just so long as a person lives under the shadow of real, unacknowledged and unexpiated guilt, he cannot (if he has any character at all) "accept himself", and all our efforts to reassure and accept him will avail nothing. He will continue to hate himself and to suffer the inevitable consequences of self-hatred. (pp. 303-304)

The dilemma for a non-religious psychology is that if one believes that people cannot forgive themselves, then where are they to find forgiveness? Who can dispense forgiveness? As Freud himself once said: "And now, just suppose I said to a patient: 'I, Professor Sigmund Freud, forgive thee they sins.' What a fool I should make of myself" (Freud/Pfister, 1963, p. 125).

Although forgiveness involves pardoning another person, we propose that self-forgiveness or self-pardon is not a defensible position. When an individual forgives another person, that individual is asked to judege the other's action, and forgiveness is to pardon it. The individual does not judge the other person, but only the action. He or she is to "hate the sin but not the sinner," however psychologically difficult this is to do. But if an individual can pardon the sin of another perosn, why can't that individual pardon (forgive) his or her own sin? First, the fact that one can apply a principle to others does not necessarily mean that one can apply it to oneself. For example, in the legal world, which is rather similar to the forgiveness situation, a judge can judge the cases of other people but is not allowed to judge his or her own case. In fact, a judge is not allowed to judge a case in which he has any interest. This, of course, is known as the problem of conflict of interest. The reason for this position is that the law recognizes the great difficulty people have in being fair or just when their own interests are involved. Analogously, people are not to forgive - judge - their own actions. People can be the jury - they can examine the facts, recognize their sins, but they are not to be the judges who pass sentence and condemn.

Likewise, people are not to hate themselves. For example, a person who hates himself or herself has taken over - usurped - the role of God, since judgement is the Lord's. For this reason, the self-hater, to the extent that he or she still has freedom, must seek God's forgiveness, not his or her own. In short, self-hatred is a sin because it involves taking over one of God's prerogatives, and because it is an act of destructive aggression against the self. People are not to condemn themselves amy more than they are to condemn others.

Therefore, we propose that sorrow (repentance) for the harm one has done is not capable of true resolution without forgiveness, and forgiveness of the self requires God's action - or, at the very least, a belief in God's action. It is at this crucial point that psychology must defer to religion, since psychology has no effective answer to the problem of genuine guilt or to its correlate, the need for forgiveness. Of course, false or pseudo-guilt - namely, painful guilt feelings caused by defective parenting, manipulation by the superego, envioromental forces, and faulty cognitive processes - is not healed by forgiveness proper, but by effective psychotherapy, cognitive restructuring, and the acceptance of love from others.

POSITIVE SIGNS OF FORGIVENESS

The following specific signs are proposed as evidence that genuine forgiveness has occurred, and that a person's object relations are healthier.

1. One sign of genuine forgiveness is the ability to use anger constructively, i.e., markedly reduced repression or destructive acting-out,

as in violence, passive-aggression, apathetic withdrawl, chronic gossip, and detraction. Hatred is no longer used as a pathological defense mechanism (e.g., Vitz & Mango, 1997). Instead, there is the direct verbal expression of anger: "I feel ..." or "I am ..." and the use of the anger to initiate and sustain constructive activity, i.e., to stop injustice, defend and prtect the material, psychological and spiritual good of the self and others or engage in constructive conflict-resolution. Thus, the person is no longer controlled by anger or fearful of its expression.

2. Another sign of genuine forgiveness is an increase in genuine positive attitudes, especially toward the person forgiven. There is also a general increase in affects such as peace, joy, hope, and a decrease in negative attitudes and affects such as depression, despair, irritability, impatience, tension, and cynicism. One important positive response is a greater capacity to give and receive love; also there is a greater capacity for graditude. These positive responses can be understood as fruits of the Holy Spirit.

3. A third sign of genuine forgiveness is an ability to ask forgiveness from others and to give forgiveness, even when the other refuses to forgive; the positive character traits of courage and humility are often developed here.

