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Forgiveness and Mental Health Variables among Psychotherapy Outpatients

Związek między przebaczeniem a wskaźnikami zdrowia psychicznego wśród uczestników
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ABSTRACT

High cost of mental health problems to societies requires searching for factors that may have salutary effect on psychological health. Forgiveness might be one of such variables. Although empirical studies of forgiveness and mental health have been increasingly undertaken, there is a deficiency in examining the connections in clinical samples. The aim of the present research was to explore the relationships between multidimensional disposition to forgive and mental health variables, such as positive and negative affect and satisfaction with life, among outpatient psychotherapy participants in comparison to untreated individuals. The study included 137 respondents, 68 of whom were outpatients and 69 the controls. The Heartland Forgiveness Scale, the Positive and Negative Affect Schedule and the Satisfaction with Life Scale were used. The results showed no differences in forgiveness between the treatment and control group but revealed poorer mental health (lower positive affect and satisfaction with life, and higher negative affect) in outpatients. In the outpatients sample, positive associations between forgiveness and affect and life satisfaction were significantly stronger than in the controls. The findings suggest that treated individuals have more to gain through forgiveness than untreated ones.

Keywords: forgiveness; mental health; positive affect; negative affect; satisfaction with life; psychotherapy

1. INTRODUCTION

In search of protecting factors or variables related to mental health, researchers have pointed out dealing with different difficult situations (Thompson, Snyder, Hoffman, Michael, Rasmussen, Billings, Heinze, Neufeld, Shorey, Roberts, Roberts, 2018; Labrum, Solomon, 2016; Maltby, Day, Barber, 2005), including interpersonal conflicts, mistreatment, experience of failures or negative life events. The source of such transgressions might be oneself, another person or situation beyond anyone's control (Thompson et al., 2005). People deal with transgressions in many different ways (Wade, Worthington, 2003; Worthington, Wade, 1999). For instance, they keep distance from wrongdoings and wrongdoers, they deny or minimize the harm or accept the injustice. On the other hand, people use ruminative thinking about the hurt and sense of misfortune, they blame themselves and "live and breathe" the transgression. Sometimes they deal with an injury by finding meaning of it or by seeking justice (Enright, Eastin, Golden, Sarinopoulos, Freedman, 1991) and revenge (McCullough, Worthington, Rachal, 1997). Another possible way to cope with negative consequences of transgressions is forgiveness, which is interpreted as a positive response to hurt and a functional strategy of enhancing one's psychological health and well-being (Thompson et al., 2005; Wade, Worthington, 2005).

1.1. Understanding of forgiveness

Forgiveness is a process of reframing or altering emotions, thoughts, perceptions, judgments, and behaviors towards the person who caused the hurt in that negative reactions are reduced and positive responses are increased (Rye, Pargament, 2002; McCullough, Worthington, Rachal, 1997; Enright, 1996).

When defining forgiveness, researchers focus on different aspects of the process. For example, Robert Enright (1996) underlines specific changes in cognition and emotion, following one's decision to abandon his or her natural negative reactions after being treated unjustly. The changes imply moving from negative to neutral or positive states and actions toward the harm-doer. Michael McCullough, Everett Worthington, and Chris Rachal (1997) highlight a motivational nature of forgiveness and indicate such types of motivation as revenge, avoidance or benevolence motivation toward the offender. Worthington acknowledges two types of forgiveness: decisional, which refers to a victim's intention to control his or her behaviors toward an offender, and multifaceted emotional forgiveness involving changes in emotions, and following changes in thoughts and motivations (Worthington, 2019; Worthington, Jennings, Diblasio, 2010). In the present study, we consider the cognitive approach to forgiveness proposed by Laura Thompson and Patricia Snyder (2003). In this conception, forgiveness is the process of reframing

the perceived harm and modifying person's beliefs about oneself, people and the world, and forming new realistic ones so that negative responses are transformed into neutral or positive (Thompson et al., 2005).

