The Anthropological Paradigm of Therapeutic Forgiveness:

A Conceptual Framework Integrating Psychology and Theology

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Abstract

This paper introduces the Anthropological Paradigm of Therapeutic Forgiveness, a conceptual framework proposing that authentic forgiveness requires simultaneous engagement of two dimensions: the therapeutic (engagement with evidence-based psychological treatment) and the theological/existential (openness to meaning beyond the self). When crossed, these dimensions produce four typological positions: Resentment (dual rejection), Self-Interest (therapeutic engagement without existential orientation), Spiritual Captivity (existential engagement without therapeutic processing), and Therapeutic Forgiveness (dual integration). Existing forgiveness models — including the Enright Process Model, Worthington's REACH, and the Stanford Forgiveness Project — measure forgiveness outcomes but do not assess the interaction between these two dimensions. The framework addresses this gap by providing a dual-axis assessment structure and a shared clinical language for cross-discipline collaboration between mental health practitioners and spiritual care providers. The paper presents the Therapeutic Forgiveness Inventory (TFI), a preliminary 24-item clinical discussion instrument mapped to the four-quadrant matrix, and discusses implications for integrative assessment, treatment planning, and longitudinal tracking. The framework is explicitly ecumenical and applicable across faith traditions and secular contexts.

Keywords: therapeutic forgiveness, integrative psychology, forgiveness research, clinical instrument, existential meaning, pastoral counseling, conceptual framework

1. Introduction

For centuries, two powerful intellectual traditions have attempted to answer the same fundamental question: How does a human being move from the experience of being wronged toward wholeness?

Theology, particularly in the Catholic tradition, has understood this movement through the lens of grace — the unmerited gift of divine mercy that enables the human person to transcend injury and participate in reconciliation. Psychology, particularly since the mid-twentieth century, has understood this movement through the lens of mental health — the evidence-based therapeutic process by which individuals process trauma, restructure cognition, and rebuild relational capacity.

Both traditions have produced extraordinary insight. Neither, alone, has proven sufficient.

The clinician who treats forgiveness as a cognitive-behavioral exercise — a coping strategy for the individual's benefit — captures something real but incomplete. The pastoral counselor who prescribes forgiveness as a spiritual duty — "forgive as the Lord forgave you" (Colossians 3:13, New International Version) — honors a profound truth but risks bypassing the psychological reality of the wound. The result, in both cases, is a fragmented person: healed in one dimension, unaddressed in the other.

This fragmentation is not merely an intellectual problem. It is a clinical one. In *The Invisible Life*, the capstone volume of The Invisible Series, the author identifies the central question that motivates the framework: "What does my suffering mean? ... This is a question that psychology alone cannot answer, because psychology's domain is the mechanism of suffering — its causes, its symptoms, its treatments, its prognosis — not its meaning. This is a question that theology alone cannot answer, because theology's domain is the transcendent framework within which suffering is interpreted — sin, grace, redemption, divine will — not the lived, embodied,

neurobiological experience of the person who is actually suffering. The question lives in the space between the two disciplines. It requires both. It is answered by neither in isolation" (Fisher, 2026, Prologue).

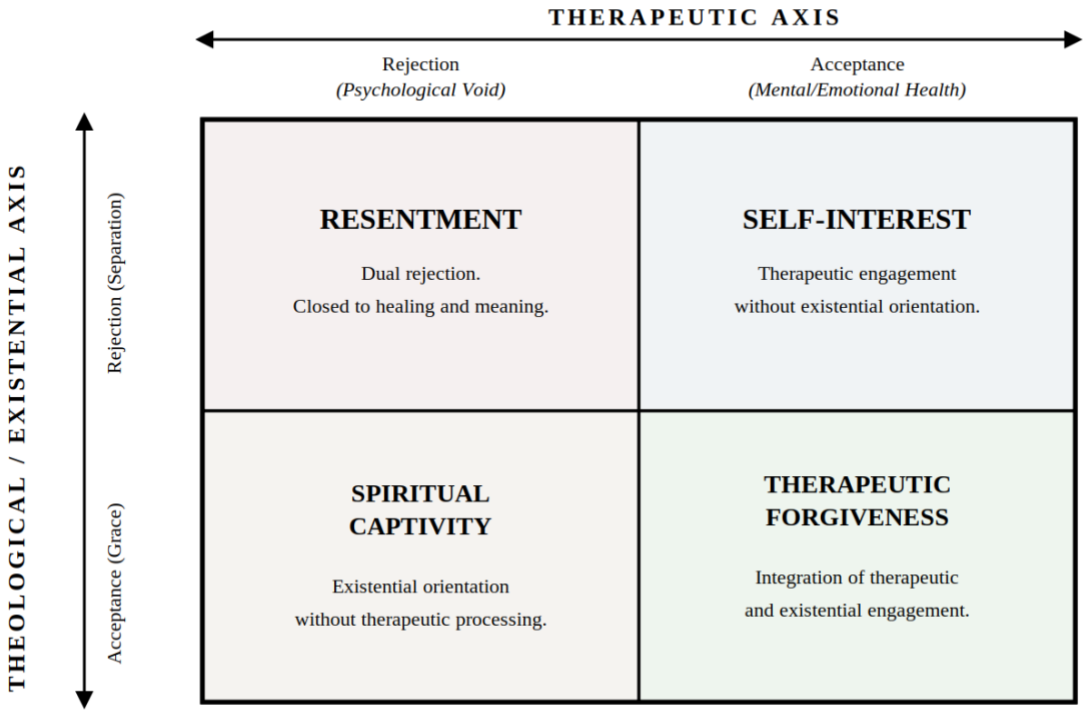
The Therapeutic Forgiveness Framework proposes that these two dimensions were never meant to operate in isolation. Drawing on Catholic theological anthropology, phenomenological method, and four decades of forgiveness research (Enright, 2001; Enright & Fitzgibbons, 2015; Worthington, 2001, 2006; Luskin, 2003; Wade et al., 2014), this paper presents an integrative model — the Anthropological Paradigm of Therapeutic Forgiveness — that maps the intersection of therapeutic engagement and theological orientation onto a four-quadrant matrix, identifies the typological positions that emerge, and provides a clinical instrument (the Therapeutic Forgiveness Inventory) for assessment, treatment planning, and longitudinal tracking.