The positive effects of forgiveness and the destructive effects of the refusal to forgive have been noted by Fitzgibbons (1986). He has proposed that forgiveness provides still other positive consequences such as helping people to forget painful experiences of their past and to free them from the subtle control of persons and events of the past. Forgiveness can facilitate the process of reconciliation with the persons who have hurt the patient. (Of course, reconciliation requires a positive response from the other person. A failure to respond positively is the other person's problem.) Forgiveness also decreases the possibility that anger will be misdirected in later loving relationships; it lessens the fear of retaliation due to unconscious violent impulses and it frees the patient from guilt. (This completes a process begun by acceptance of God's forgiveness.) Finally, forgiveness often resolves physical illness caused by anger (e.g., Barefoot, 1983; Dembroski, MacDougall, & Williams, 1985).

We are aware that good empirical research to support the proposed benefits of forgiveness does not yet exist. (See McCullouch & Worthington, 1994; see also, however, Hebl & Enright, 1993.) Before such evidence can be found, however, the logic and proposed consequences of forgiveness must be spelled out.

FALSE FORGIVENESS

Forgiveness can, however, be distorted by a patient's conscious or unconscious motives. the result can be a pseudo- or false forgiveness put in the service of pathology. The more common examples of pseudo-forgiveness include the following: (a) *Narcissistic condescension*: For example, so-called forgiveness given from an attitude of moral superiority, as when a wife forgives her husband because she feels morally superior to him and forgiveness is the thing to do. This type of pseudo-forgiveness appears to be more common in female patients than in male patients, on the basis of our experience. (b) *Denial:* For example, forgiveness given without direct confrontation with one's own hatred of the other. This seems to be more common in male patients, who want to solve the problem from a practical viewpoint, but without confronting their own feelings or the relationship in any honest or specific way. (c) *Reaction formation:* This involves giving forgiveness along with a forced positive attitude and feeling of affection, etc. However, this covers over a repressed and still strong hatred. (d) *Undoing:* This involves using forgiveness as a way to escape guilt based on the following rationale: The person is forgiven in order to undo the harm that has been done - to make it magically not have happened. But this is not real forgiveness, not a gift to the other; rather, it is for one's own benefit. (e) *Neurotic dependency:* This is the use of the language and behavior of forgiveness in order to maintain a patholgical dependecy on someone, or to maintain a masochistic relation. Such dependency is usually rooted in a painfully negative self-concept. (f) *Symbiosis:* This involves a pseudo-forgiveness in which a person has yet to achieve a secure object constancy. Persons use the language and behavior of forgiveness to ward off deep anxieties about abandonment by the person with whom they are still symbiotically fused. (This is, of course, a serious pathology, found typically in individuals with borderline personality disorder.) (g) *Manipulative use of power:* For example, this occurs when an appearance of forgiveness is used to put pressure on others, to force them to admit their guilt or wrong-doing, and to escape responsibility for one's own actions (e.g., to hide one's guilt behind the others' forced confession). Again, one should keep in mind

that genuine forgiveness is a free gift without any demand for a return, without any strings attached. Pseudo-forgiveness of others defends against the painful, necessary, and healthy process of true forgiveness.

From the start, the therapist must be especially aware of his or her own possible contributions to false forgiveness. In particular, all moralizing and judgemental pressure for a quick fix is a form of countertransference acting-out in the treatment. These behaviors strengthen unforgiveness in the patient, who often feels the need to protect the self from the therapist's intrusions and the probability of pseudo-forgiveness also increases. The patient must freely choose forgiveness and not pretend to forgive because of implicit pressure from the "parent" therapist. This requires patience and a good sense of timing.

CLINICAL PROCEDURES TO FACILITATE FORGIVENESS

For borderline patients, forgiveness is primarily facilitated by techniques that aid in overcoming splitting, plus explicit or implicit forgiveness (as identified previously by Gartner, 1992). For less disturbed patients, Fitzgibbons (1986) has encouraged a cognitive forgiveness exercise as early as the first session. The patient is asked to spend time each day trying to let go of resentments for past and present hurts. If indicated by the history, the patinet may be asked to forgive loved ones daily for ways for ways in whcih they failed to meet needs for love, praise, safety, and the like.