Scholars distinguish between a single act of forgiveness and a general propensity to forgive regardless of time, relationships and situations (e.g. Eaton, Struthers, Santelli, 2006; Thompson et al., 2005; Brown, 2003; Berry, Worthington, Parrott, O'Connor, Wade, 2001). The former, episodic forgiveness, refers to forgiveness for a particular wrongdoing within a specific interpersonal context (Palleari, Regalia, Fincham, 2009). The latter, dispositional forgiveness (named *forgiveness* by Roberts, 1995), covers the tendency to forgive (oneself, others, etc.) and is perceived as a personality trait (Brown, 2003; Berry et al., 2001). Researchers have also pointed out distinct positive and negative dimensions of forgiveness. The positive aspect involves prosocial emotions (love, compassion, sympathy, pity), approach behavior and benevolent motivation towards objects of forgiveness. Negative dimension of forgiveness entails overcoming unforgiveness by reducing negative feelings (e.g. anger, bitterness, hostility), motivation (e.g. tendency to avoid and revenge), and behavior (e.g. punishment) (Fincham, Beach, Davila, 2004; Rye, Loiacono, Folck, Olszewski, Heim, Madia, 2001; Worthington, Wade, 1999). What is more, scholars show differences between forgiveness of others, forgiveness of self, forgiveness by God, and forgiveness of situations beyond anyone's control (Davis, Worthington, Hook, Hill, 2013; Thompson et al., 2005). Multidimensional forgiveness conceptualized in this manner is associated with various aspects of mental health, including symptoms of clinical disorders, nonspecific psychological distress and indicators of well-being (Tse, Yip, 2009).

1.2. Forgiveness and mental health

The relationships between different types of forgiveness and mental health have been revealed in a considerable body of studies (e.g. Macaskill, 2012; Sandage, Jankowski, 2010; Maltby, Day, Barber, 2005). However, the precise knowledge regarding the role of forgiveness for psychological health is still scarce (Green, Decourville, Sadava, 2012; Riek, Mania, 2012). Few mechanisms, both direct and indirect, have been proposed to explain the link (Toussaint, Webb, 2005).

The direct effect of forgiveness on mental health can be described in terms of unforgiveness, through rumination and its connection to negative emotions (Burnette, Davis, Green, Worthington, Bradfield, 2009; McCullough, Bono, Root, 2007; Berry, Worthington, O'Connor, Parrott, Wade, 2005; Nolen-Hoeksema, 2000). They cause a variety of physiological changes (Harris, Thoresen, 2005), which in turn may impair mental and physical health and well-being. For instance, unforgiveness leads to anxiety, depression, hostility, and heart diseases (van Oyen Witvliet, 2005). In contrast, high levels of forgiveness are associated with re-

duced risk for suicidal behavior (Hirsch, Webb, Jeglic, 2011), lower indices of cardiovascular risk (Lawler, Younger, Piferi, Billington, Jobe, Edmondson, Jones, 2003), lower indices of PTSD (Weinberg, 2013; Orcutt, Pickett, Pope, 2005), fewer eating disorders symptoms (Feibelman, Turner, 2015), lower levels of negative affect (Allemand, Job, Christen, Keller, 2008), depression, anxiety, stress (Messay, Dixon, Rye, 2012), anger, fear, and hostility (Berry et al., 2005). On the other hand, the benefits of forgiveness are manifested in positive psychological functioning, such as life satisfaction (Kaleta, Mróz, 2018; Toussaint, Friedman, 2009), optimism (Allemand, Hill, Ghaemmaghami, Martin, 2012) and positive affect (Thompson et al., 2005). People who are more forgiving are also more optimistic and content with their life. These associations, however, depend on age; for example, forgiveness turned out to be of minor importance for life satisfaction among adults aged 31–40 when compared to younger and older people (Kaleta, Mróz, 2018).

The indirect effect operates through distinct variables, such as social support, health behavior, interpersonal functioning, stress, existential and religious well-being (Green, Decourville, Sadava, 2012; Webb, Robinson, Brower, 2011; Stoia-Caraballo, Rye, Pan, Kirschman, Lutz-Zois, Lyons, 2008; Lawler-Row, Piferi, 2006; Worthington, Berry, Parrott, 2001). For instance, more forgiving people maintain more fulfilling relationships with others (Fincham, Beach, Davila, 2004), which in turn is associated with better well-being (Acevedo, Aron, Fisher, Brown, 2012).