This paper introduces the Therapeutic Forgiveness Framework and the accompanying Therapeutic Forgiveness Inventory (TFI), a preliminary 24-item clinical discussion instrument designed to assess the interaction between therapeutic engagement and existential orientation. The framework contributes a dual-axis model that allows clinicians and spiritual care providers to identify the typological position that results from the intersection of these dimensions and coordinate care across disciplines using a shared visual language.

The model is summarized visually in Figure 1. The remainder of this paper provides the theoretical, empirical, and clinical basis for this matrix and its accompanying clinical instrument.

Figure 1. The Therapeutic Forgiveness Matrix

(Fisher, 2007/2026; adapted from the Anthropological Paradigm of Therapeutic Forgiveness)



The framework was first developed in the author's Master of Arts thesis at St. Mary Seminary and Graduate School of Theology (Wickliffe, Ohio, 2007), refined through doctoral research in educational psychology at Walden University (Fisher, 2021), and formalized in *The Invisible Life*, the tenth and capstone volume of The Invisible Series (Fisher, 2026).

2. The Model: Two Axes, Four Positions

2.1 The Two Axes

The Theological/Existential Axis measures the person's orientation toward existential meaning. *Acceptance (Grace)* — defined here as openness to meaning, compassion, or moral orientation beyond the self — reflects openness to mercy, interconnection, and purpose — whether expressed through religious practice, spiritual contemplation, philosophical commitment, or secular

humanistic values. These two axes represent the two domains in which human suffering is processed: psychological regulation and existential meaning. *Rejection (Separation)* reflects closure to these dimensions: existential isolation, refusal of meaning, or active hostility toward the transcendent.

This axis is explicitly non-denominational. Grace may manifest as Catholic sacramental life, Buddhist engagement with *dukkha* (the recognition of suffering as inherent to existence) and the cultivation of *mettā* (loving-kindness), Jewish *teshuvah* (repentance/return) and *tikkun olam* (repair of the world), Islamic *sabr* (patience in adversity) and *'afw* (pardoning), or a secular commitment to human connection and service. The framework asks only: *Are you open to something beyond yourself?*

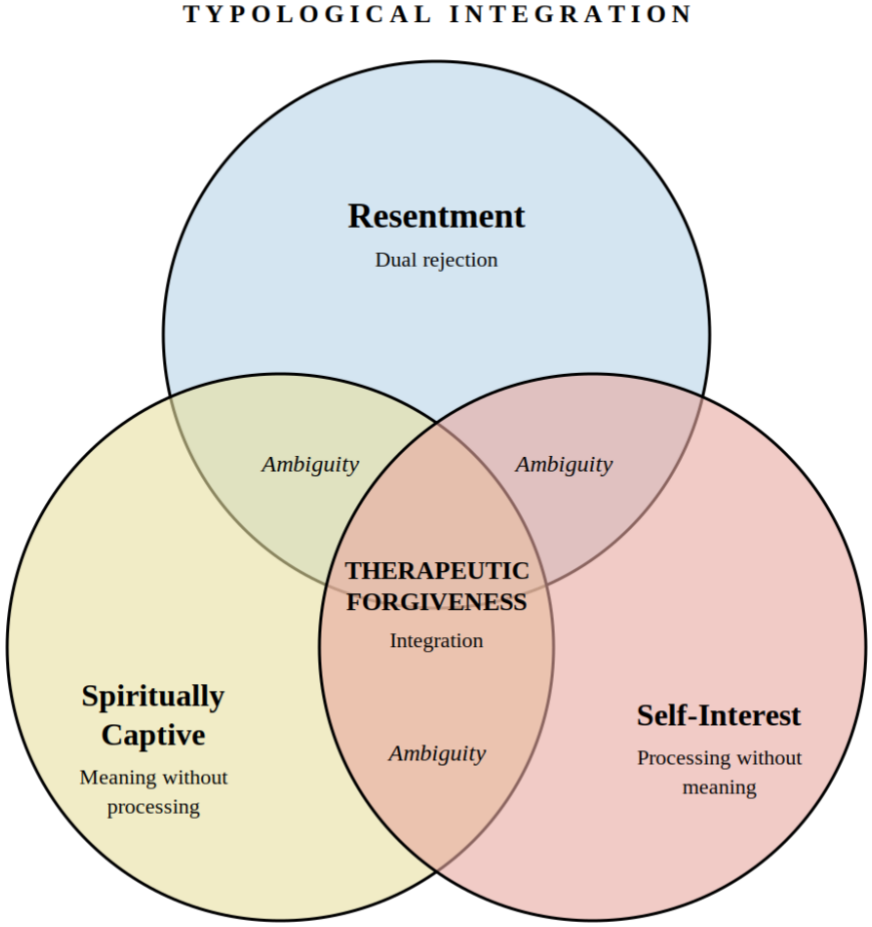
The Therapeutic Axis measures engagement with psychological health. *Acceptance (Health)* reflects willingness and active participation in evidence-based therapeutic process — across any modality: Cognitive Behavioral Therapy, Acceptance and Commitment Therapy, Dialectical Behavior Therapy, psychodynamic, humanistic, somatic, Eye Movement Desensitization and Reprocessing, neurofeedback. *Rejection (Void)* reflects the absence of therapeutic engagement: avoidance, resistance, lack of access, or systemic failure to provide adequate mental health support.

2.2 The Four Quadrants

When the two axes are crossed, four typological positions emerge (see Figure 1). These are *states*, not identities — a person can move between them across a lifetime, a year, or a single clinical session. The transitional dynamics between positions, including the ambiguity zones where clients occupy overlapping states, are illustrated in Figure 2.

Figure 2. Typological Integration: Transitional Dynamics

(Fisher, 2007/2026; adapted from the Anthropological Paradigm of Therapeutic Forgiveness)



Overlap regions represent ambiguity zones (TFI Moderate range, 29–43). Center represents dual-axis integration.