Patients may focus on this process for weeks or months while thinking of themselves as children, adolescents, or adults who must forgive parents, siblings, relatives, friends, co-workers, authorities, etc. At every session, some time is spent reviewing the forgiveness process with the patient. In this way, resistances and cognitive issues such as differentiating between true and false beliefs about forgiveness and the positive results of forgiveness can be explored. As some patients forgive, they come to realize how much they have been injured, deprived, or frustrated, and they feel unable to continue the process. In these instances it is time to stop and allow the patient to own and expreience the previously denied anger and hatred before letting go of it. In this sense, a patient may cycle through the stages in Table 1 more than once. It is also necessary in some cases to take time off from forgiveness work to help build the patient's sense of self since patients need a reasonably strong self in order to forgive.

For most patients, Fitzgibbons noted that forgiveness continues for a time as a cognitive process. We would add that it is a volitional, free decision but without positive affect for many patients. The empathy is real but purely intellectual. "I can understand his being like that," they say, but the additional positive affective experience is often lacking. Quite simply, the patient often does not feel like forgiving and frequently mentions the presence of continued negative affect. Such negative feelings are signs that repeated acts of forgiveness are needed. They are also commonly signs that the original trauma must be worked through again at a deeper level. The patient must continue to be willing to forgive and go through the process as long as negative affect is experienced. But even before all such emotions are gone, at least partial forgiveness has been given and commonly some of the previously mentioned benefits of forgiveness for the patient will be observed.

The feeling of wanting to forgive and feelings of tenderness, warmth, and even liking can emerge (though they do not necessarily do so), when the patient comes to a deeper understanding of those who have hurt him (e.g., Fitzgibbons, 1986).

As patients begin to use forgiveness exercises regularly, they feel relief from the psychic pressure of hatred toward the persons discussed in the therapy sessions. But often there are associations to other past experiences in which they were hurt in a similar way. Forgiveness exercises are thus a powerful therapeutic mechanism for making the unconscious conscious. Last, but by no means least, it is important to discover the patient's memories of forgiving or being forgiven. Did parents and others provide models of forgiveness and reconciliation in marriage, family life, etc.? Did parents admit when they were in the wrong and ask for forgiveness and change their behavior positively? What are the patient's fantasies regarding forgiveness? Can the patient imagine himself or herself forgiving? If the patient believes in God (that is, a personal God, not an impersonal higher power), what is his or her image of God and of God's forgiveness?

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REFERENCES

Barefoot, J.C. (1983). Hostility, and incidence, and total mortality: A 25 year follow-up of 225 physicians. *Psychosomatic Medicine, 45, 59-63.*

Bowlby, J., & Parkes, C. M. (1970). Separation and loss within the family. In E. J. Anthony & C. Koupernik (Eds.), *The child in his family: International yearbook of child psychiatry and allied professions* (pp. 197-216). New York: Wiley.

Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental Psychology, 28,* 759-775.

Cunningham, B. B. (1985). The will to forgive: A pastoral theological view of forgiving. *Journal of Pastoral Care, 39,* 141-149.

Dembroski, T. M., MacDougall, J. M., & Williams, R. B. (1985). Components of Type A, hostility, and anger – in relationship to angiographic findings. *Psycosomatic Medicine, 47,* 219-233.

Enright, R. D., & Human Development Study Group. (1991). The moral development of forgiveness. In W.M. Kurtines & J. L. Gerwirtz (Eds.), *Handbook of moral behavior and development, Vol. 1* (pp. 123-152). Hillsdale, NJ: Erlbaum.

Fitzgibbons, R. (1986). The cognitive and emotive uses of forgiveness in the treatment of anger. *Psycotherapy, 23,* 629-633.