In the present study, we are especially interested in mental health outcomes of forgiveness in a sample of treated outpatients when compared to untreated individuals. Clinical outpatients often experienced events that harmed them, and they may have the most to gain through forgiveness (Toussaint, Friedman, 2009). We are interested in measures of positive mental health variables, such as positive affect, reduced negative affect and satisfaction with life (Maltby, Day, Barber, 2005).

1.3. Aims of the study

To the best of our knowledge, no prior studies have included psychotherapy and non-psychotherapy samples and explored the effect of forgiveness on mental health in both groups. Thus, the first goal of the present study was to examine differences in the levels of dispositional forgiveness and indicators of mental health (positive and negative affect, and satisfaction with life) between a treatment and a control group. Outpatient psychotherapy participants usually have issues regarding relationships and their levels of well-being are overall much lower than in the general population samples (Toussaint, Friedman, 2009; Henning, Turk, Mennin, Fresco, Heimberg, 2007). Thus, we put forward the hypothesis that patients re-

ceiving psychotherapy would score lower in multiple dimensions of forgiveness, positive affect and life satisfaction, and higher in negative affect when compared to untreated individuals (H1). The second goal of the study was to explore the forgiveness–mental health links in the treatment and control groups. We expected that there would be significant differences between the groups in the analyzed associations, in that forgiveness would be significantly and inversely related with negative affect in both groups, but more strongly in the treatment sample. On the other hand, we expected that forgiveness would be positively related to positive affect and life satisfaction in both groups and more strongly in psychotherapy outpatients (H2).

2. METHODS

2.1. Participants

Two groups of individuals were studied. The first group included 68 individuals (82% females) aged 21–58 years old ($M = 37.46$; $SD = 8.98$) who were individual outpatient psychotherapy participants from southern Poland. Outpatients were treated for general distress, quality of life problems, mild depressive or anxiety symptoms. They were diagnosed with adjustment, mild depressive or anxiety disorders using an open clinical interview and clinical documentation. The reference (control) group was well-matched in terms of socio-demographic characteristics and consisted of 69 (82% females) individuals not receiving psychotherapy treatment, aged 22–59 years old ($M = 38.21$; $SD = 9.34$).

2.2. Procedure

The current investigation was conducted in accordance with the Declaration of Helsinki. All respondents provided their oral consent to participate in the study. Participants were recruited during their psychotherapy sessions in community mental health center and private practice settings. Weekly individual psychotherapy, eclectic in orientation and primarily supportive was “treatment as usual” in the community. The therapists differentially combined psychodynamic, cognitive-behavioral and systemic techniques. Individual sessions typically took 50 min. The mean duration of therapy was 7.1 months. Treatment providers were psychologists or medical doctors. The respondents were requested to voluntarily agree (with no remuneration) to participate in the study. They had to take paper-and-pencil questionnaires, answer all the questions in private, and return the completed questionnaires. Participants of the control group were recruited during eligibility interviews conducted by psychology students. Participants were asked to complete paper and pencil questionnaires.

2.3. Measures

Participants completed the following measures of mental health.

2.3.1. Forgiveness was measured using the Heartland Forgiveness Scale (HFS) (Thompson, Snyder, 2003; Thompson et al., 2005; Polish adaptation by Kaleta, Mróz, Guzewicz, 2016). The HFS assesses the dispositional forgiveness in the multidimensional way. The original tool consists of 3 subscales (forgiveness of self, forgiveness of others, and forgiveness of situations beyond anyone's control), the Polish version, however, obtained a different structure. The scale is made of two primary scales measuring positive dimension of forgiveness (P scale, benevolent thoughts, feelings and behaviors) and negative dimension of forgiveness (N scale, reduction of hostile thoughts, feelings and behaviors). Both P scale and N scale include three subscales with the distinction of forgiveness of self, others, and situations. Higher scores on each scale reflect a higher level of forgiveness in every scales. Participants rate their responses to 18 items using a 7-point Likert-scale from 1 (almost always false of me) to 7 (almost always true of me). The items are added together: general forgiveness from 18 to 126 points, positive and negative dimension from 9 to 63 points per each, six subscales from 3 to 21 points per each. Sample items include "Although I feel badly at first when I mess up, over time I can give myself some slack" (P scale) and "If others mistreat me, I continue to think badly of them" (N scale). Cronbach's alpha (internal consistency) ranged from 0.70 to .81.