Resentment (Theological Rejection × Therapeutic Rejection). Both doors are closed. The person is disengaged from psychological process and closed to existential meaning. Resentment is often a rational protective response — the person may have been failed by both a therapist who did not listen and a religious institution that caused harm. In *The Invisible Life*, this position is described precisely: "What the resentment quadrant produces is not a false belief but a true belief that has become a prison — a belief so thoroughly confirmed by experience that it has become unfalsifiable. No amount of evidence that this time is different can penetrate a fortress built from

the accumulated evidence that every time before was the same" (Fisher, 2026, Ch. 3). Clinical presentation includes chronic bitterness, externalized blame, treatment resistance, and existential anger. *Therapeutic priority:* trust-building. The first door to open is whichever feels least threatening.

Self-Interest (Theological Rejection × Therapeutic Acceptance). The therapeutic door is open; the meaning door is closed. The person is engaged with mental health but operates within a framework bounded by individual benefit. Forgiveness is instrumentalized: "I forgive because holding on hurts me." This is the position Enright's model addresses most directly and Luskin's Stanford methodology targets explicitly — forgiveness as a health behavior, a stress-reduction technique. It is a valid and necessary stage — self-care must precede self-transcendence. But permanent residence here limits what forgiveness can become. In *The Invisible Life*, this position is identified as "psychological health without spiritual depth, the state of functional wellness that the pharmaceutical system produces and that the culture calls 'fine'" (Fisher, 2026, Prologue). *Therapeutic priority:* compassion expansion, values-based work (ACT), community engagement.

Spiritual Captivity (Theological Acceptance × Therapeutic Rejection). The meaning door is open; the therapeutic door is closed. The person has a robust spiritual framework but actively rejects psychological process. This is the position of the congregant who volunteers for everything but cries in the parking lot — whose faith community reinforces their identity as "whole" while the psychological void persists. The *Catechism* warns against a form of this: presumption — "hoping to obtain his forgiveness without conversion" (CCC §2092). Spiritual captivity is the clinical expression of that warning applied to the self. In *The Invisible Life*, this is "the state of the person who has faith but no treatment, who prays but does not heal, who believes in grace but cannot receive it because the psychological wound has not been named" (Fisher, 2026, Prologue).

Therapeutic priority: collaborative care with spiritual leaders; framing therapy as complementary to faith, not a failure of it.

Therapeutic Forgiveness (Theological Acceptance × Therapeutic Acceptance). Dual-axis integration is achieved. The person is engaged with psychological health and oriented toward existential meaning. Forgiveness emerges as genuine relational and existential process — neither instrumentalized nor spiritually bypassed. This is the position where, in Aquinas's terms, grace perfects nature: therapeutic honesty deepens the capacity for mercy, and openness to mercy deepens the capacity for therapeutic honesty. This is not a permanent destination but a practice — the person will revisit other quadrants during crisis, grief, or transition. The framework provides the map back.

3. The Contemporary Forgiveness Movement: A Brief History

3.1 The Birth of Forgiveness Science (1985–1994)

The scientific study of forgiveness began in 1985 when Robert D. Enright, a professor of Educational Psychology at the University of Wisconsin–Madison, published the first social scientific journal article on person-to-person forgiveness (Enright et al., 1989). Prior to this work, forgiveness had been studied almost exclusively within philosophy and theology. Enright and the Human Development Study Group at Wisconsin developed a definition of forgiveness that proved durable across diverse cultures and worldviews: "When unjustly hurt by another, we forgive when we overcome the resentment toward the offender, not by denying our right to the resentment, but instead by trying to offer the wrongdoer compassion, benevolence, and love" (International Forgiveness Institute, n.d.).

From this definition, Enright developed the Process Model of Forgiveness — a four-phase, 20-unit pathway consisting of the Uncovering Phase (gaining insight into how the injustice has

compromised one's life), the Decision Phase (committing to forgiveness as a healing strategy), the Work Phase (developing empathy, bearing pain, and offering the "moral gift" of forgiveness), and the Deepening Phase (discovering meaning in suffering and release from the "emotional prison" of unforgiveness) (Enright, 2001; Enright & Fitzgibbons, 2015). The model was first empirically tested in 1993 by Enright and Monsignor John Hebl (Enright & the Human Development Study Group, 1991; Hebl & Enright, 1993).

In 1994, Enright co-founded the International Forgiveness Institute (IFI), a 501(c)(3) nonprofit based in Madison, Wisconsin, dedicated to the dissemination of forgiveness knowledge and community renewal through forgiveness. The IFI has since developed forgiveness education curricula operating in more than 30 countries, including programs in Belfast, Northern Ireland (operating continuously since 2002), Liberia, Israel-Palestine, and Pakistan (International Forgiveness Institute, n.d.). Notably, the Enright Forgiveness Inventory (EFI), developed as an objective measure of the degree to which one person forgives another, is now used by researchers worldwide.

In 2022, Enright received the American Psychological Foundation's Gold Medal Award for Impact in Psychology — described by the APA as "psychology's highest award" — for his pioneering work on forgiveness science. In 2019, Enright and Dr. Richard Fitzgibbons, MD, Director of the Institute for Marital Healing, jointly received the Expanded Reason Award from the University Francisco de Vitoria (Madrid, Spain) in collaboration with the Vatican Foundation Joseph Ratzinger/Benedict XVI, recognizing their forgiveness therapy research as innovative work bridging the social sciences (International Forgiveness Institute, 2019).

3.2 The REACH Model and Emotional Forgiveness (1990–present)

A second major tradition in forgiveness research emerged from the work of Everett L. Worthington Jr., a clinical psychologist and professor at Virginia Commonwealth University. Worthington's contribution centers on the distinction between *decisional forgiveness* (a behavioral commitment to not seek revenge) and *emotional forgiveness* (the replacement of negative emotions with positive ones such as empathy, compassion, and love). His REACH Forgiveness model provides a five-step pathway: Recall the hurt, Empathize with the offender, give the Altruistic gift of forgiveness, Commit to forgive, and Hold onto forgiveness (Worthington, 2001, 2006).