Freud, S., & Pfister, O. (1963). *Psycoanalysis and faith: The letters of Sigmund Freud and Oskar Pfister* (E. L. Freud & H. Meng, Ed.; E. Mosbachen, Trans.). New York: Basic Books.

Gartner, J. (1992). The capacity to forgive: An object relations perspective. In M. Finn & J. Gartner (Eds.). *Object relations theory and religion* (pp. 21-33). Westport, CT: Praeger.

Hebl, J. H., & Enright, R. D. (1993). Forgiveness as a psychotherapeutic goal with elderly females. *Psychotherapy, 30,* 658-667.

Hunter, R. (1978). Forgiveness, retaliations and paranoid reactions. *Journal of the Canadian Psychiatric Association, 23,* 167-173.

Kernberg, O. (1984). *Severe personality disorders: Psychotherapeutic strategies.* New Haven, CT: Yale University Press.

Kernberg, O. (1992). *Aggression in personality disorders and perversions.* New Haven, CT: Yale University Press.

Klein, M. (1964). Love, hate and reparation. In M. Klein & J. Riviere (Eds.), *Love, hate and reparation.* New York: Norton.

Kubler-Ross, E. (1969). *On death and dying.* New York: Macmillan.

Linn, M. & Linn, D. (1978). *Healing life's hurts.* New York: Paulist Press.

McCullouch, M., & Worthington, E. (1994). Encouraging clients to forgive people who have hurt them: Review, critique, and research prospectus. *Journal of Psychology and Theology, 22,* 3-20.

Mower, O. H. (1960). “Sin,” the lesser of two evils. *American Psychologist, 15*, 301-304.

Pingleton, J. P. (1989). The role and function of forgiveness in the psychotherapeutic process. *Journal of Psychology and Theology, 17,* 27-35.

Robertson, J., & Bowlby, J. (1952). Responses of young children to separation from their mothers. *Courrier of the International Children's Center, Paris, II,* 131-140.

Waldinger, R. S., & Gonderson, J. G. (1987). *Effective psychotherapy with borderline patients.* New York: Macmillan.

Vitz, P. C., & Mango, P. (1997). Kleinian psychodynamics of hatred as a defense mechanism. *Journal of Psychology and Theology, 25,* 64-71.

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Table 1

Stages in Recovery from Psychological Trauma as Proposed by Different Theorists

	1	2	3	4	5
A. In healing a memory (Linn & Linn, 1978)	Denial I don't admit I was ever hurt (denial, reaction-formation, idealiziation).	Anger I blame others for hurting and trying to destroy me.	Bargaining I set up conditions to be fulfilled before I'm ready to forgive.	Depression I blame myself for letting hurt destroy me.	Acceptance I look forward to growth from resolved hurts; I accept self and forgive others; I repent for hurting others.
B. In recovery from Borderline Personality Disorder (Kernberg, 1992)	Psychopathic Transference Deceptive, narcissistic denial of vulnerability and hurt.	Paranoid Transference Projected anger at therapist for breaking down psycopathic defenses.	(For Kernberg, no stage is given here, but resistance is recognized.)	Depressive Transeference Patient recognizes depth of his hatred, envy. Experiences shame, guilt, depression.	Acceptance Accept self/others based on empathy with self/others, including negative aspects; positive modifications of super-ego.
C. In healing any psychological trauma (Vitz & Mango)	Denial Same as A or B, depending on depth of pathology.	Anger and Hatred Same as A or B, depending on depth of pathology.	Resistance Partial recognition that problem, e.g., hatred, is within self; this creates resistance; narcissistic/anxious avoidance; bargaining is one kind of resistance.	Depression Similar to A or B, depending on depth of pathology; recognition of self's contribution to hatred. Self blame leads to: (a) guilt/mourning or (b) clinical depression which can block resolution.	Resolution Accept self/others. Repent of hatred and envy that hurt others/self. Accept God's forgiveness of self; forgive others. Qualitative change in super-ego.