2.3.2. Affect was measured using the Polish version of the Positive and Negative Affect Schedule (Watson, Clark, Tellegen, 1988; Polish version – SUPIN C30, Brzozowski, 2010). The scale consists of 30-items, 15-items for positive affect (from 15 to 75 points) and 15-items for negative affect (from 15 to 75 points). Using a 5-point scale, the participants are asked to indicate the degree to which they usually experience each of the emotions. The higher the score, the higher the level of particular affect. Cronbach's alpha for PANAS ranged from .73 to .95 (Brzozowski, 2010).

2.3.3. Life satisfaction was measured with the Satisfaction with Life Scale (SWLS) assessing the cognitive aspect of subjective well-being, developed by Ed Diener, Robert Emmons, Randy Larsen, and Sharon Griffin (1985) and adapted by Zygryd Juczyński (2001). The SWLS consists of five items rated by a respondent using a seven-point scale, ranging from "strongly disagree" (1) to "strongly agree" (7). Items are added together to give a total score ranging from 5 (low satisfaction) to 35 (high satisfaction). A sample item includes, e.g. "So far, I have gotten the important things I want in life". The Polish version of the SWLS had shown test-retest reliability (0.86), internal consistency – Cronbach's alpha (0.81), and discriminant validity (up 0.50; Juczyński, 2001).

2.4. Data Analysis

In the statistical analysis of obtained scores, descriptive and statistical inference methods were applied. The data were analyzed using the mean (M), and standard deviation (SD). We used Mann–Whitney U test to compare the levels of variables in both groups. In order to examine the relationships between the studied variables, Pearson's correlation coefficient (r) and four separate multiple regressions were used. The statistical analyses were performed using the *Statistica PL 13.0* statistical package.

3. RESULTS

3.1. Comparison of the levels forgiveness, affectivity, and life satisfaction between the groups

The scores of both groups were compared with the use of the Mann–Whitney U test (Table 1). The outpatients and the controls did not differ significantly in any dimension of dispositional forgiveness. In case of positive-negative affect and satisfaction with life, there were significant differences between the groups, in that positive affectivity and life satisfaction were lower and negative affectivity was higher in the psychotherapy participants than in the control group.

3.2. Correlations between forgiveness and mental health variables

In the next step, we analyzed (compared) correlations between forgiveness and affectivity and life satisfaction in both groups. As shown in Table 2, overall forgiveness, as well as positive forgiveness (total score, of self, of others) and reduced unforgiveness (total score, of self, of situations) had an inverse correlation with negative affect among outpatient psychotherapy participants. Forgiveness (total score) and reduced unforgiveness (total score, of situations) displayed a positive correlation with positive affect among outpatients. Also, every dimension of forgiveness (except positive forgiveness of situations) was positively related to satisfaction with life in the psychotherapy group. In the case of the control group, forgiveness (except reduced unforgiveness of others) was not related to affectivity nor to life satisfaction.

Subsequently, a series of regression analyses were performed for the treatment group. Table 3 shows the results of the multiple regression analysis conducted to reveal which dimensions of forgiveness significantly predicts particular aspects of mental health (positive affect, negative affect, and life satisfaction). Reduced unforgiveness of situations, as the only dimension of forgiveness, sig-

Table 1. Comparison of forgiveness, affectivity and life satisfaction between treatment and control groups (Mann-Whitney U test)