Worthington's work carries particular weight because of its personal foundation. In 1995, his mother was brutally murdered during a home invasion. He subsequently applied his own forgiveness methodology to forgive her killer — an experience he has described publicly and which gave his research an unusual credibility in both clinical and popular settings (Worthington, 2001). His model has been supported by more than 25 published randomized controlled trials conducted across multiple laboratories (Worthington, n.d.) and has been used in secular and Christian universities, churches, couple counseling, workplace reconciliations, drug rehabilitation, and international peacemaking efforts.

3.3 The Stanford Forgiveness Project (1999–present)

A third major center of forgiveness research developed at Stanford University under Dr. Fred Luskin, who directs the Stanford Forgiveness Projects — among the largest interpersonal forgiveness training research programs ever conducted. Funded by a major grant from the John Templeton Foundation (which has supported more than 58 forgiveness studies totaling over $6.4 million), the Stanford project recruited 259 adult participants and developed a nine-step forgiveness methodology (Luskin, 2003).

The Stanford project's most dramatic results came from its work with victims of the Northern Ireland conflict. Mothers who had lost their sons reported that their perception of hurt decreased from 8.6 to 3.4 on a 10-point scale, along with a statistically significant increase in optimism and a 20% decline in depression symptoms and 35% decline in stress markers (Harris et al., 2006). In the initial Stanford student studies, participants reported a 70% reduction in how much hurt they felt about the specific incident that brought them to the project (Harris et al., 2006; Luskin, 2003).

3.4 The Meta-Analytic Evidence (2014)

The most comprehensive synthesis of the forgiveness evidence base came in 2014, when Nathaniel G. Wade, William T. Hoyt, Julia E. M. Kidwell, and Everett L. Worthington Jr. published a meta-analysis of all outcome research on forgiveness in the *Journal of Consulting and Clinical Psychology*. Their findings confirmed that forgiveness interventions produce reliable effects on depression, anxiety, and hope. Critically, they found that REACH Forgiveness and Enright's Process Model were used with equal frequency, and the number of randomized controlled trials on each model equaled the number on all other treatments combined. When statistically adjusted for treatment time, no model was superior to any other — participants increased their forgiveness by approximately 0.1 standard deviations per hour of treatment across all approaches (Wade et al., 2014).

3.5 What Remains Missing

Existing forgiveness models measure forgiveness outcomes — reductions in resentment, increases in empathy, improvements in well-being (McCullough, 2000; Toussaint et al., 2015) — but they do not assess the interaction between therapeutic engagement and existential orientation. No published instrument maps where a person stands on both dimensions simultaneously or tracks

movement across their intersection over time. Enright's model acknowledges the moral and even spiritual nature of forgiveness — his Deepening Phase includes "discovering meaning in suffering" — but does not provide a clinical framework for integrating existential meaning-making with therapeutic process. Worthington's REACH model has been adapted for Christian contexts but maintains a primarily emotion-focused orientation. Luskin's approach explicitly frames forgiveness as a health behavior, largely independent of existential or spiritual considerations.

None of these models — individually or collectively — provide the clinician with a systematic tool for assessing where a person stands on *both* dimensions simultaneously, or for tracking movement across those dimensions over time. This is the gap the Therapeutic Forgiveness Framework addresses.

4. Integrative Literature and the Remaining Gap

4.1 Existing Integrative Approaches and Their Limits

Several existing frameworks address aspects of the integration this paper proposes. Acknowledging them clarifies what the Therapeutic Forgiveness Framework contributes that they do not.

Logotherapy. Viktor Frankl's logotherapy, developed from his experiences in Nazi concentration camps, posits that the primary human motivation is the will to meaning (Frankl, 1946/2006). Frankl's insight that suffering becomes bearable when it acquires meaning is foundational to the theological/existential axis of the present framework. However, logotherapy does not provide a systematic tool for assessing the *therapeutic* dimension — a client's engagement with evidence-based psychological treatment — nor does it map the interaction between meaning-orientation and therapeutic engagement across distinct clinical positions.

Meaning-making theory. Crystal Park's meaning-making model distinguishes between global meaning (overarching beliefs, goals, and sense of purpose) and situational meaning (interpretations of specific stressful events), proposing that discrepancies between the two generate distress and motivate meaning-making efforts (Park, 2010). Park's framework is empirically robust and directly relevant to the theological/existential axis. What it does not address is the clinical reality that meaning-making and therapeutic engagement can operate independently — a person may be actively constructing meaning (high on the existential axis) while refusing therapeutic help (the Spiritual Captivity quadrant), or may be fully engaged in therapy (high on the therapeutic axis) while reporting no connection to meaning whatsoever (the Self-Interest quadrant). The present framework maps these dissociations explicitly.

Self-compassion. Kristin Neff's self-compassion construct — comprising self-kindness, common humanity, and mindfulness — provides a well-validated positive psychological resource relevant to forgiveness processes (Neff, 2003). Self-compassion research demonstrates that individuals who treat themselves with kindness during suffering report lower depression and anxiety and greater life satisfaction. The TFI's therapeutic dimension captures elements of self-compassion orientation, but the framework adds a second axis — the existential/theological — that self-compassion research does not systematically assess.

Moral injury. Litz and colleagues defined moral injury as the lasting psychological, behavioral, spiritual, and social impact of "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" (Litz et al., 2009, p. 700). The moral injury construct is directly relevant to the framework's Resentment and Spiritual Captivity quadrants, where individuals have experienced betrayal by systems (healthcare, legal, religious) that were supposed to protect them. Moral injury research demonstrates that standard

PTSD treatments may be insufficient when the wound is fundamentally moral rather than threat-based — precisely the clinical observation that motivated the present framework's dual-axis structure.