	Psychotherapy outpatients		Control group		U M-W	p
	M	SD	M	SD		
Forgiveness (Total)	84.32	13.20	86.16	9.87	-0.83	0.406
Positive_forgiveness	44.14	6.91	44.81	6.24	-0.64	0.519
P-self	15.20	2.48	15.32	3.03	-0.94	0.346
P-others	14.02	2.93	14.39	2.78	-0.58	0.565
P-situations	14.92	3.13	15.10	2,36	-0.95	0.340
Reduced unforgiveness	40.18	8.45	41.35	8.72	-0.35	0.723
N-self	13.71	3.89	13.74	3.97	0.00	0.996
N-others	13.60	3.48	13.01	3.62	1.27	0.204
N-situations	12.88	3.92	13.35	3.61	-0.79	0.430
Positive affect	44.55	11.18	50.72	10.35	-3.14	0.002
Negative affect	41.20	13.88	32.54	11.34	3.68	0.000
Life satisfaction	18.02	6.36	20.26	5.88	-2.10	0.036

	Positive affect			Negative affect			Life satisfaction		
	Patience	Control group	Z	Patience	Control group	Z	Patience	Control group	Z/p
Forgiveness (general)	0.25*	-0.09	Z = 1.96*	-0.58***	-0.03	Z = -3.59***	0.50***	-0.12	Z = 3.8***
Positive forgiveness	0.12	-0.05	Z = .97	-0.36**	0.08	Z = -2.59**	0.30**	0.05	Z = 1.47
P-self	0.18	-0.05	Z = 1.32	-0.31**	0.04	Z = -2.05*	0.27*	0.16	Z = 0.66
P-others	0.08	-0.01	Z = .51	-0.32**	0.03	Z = -2.05*	0.33**	-0.03	Z = 2.12**
P-situations	0.04	-0.05	Z = .51	-0.23	0.13	Z = -2.07*	0.12	-0.03	Z = 0.85
Reduced unforgiveness	0.29*	-0.07	Z = 2.09*	-0.61***	-0.09	Z = -3.51***	0.53***	-0.17	Z = 4.33***
N-self	0.19	0.00	Z = 1.09	-0.61***	0.01	Z = -4.08***	0.49***	-0.07	Z = 3.44***
N-others	0.01	-0.09	Z = .57	-0.22	0.09	Z = -.76	0.27*	-0.25*	Z = 3.02**
N-situations	0.40**	-0.23	Z = 3.73***	-0.57**	0.22	Z = -4.95***	0.43*	-0.15	Z = 3.47***

* $p < .05$; ** $p < .01$; *** $p < .001$

Source: Authors' own study.

Table 2. Correlations between forgiveness and affectivity and life satisfaction among treatment and the control groups

	Positive affect		Negative affect		Life satisfaction	
	Outpatients	Controls	Outpatients	Controls	Outpatients	Controls
Forgiveness (general)	0.25*	-0.09	-0.58***	-0.03	0.50***	-0.12
Positive forgiveness	0.12	-0.05	-0.36**	0.08	0.30**	0.05
P-self	0.18	-0.05	-0.31**	0.04	0.27*	0.16
P-others	0.08	-0.01	-0.32**	0.03	0.33**	-0.03
P-situations	0.04	-0.05	-0.23	0.13	0.12	-0.03
Reduced unforgiveness	0.29*	-0.07	-0.61***	-0.09	0.53***	-0.17
N-self	0.19	0.00	-0.61***	0.01	0.49***	-0.07
N-others	0.01	-0.09	-0.22	0.09	0.27*	-0.25*
N-situations	0.40**	-0.23	-0.57**	0.22	0.43*	-0.15

* $p < .05$; ** $p < .01$; *** $p < .001$

Source: Authors' own study.

Table 3. Regression results predicting positive affect, negative affect, life satisfaction among outpatients

		Positive affect			Negative affect			Life satisfaction		
		β	SE	p	β	SE	p	β	SE	p
Positive forgiveness	self	0.15	0.14	0.296	-0.02	0.11	0.843	0.10	0.13	0.427
	others	-0.06	0.16	0.713	0.08	0.13	0.547	0.11	0.15	0.478
	situations	-0.18	0.14	0.211	-0.08	0.12	0.471	-0.12	0.14	0.375
Reduced unforgiveness	self	-0.05	0.14	0.726	-0.41	0.11	0.000	0.35	0.13	0.010
	others	-0.09	0.13	0.477	-0.04	0.10	0.674	0.10	0.12	0.398
	situations	0.48	0.15	0.003	-0.38	0.12	0.003	0.15	0.14	0.291
		$R^2 = .18$; Adj. $R^2 = .10$ F(6,61) = 2.25 $p < .049$			$R^2 = .48$; Adj. $R^2 = .43$ F(6,61) = 9.35 $p < .001$			$R^2 = .30$; Adj. $R^2 = .23$ F(6,61) = 4.34 $p < .001$		

Source: Authors' own study.

nificantly predicted positive affect ($\beta = 0.48$). Next, the analysis showed that the dimensions of forgiveness significant for negative affect were: reduced unforgiveness of self ($\beta = -0.41$) and reduced unforgiveness of situations ($\beta = -0.38$). Reduced unforgiveness of self ($\beta = 0.35$) significantly predicted life satisfaction.

As shown in Table 3, dimensions of forgiveness accounted for 10–46% of the variance in positive affect, negative affect, and life satisfaction.

4. DISCUSSION

The purpose of the study was to shed light on the associations between the tendency to forgive and indicators of mental health, such as affectivity and life satisfaction in the outpatient psychotherapy and the control groups.

Our first hypothesis about a lower tendency to forgive and poorer mental health among psychotherapy patients in comparison to untreated respondents was only partially supported. There were no significant differences in the level of forgiveness between the groups, which is not consistent with the previous findings. In prior studies, clinical participants scored lower in forgiveness than the controls. For example, Fatemeh Fayyaz and Mohammad Besharat (2011) who compared clinical depressed people and people with no symptoms found that the clinical group was less forgiving than the healthy group. Our study, however, included dispositional forgiveness, not forgiveness of a particular transgression. It is possible that receiving psychotherapy improved positive self-image of outpatients who perceive themselves as generally able to forgive despite still having difficulty forgiving actually. Also, psychotherapy could have made them more understanding for themselves and more self-compassionate, which increased initial forgiveness (Sakiz, Sariçam, 2015). As a result, we found no difference between psychotherapy users and control-group respondents.

As regards outpatients' poorer mental health, our results met our expectations. Clinical individuals scored significantly lower in positive affect and life satisfaction, and higher in negative affect, when compared to non-clinical participants. Global data shows that people seeking and using psychotherapy, suffer from impaired psychological functioning, including diagnosed disorders and sub-syndromal mental health-related problems (da Silva, Blay, 2010; Olfson, Marcus, 2010; Vessey, Howard, 1993). Higher levels of anxiety, depression and distress common in outpatients interfere with their work and daily activities, impair social life and cause mood dysregulation (Henning, Turk, Mennin, Fresco, Heimberg, 2007; Hunt, Slade, Andrews, 2004). Consequently, they score lower than the controls in affective and cognitive components of positive mental health, such as positive affect, reduced negative affect and satisfaction with life (Daig, Herschbach, Lehmann, Knoll, Decker, 2009; Henning et al., 2007; Frisch, Cornell, Villanueva, Retzlaff, 1992). Our results are consistent with the previous ones.

The second hypothesis was partly supported by the evidence showing that there are significant correlations between forgiveness and mental health outcomes in the treatment group and there are no such associations in the untreated individuals. In line with our prediction, outpatients receiving psychotherapy who were more forgiving reported more positive affect, greater life satisfaction and less negative affect.