Acceptance and Commitment Therapy (ACT). ACT's emphasis on values-based living and psychological flexibility represents perhaps the closest existing therapeutic modality to the framework's integrative intent (Hayes et al., 2006). ACT explicitly addresses meaning and purpose alongside evidence-based therapeutic technique. However, ACT operates within a single therapeutic relationship; it does not provide a shared assessment language for cross-discipline collaboration between clinicians and spiritual care providers. The TFI and its four-quadrant matrix are designed specifically to fill this gap — providing a common visual language that both the therapist and the spiritual director can use simultaneously, with the person who is suffering at the center rather than at the seam between two systems.

What the present framework adds. None of the above models — individually or collectively — provide the clinician with a tool for (a) assessing where a person stands on *both* dimensions simultaneously, (b) identifying the specific clinical position that results from that intersection, (c) recommending dimension-specific therapeutic priorities for each position, or (d) tracking movement across positions over time in a format accessible to both clinical and pastoral care providers. That is the contribution of the Anthropological Paradigm of Therapeutic Forgiveness.

5. Theological Foundations

5.1 Catholic Theological Anthropology

The framework's theological dimension is rooted in the Catholic understanding of the human person as a unity of body and soul, created in the image of God (*imago Dei*), wounded by original

sin, and oriented toward redemption through grace. The *Catechism of the Catholic Church* teaches that forgiveness is not merely a human act of will but a participation in God's own mercy:

> "It is not in our power not to feel or to forget an offense; but the heart that offers itself to the Holy Spirit turns injury into compassion and purifies the memory in transforming the hurt into intercession" (CCC §2843).

This passage is clinically significant. It acknowledges what every therapist knows: the wound does not disappear because the person decides to forgive. The feelings persist. What changes is the *orientation* — from injury toward intercession, from hurt toward compassion. That reorientation requires both the therapeutic processing of the emotion and the theological openness to a mercy that transcends the individual's own capacity.

5.2 Grace Perfects Nature: Thomas Aquinas

The philosophical warrant for integration comes from Thomas Aquinas: *gratia non tollit naturam, sed perficit* — "grace does not destroy nature, but perfects it" (*Summa Theologiae* I, q. 1, a. 8, ad 2). If grace perfects nature rather than replacing it, then psychological health is not a competitor to spiritual wholeness but its substrate — a person who has processed trauma therapeutically is more capable of receiving grace, not less. Conversely, the *Catechism* warns against *presumption* — "hoping to obtain his forgiveness without conversion" (CCC §2092) — which describes clinically what the framework identifies as Spiritual Captivity: faith without therapeutic engagement.

The framework does not require Catholic faith to function, but it takes seriously what Catholic anthropology insists: the whole person must be addressed. John Paul II affirmed this in *Fides et Ratio* (1998), describing faith and reason as complementary modes of knowledge (§1).

5.3 The Lord's Prayer and the Conditional Structure of Forgiveness

The fifth petition of the Lord's Prayer — "Forgive us our debts, as we also have forgiven our debtors" (Matthew 6:12) — provides direct scriptural support for the framework's dual-axis structure. The *Catechism* calls this petition "astonishing," noting that "our petition will not be heard unless we have first met a strict requirement" — the conditional word "as" joining our request for mercy to our own willingness to extend it (CCC §2838). The *Catechism* further states: "This outpouring of mercy cannot penetrate our hearts as long as we have not forgiven those who have trespassed against us" (CCC §2840). The "hardness" that blocks mercy corresponds clinically to treatment resistance and emotional avoidance; the "confessing" that opens the heart corresponds to therapeutic processing and reframing. The Lord's Prayer articulates in theological language what the framework proposes clinically: forgiveness requires both the reception of mercy (the theological axis) and active engagement with healing (the therapeutic axis).

Jesus's instruction to forgive "seventy times seven" (Matthew 18:22) reinforces the framework's design principle: forgiveness is not an event but a repeated practice, which is why the TFI is designed for re-administration at clinical milestones.

5.4 Salvifici Doloris and the Theology of Suffering

John Paul II's apostolic letter *Salvifici Doloris* (1984) provides the most sustained Catholic reflection on suffering's relationship to meaning. John Paul II begins with a phenomenological observation: "Man suffers on account of evil, which is a certain lack, limitation or distortion of good" (§7) — suffering as a response to absence, aligning with the framework's therapeutic axis where psychological void is the space where suffering persists without professional response. He then argues that suffering can acquire redemptive meaning when met with both honesty and openness: "It has been linked to love ... to that love which creates good, drawing it out by means of suffering" (§18). The letter's most clinically resonant passage appears in §27: "It is suffering,

more than anything else, which clears the way for the grace which transforms human souls" — describing what clinicians recognize as the breakthrough moment when a defended client allows pain to surface.

In *The Invisible Life*, this integration is observed clinically: "The bearability — the capacity to carry what had seemed uncarriable — came not from the medication alone and not from the faith alone but from the integration of both" (Fisher, 2026, Prologue). The framework holds that both the therapeutic description (processing) and the theological description (grace) are accurate, and that neither is complete without the other.

5.5 The Phenomenology of Suffering

The framework adopts a phenomenological stance consistent with the author's doctoral methodology, which employed Husserl's descriptive phenomenology (Fisher, 2021). In *The Invisible Life*, healing is described as requiring "an encounter with a presence that holds the wound without trying to fix it, that witnesses the suffering without flinching" (Fisher, 2026, Ch. 3). The clinical question is whether the person has access to both dimensions — therapeutic processing and existential meaning — simultaneously.

6. The Therapeutic Forgiveness Inventory (TFI)

The TFI is a preliminary 24-item clinical discussion instrument — intended for collaborative assessment rather than standalone diagnosis — designed to operationalize the framework for use in both clinical and pastoral settings. It consists of two 12-item subscales:

Section A: The Therapeutic Dimension — "How I Relate to My Healing." Twelve items assessing engagement with psychological process, willingness to seek help, emotional processing capacity, and orientation toward therapeutic growth.

Section B: The Theological/Existential Dimension — "How I Relate to Meaning and Purpose." Twelve items assessing openness to existential meaning, capacity for mercy, connection to something larger than the self, and orientation toward grace.