This outcome corresponds with results of other studies which showed that the associations between forgiveness and mental health are statistically signifi-

cant in the psychotherapy outpatient participants (Toussaint, Friedman, 2009) and ambiguous in the general population (Kaleta, Mróz, 2018; Maltby, Day, Barber, 2005; Sastre, Vinsonneau, Neto, Girard, Mullet, 2003). Loren Toussaint and Philip Friedman (2009) emphasized that forgiveness leads to more positive effect for individuals struggling with life issues. People who start psychotherapy often insufficiently deal with different difficult situations which prompted exhaustion of flexibility coping with wrongdoing. During psychotherapy, the resources are rebuilt and they enhance emotional and cognitive well-being. The rebuilding and creating new resources is consistent with the conservation of resources (COR) theory (Hobfoll, 2002, 1989). Forgiveness, as a rebuilding skill, is associated with better psychological functioning, creating caravans of resources. The process of psychotherapy leads to cognitive transformation. Forgiveness may be a dynamic process, moving from revenge motivation, negative thoughts to benevolent behaviors and positive thoughts. Outpatients change their attitudes towards wrongdoers, wrongdoing and life as a whole, which is manifested in greater satisfaction with life.

Lack of a relationship between forgiveness and satisfaction with life in the control group may be due to another reason. Our sample was dominated by people in their forties. In line with our recent study (Kaleta, Mróz, 2018), the relationship between forgiveness and life satisfaction in this age group is weak, suggesting that people in their forties draw satisfaction from other sources than forgiveness.

LIMITATIONS

There are limitations to the study that warrant attention. First, we used only self-reporting measurements, whereby data are subject to response bias. Our research used neither behavioral observations nor experimental manipulations, which would give more objective outcomes. The tools measured only the tendency to forgive and future studies should include methods that assess episodic forgiveness.

Second, in the clinical sample we did not control many variables, such as symptoms and type of disorders, intensity and length of psychotherapy, important for exploring the relationships between forgiveness and mental health. They might be significant moderators of the link. Third, cross-sectional and correlational study design limits our ability to make any causal inferences. As the disposition to forgive changes over lifetime (Kaleta, Mróz, 2018), longitudinal research would be more adequate for the analyzed variables and to draw cause and effect conclusions. Another weakness is the sample dominated by females, who usually score higher than males in negative affect (Fujita, Diener, Sandvik, 1991) which may affect the analyzed relationships. Moreover, forgiveness is sometimes related to gender (Miller, Worthington, McDaniel, 2008). All this restrict generalization of our results.

We certify that all applicable institutional and governmental regulations concerning the ethical use of human volunteers were followed during the course of this research.

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STRESZCZENIE

Wysokie koszty, jakie ponoszą społeczeństwa z powodu problemów zdrowia psychicznego, stawiają przed badaczami zadanie poszukiwania czynników mających korzystne działanie. Jednym z takich czynników może być przebaczenie. Badania dotyczące związków między przebaczeniem a zmiennymi zdrowia psychicznego stają się coraz częstsze, lecz nadal istnieje wyraźny niedobór analiz w grupach klinicznych. Celem prezentowanych badań była eksploracja związków między przebaczeniem dyspozycyjnym w ujęciu wielowymiarowym a takimi wskaźnikami zdrowia psychicznego, jak pozytywny i negatywny afekt oraz satysfakcja z życia wśród uczestników psychoterapii w porównaniu z grupą kontrolną. W badaniu wzięło udział 137 osób, spośród których 68 uczestniczyło w psychoterapii ambulatoryjnej, a pozostałe 69 stanowiło grupę kontrolną. Zastosowano Skalę Przebaczenia Heartland Forgiveness Scale (HFS), Skalę Uczuć Pozytywnych i Negatywnych (SUPIN) oraz Skalę Satysfakcji z Życia (SWLS). Wyniki wskazują na brak istotnych różnic między badanymi grupami w poziomie przebaczenia, ale ujawniają gorsze wskaźniki zdrowia psychicznego (niższy pozytywny afekt i satysfakcja z życia oraz wyższy afekt negatywny) u uczestników psychoterapii. Pozytywne związki między przebaczeniem a afektem i satysfakcją z życia były istotnie silniejsze u osób biorących udział w terapii niż w populacji ogólnej. Uzyskane rezultaty sugerują, że osoby z grupy klinicznej mogą poprzez przebaczenie uzyskać więcej w zakresie zdrowia psychologicznego niż osoby z grupy nieklinicznej.

Słowa kluczowe: przebaczenie; zdrowie psychiczne; pozytywny afekt; negatywny afekt; satysfakcja z życia; psychoterapia