Items are scored on a 5-point Likert scale (Strongly Disagree to Strongly Agree) with reverse scoring on selected items. Each subscale produces a score classified as Low (Rejection), Moderate (Ambiguity), or High (Acceptance). The intersection of the two scores identifies the person's primary quadrant position and any transitional ambiguity zones.

The TFI is written at an eighth-grade reading level, uses ecumenical language adaptable to any faith vocabulary or secular framework, and is available in English and Spanish (*Inventario de Perdón Terapéutico*). The Spanish version employs gender-inclusive language throughout (e.g., *abierto/a*, *dispuesto/a*, *conectado/a*). It includes a scoring worksheet, quadrant interpretation guide, clinical discussion protocol, and goal-setting framework.

The instrument is designed for dual audiences: licensed mental health practitioners (counselors, psychologists, social workers, therapists) and spiritual care providers (priests, rabbis, imams, chaplains, pastoral counselors, spiritual directors). When both providers can see the same matrix, the person in the middle stops being fragmented between two systems that do not speak each other's language.

7. Clinical Implications

7.1 Assessment and Treatment Planning

The framework provides a collaborative orientation tool — not a diagnostic instrument. The person's self-identified position on the matrix is the starting point; discrepancies between clinician observation and self-report are themselves clinically meaningful. Each quadrant suggests different therapeutic priorities, modality selections, and referral pathways.

7.2 Clinical Interpretation of Quadrants

Each quadrant position carries distinct clinical implications. Two brief composite vignettes illustrate:

Spiritual Captivity. A 42-year-old woman active in religious ministry reports persistent depressive symptoms (PHQ-9 score: 16) but declines referral for psychotherapy, stating that "God will handle it." She attends weekly prayer services, maintains a gratitude journal, and serves as a lay counselor in her parish. Her TFI scores — high on the theological/existential subscale, low on the therapeutic subscale — place her in the Spiritual Captivity quadrant. The therapeutic priority is reframing clinical treatment as complementary to her faith, ideally in collaboration with her pastor.

Self-Interest. A 35-year-old man has been in cognitive-behavioral therapy for 18 months following a workplace betrayal. His anxiety symptoms have improved substantially (GAD-7 reduced from 14 to 5), and he reports using forgiveness language in session — but describes it exclusively as stress reduction. When asked whether the forgiveness process has changed his sense of life's meaning or purpose, he responds: "I don't think about it that way. I just want to feel better." His TFI scores — high on the therapeutic subscale, low on the theological/existential subscale — place him in the Self-Interest quadrant. The therapeutic priority is values exploration and meaning-oriented work. Resentment (dual rejection) typically presents with chronic bitterness, externalized blame, and treatment resistance; therapeutic priority is trust-building before any intervention. Self-Interest (therapeutic acceptance, theological rejection) presents as functional improvement with persistent existential emptiness; priority is compassion expansion and values-based work. Spiritual Captivity (theological acceptance, therapeutic rejection) presents as robust faith with unprocessed psychological distress and potential shame cycles; priority is reframing therapy as complementary

to faith. Therapeutic Forgiveness (dual acceptance) presents as dynamic integration requiring ongoing practice and relapse monitoring. Discrepancies between the client's self-identified quadrant and TFI results are themselves clinically meaningful and should be explored collaboratively.

7.3 The Bridge: Spiritual Directors, Pastoral Counselors, and Clinicians

The Therapeutic Forgiveness Framework is designed not as a tool for one profession but as a *shared language* between professions that have historically operated in parallel without intersection.

For spiritual directors and pastoral counselors: The framework provides clinical language for experiences they already encounter. The congregant who volunteers for every parish ministry but cannot name their pain is in Spiritual Captivity — a position the spiritual director may intuit but lack vocabulary to name or refer. The TFI gives the spiritual director a structured way to assess whether the person before them needs not only prayer and accompaniment but also clinical intervention. It validates the spiritual director's instinct that something is unfinished while providing a concrete recommendation: "This person would benefit from concurrent therapeutic engagement." The spiritual director does not become a therapist. They become a *referral-capable collaborator* who can articulate what they observe in language the therapist will recognize.

For priests, rabbis, imams, and chaplains: The framework honors the reality that religious leaders are often the first responders to human suffering — long before a therapist is consulted. Studies consistently show that individuals in distress are more likely to seek help from clergy than from mental health professionals (Wang et al., 2003). The framework equips clergy to triage: Is this person in Resentment (dual rejection — build trust before anything else)? Self-Interest (therapeutic door open — affirm the work, gently explore meaning)? Spiritual Captivity

(theological door open — normalize therapeutic engagement as complementary to faith)? Or Therapeutic Forgiveness (dual-axis integration — walk alongside them)? Each position suggests a different pastoral response.

For licensed clinicians (LPCs, psychologists, social workers, therapists): The framework provides a systematic way to assess the dimension of human experience that evidence-based training often brackets: the client's relationship to meaning, purpose, and transcendence. Most clinical training teaches practitioners to "respect the client's spiritual beliefs" but provides no instrument for *assessing* them or *integrating* them into treatment planning. The TFI fills this gap. When a clinician administers the TFI and finds a client scoring high on the therapeutic dimension but low on the theological/existential dimension (Self-Interest), they have clinical data — not speculation — to inform a conversation about whether the client's forgiveness work might benefit from engagement with meaning-making, community, or spiritual practice. The clinician does not become a spiritual director. They become a *referral-capable collaborator* who can identify when existential factors are relevant to therapeutic progress.

The shared matrix: When both providers — the clinician and the spiritual director — can see the same four-quadrant map, the person in the middle stops being fragmented between two systems that do not speak each other's language. The clinician can say: "Your client is in Spiritual Captivity — they have a robust faith framework but are avoiding therapeutic engagement. Can you help frame therapy as complementary to their faith?" The spiritual director can say: "Your client is in Self-Interest — the therapy is working but they seem cut off from any source of meaning beyond themselves. Can you explore that?" This shared vocabulary is the framework's most significant practical contribution. It does not merge the two professions. It builds a bridge between them — and places the person who is suffering at the center rather than at the seam.

7.4 Longitudinal Tracking

The matrix is designed for repeated use. A person's position at intake, at three months, at a year, and at discharge can be plotted, creating a longitudinal map of movement that captures what symptom-reduction measures alone cannot: the integration of psychological healing with existential coherence.

8. Limitations and Future Directions

The Therapeutic Forgiveness Framework is a theoretical and clinical model, not yet subjected to empirical validation through controlled research. The TFI has face validity and clinical utility as a discussion instrument but has not undergone formal psychometric validation (reliability analysis, factor analysis, convergent/discriminant validity testing). A planned validation program will include exploratory factor analysis to confirm the two-subscale structure, internal consistency reliability (Cronbach's alpha), test-retest reliability over a three-month interval, and convergent validity testing with established forgiveness measures including the Enright Forgiveness Inventory (EFI-30) and Worthington's Transgression-Related Interpersonal Motivations Inventory (TRIM-18), and outcome studies examining whether framework-guided interventions produce differential effects compared to standard forgiveness therapy protocols.

Potential hypotheses for future investigation include: (1) Individuals scoring high on both TFI dimensions will report higher forgiveness outcomes than those scoring high on only one dimension. (2) Movement across the matrix quadrants over time will correlate with reductions in depression and anxiety as measured by standardized instruments (e.g., PHQ-9, GAD-7). (3) Clients in the Spiritual Captivity quadrant will demonstrate greater therapeutic improvement when evidence-based therapy is paired with concurrent spiritual support or pastoral collaboration.

The framework's Catholic theological origins, while deliberately universalized in application, would benefit from formal engagement with scholars in other faith traditions to ensure the theological/existential axis accurately captures non-Christian experiences of existential meaning. The Spanish-language TFI has been translated with attention to gender-inclusive language but has not been validated with native Spanish-speaking clinical populations.

9. Conclusion

The Anthropological Paradigm of Therapeutic Forgiveness proposes that the human experience of forgiveness cannot be adequately understood, assessed, or facilitated through either a purely psychological or purely theological lens. The integration of both dimensions — what Aquinas called the meeting of grace and nature — is not merely desirable but necessary for forgiveness that is embodied, sustained, and transformative.

The forgiveness movement that began with Enright's first article in 1985 has produced four decades of extraordinary science: process models, randomized trials, meta-analyses, and interventions that have reached populations from incest survivors to inmates to mothers who lost their sons in Northern Ireland. That science has established beyond reasonable doubt that forgiveness works — it reduces anger, depression, anxiety, and stress; it increases hope, self-esteem, and life satisfaction. What it has not yet fully addressed is *why* — what makes forgiveness possible at the deepest level of the human person, and what happens when the therapeutic and the transcendent are held together rather than kept apart.

This framework and its clinical discussion instrument — the TFI — offer one answer: dual-axis integration must be open. The clinician's door and the chaplain's door. The evidence-based treatment and the encounter with meaning. The processing of the wound and the possibility of mercy.

In *The Invisible Life*, the practices of therapeutic forgiveness are described as "ongoing — daily practices that become, over time, a way of life. They are the practices of the invisible life" (Fisher, 2026, Ch. 8). The book concludes: "The invisible is not empty. It is full. ... The invisible is full of grace. It is full of the presence that arrives without conditions and remains without agenda. It is full of the meaning that the suffering contains when the suffering is held within a framework large enough to hold it" (Fisher, 2026, Epilogue).

That is the Anthropological Paradigm of Therapeutic Forgiveness. That is what dual-axis integration looks like.

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Appendix A: Original Supplemental Handout (2007)

The following is the text of the original supplemental handout prepared for the author's Master of Arts thesis oral defense at St. Mary Seminary and Graduate School of Theology, Wickliffe, Ohio (2007). The document was reprinted for a subsequent presentation in 2009. It is reproduced here to establish provenance and to illustrate the framework's intellectual evolution from its original Catholic theological vocabulary to the universalized clinical model presented in this paper.

Supplemental Handout #1

The Anthropological Paradigm of Therapeutic Forgiveness: An Integrative Model

CATEGORICAL DISPOSITIONS

• Therapeutic Rejection: Psychological Void

• Therapeutic Acceptance: Mental/Emotional Health

• Theological Rejection: Sin

• Theological Acceptance: Grace (Christian Charity)

TYPOLOGICAL DYNAMIC

• Theological, Therapeutic Rejection: **Resentment**

• Theological Rejection, Therapeutic Acceptance: **Ignorance/Self-Interest**

• Theological Acceptance, Therapeutic Rejection: **Spiritually Captive**

• Theological, Therapeutic Acceptance: **Therapeutic Forgiveness** (Ultimate Goal of Integration)

MATRIX

|---|---|---|

Supplemental Handout #2

The Anthropological Paradigm of Therapeutic Forgiveness: An Integrative Model

TYPOLOGICAL INTEGRATION

[Original Venn diagram depicting the convergence of the theological and therapeutic dimensions toward integration.]

Note on evolution: The original handout used explicitly Catholic terminology — "Sin" for theological rejection and "Grace (Christian Charity)" for theological acceptance. The current framework retains the structural architecture but universalizes the vocabulary: "Sin" becomes "Separation" (closure to existential meaning); "Grace (Christian Charity)" becomes "Grace" (openness to existential meaning across all faith traditions and secular frameworks). The position originally labeled "Ignorance/Self-Interest" was refined to "Self-Interest" as clinical observation confirmed that the position reflects not ignorance but a *bounded* orientation toward healing. These refinements represent 19 years of clinical testing across diverse populations and faith traditions, from the original Catholic seminary context to the universal clinical instrument that is the TFI.

Supplemental Handout #1
The Anthropological Paradigm of Therapeutic Forgiveness: An Integrative Model

CATEGORICAL DISPOSITIONS

Therapeutic Rejection: Psychological Void

Therapeutic Acceptance: Mental/Emotional Health

Theological Rejection: Sin

Theological Acceptance: Grace (Christian Charity)

TYPOLOGICAL DYNAMIC

Theological, Therapeutic Rejection: Resentment

Theological Rejection, Therapeutic Acceptance: Ignorance/Self-Interest

Theological Acceptance, Therapeutic Rejection: Spiritually Captive

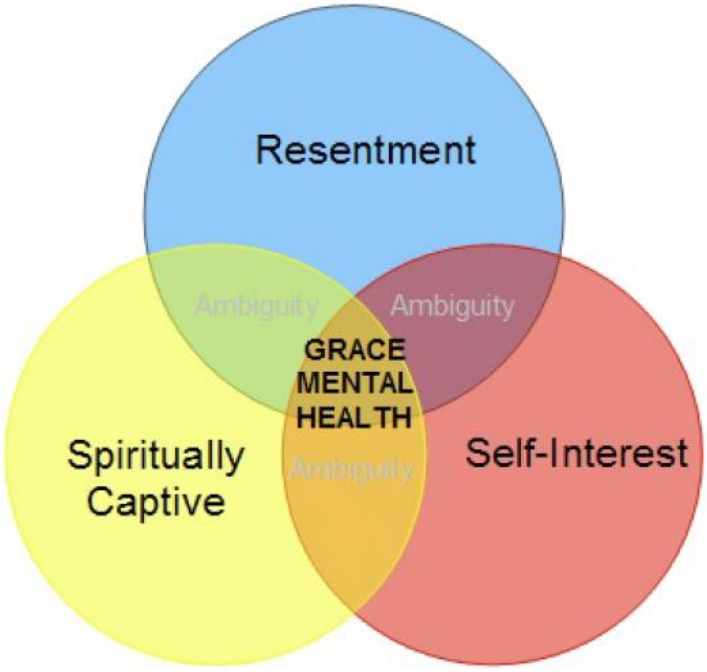
Theological , Therapeutic Acceptance: Therapeutic Forgiveness (Ultimate Goal of Integration)

THERAPEUTIC FORGIVENESS MATRIX

	Therapeutic Rejection (Psychological Void) ↓	Therapeutic Acceptance (Mental/Emotional Health) ↓
Theological Rejection (Sin) →	Theological & Therapeutic Rejection (Resentment)	Theological Rejection, Therapeutic Acceptance (Ignorance/Self-Interest)
Theological Acceptance (Grace - Charity) →	Theological Acceptance, Therapeutic Rejection (Spiritually Captive)	Theological & Therapeutic Acceptance (GOAL) Therapeutic Forgiveness

Supplemental Handout #2
The Anthropological Paradigm of Therapeutic Forgiveness: An Integrative Model

TYPOLOGICAL INTEGRATION



Appendix B: Therapeutic Forgiveness Inventory (TFI) — Item Content

The following are the 24 items of the Therapeutic Forgiveness Inventory (TFI), organized by subscale. Items marked [R] are reverse-scored. The full clinical instrument, including administration guide, scoring worksheet, quadrant interpretation guide, clinical discussion protocol, and goal-setting framework, is available from the author in English and Spanish (*Inventario de Perdón Terapéutico*).

Section A: How I Relate to My Healing (Therapeutic Dimension)

1. I believe that professional help (therapy, counseling, medication) can make a real difference in my life. 2. When I think about my past experiences with treatment, I feel mostly disappointed or let down. [R] 3. I am willing to try new approaches to improve my mental or emotional health. 4. I have given up on the idea that therapy or counseling can help someone like me. [R] 5. I can identify at least one coping strategy that has helped me manage difficult emotions. 6. The mental health system has failed me more than it has helped me. [R] 7. I am open to examining painful memories or experiences if it could lead to healing. 8. I don't see the point in talking about my problems with a professional. [R] 9. I believe I have the ability to develop healthier ways of dealing with stress and pain. 10. I have learned not to trust people who say they want to help me. [R] 11. I take an active role in managing my mental and emotional health. 12. The help that has been offered to me has mostly made things worse, not better. [R]

Section B: How I Relate to Meaning and Purpose (Theological/Existential Dimension)

13. I believe my suffering has meaning, even when I cannot see what that meaning is. 14. I see no purpose or larger significance in the pain I have experienced. [R] 15. I feel connected to something larger than myself (God, a higher power, the universe, a sense of purpose). 16. The idea that suffering has meaning feels like something people say to avoid dealing with reality. [R] 17. I have

experienced moments of unexpected peace, comfort, or grace during difficult times. 18. I feel completely alone in my suffering, with no spiritual or existential support. [R] 19. I am open to exploring how my personal beliefs or values might help me heal. 20. Religion, spirituality, and the search for meaning have not been helpful to me. [R] 21. I can identify at least one relationship, practice, or experience that gives my life a sense of purpose. 22. I have stopped looking for meaning in my suffering because there is none to find. [R] 23. I believe that forgiveness (of others, of myself, or of circumstances) is possible, even when it feels impossible. 24. The idea of forgiveness feels like being asked to pretend that what happened to me was acceptable. [R]

Scoring

Each item is rated on a 5-point Likert scale (1 = Strongly Disagree to 5 = Strongly Agree). For reverse-scored items [R], convert responses: 1→5, 2→4, 3→3, 4→2, 5→1. Each subscale produces a raw score from 12–60.

|---|---|---|

The intersection of the two subscale classifications identifies the client's primary quadrant: Resentment (Low/Low), Self-Interest (Low Theological, High Therapeutic), Spiritual Captivity (High Theological, Low Therapeutic), or Therapeutic Forgiveness (High/High). Clients scoring in the Moderate range on either dimension occupy an *ambiguity zone* — a clinically significant transitional state. Figure 2 illustrates these transitional dynamics visually, showing the overlap regions between the three non-integrated positions (Resentment, Self-Interest, Spiritual Captivity) and the convergence zone representing Therapeutic Forgiveness at the center of integration.

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Appendix A reproduces the original 2007 supplemental handout from St. Mary Seminary and Graduate School of Theology. The original PDF (reprinted 2009) is available from the author upon request.