Ανασκόπηση
Review

Hate and forgiveness

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Feelings of hate are commonly encountered in psychiatric practice and civil and international conflict ("conflict"). The author offers an integrated psycho-physiological, psychodynamic and social psychological model of the origins and impact of hate in difficult clinical situations. This model, coupled with ethical commitment to dialogue with the patient and recognition of mutual citizenship between mental health professional and patient, may help prevent the destructive acting out of feelings of hate in clinical practice in general and in multicultural societies in particular. The destructive acting out of feelings of hate is common in conflict situations. Understanding the value and practice of forgiveness, as developed in conflict situations, may further assist mental health professionals maintain dialogue in a spirit of citizenship and apply the complex model of social-psycho-biological understanding of hate proposed here in clinical practice for beneficent purposes. Limitations on the value of ideas of dialogue and citizenship are discussed, particularly in the light of the clinical realities (e.g. severe disability or psychopathy) and theories of social justice. Limits to dialogue or citizenship notwithstanding, the concept of forgiveness is proposed as a fundamental ethical value in clinical practice, of particular importance to psychiatry.

Key words: *hate, conflict, clinical practice, dialogue, citizenship, forgiveness.*

Introduction

The challenges posed to the psychiatric profession by terrorism,[1] communal violence[2] and international conflict[3] (to be collectively to referred here as *"conflict")* are increasingly being recognized, as evidenced by the World Psychiatric Association co-sponsored *First International Conference on the Role of Health and*

Culture in Conflict Resolution, in Malta, 9th to 11th June 2003. In this paper I wish to attempt a preliminary exploration of the possible relevance of clinical experience with hate to conflict and conflict resolution. I will, also, explore the possible relevance of ideas of political forgiveness to containing feelings of hate in clinical psychiatry.

It is not the aim of this paper to propose psychiatric solutions to conflict but to explore common themes in relation to the experience and relevance of hate and forgiveness in clinical and conflict situations. Though hate/ conflict and fear are commonly associated with political and military conflict situations psychiatrists and other mental health professionals are not immune from these factors. The main aim of this paper is to contribute to the training and professionalism of psychiatrists and other mental health professionals so that we may tackle such factors successfully.

Hate in clinical practice and conflict

In my practice as clinician and psychiatric educator I have been impressed by the ubiquity and destructive potential of feelings of hate in psychiatric and other medical settings. In a previous paper[4] I have drawn particular attention to the phenomenon of "malignant alienation". Morgan and colleagues at Bristol University[5] have proposed this term to highlight their finding that patients who had committed suicide, while inpatients on psychiatric wards, were less liked by mental health staff than those that had not. I have, also, drawn attention to Maltsberger and Bhui's paper on "Countertransference hate in the treatment of the suicidal patient".[6] Their vivid description of the experience of such hate by the clinician merits quoting again:

> When sadistic acting out against a patient is sometimes relatively easy to rationalize, the therapist who is well able to tolerate conscious and physical manifestations of angry and sadistic affect, i.e. he who does not have to rely on isolation or other defenses to ward off such feelings, will be able to attend to his own emotional excitation. This means for most people a sense of muscular tightness or tension; especially the abdominal muscles may feel tense, and there is a tendency rhythmically to tighten the musculature of the jaws, buttocks and anal sphincter. Sometimes there are sensations of sexual arousal. There may be a sense of righteous indignation. If the therapist can tolerate it he may experience lively impulses to kill the patient, beat him, cut him, where others may experience anxiety. Able psychotherapists monitor themselves even for slight degrees of such responses and use them as indicators that the patient is in danger of evoking an anti-therapeutic response... The kind of counter-transference acting out that is more likely to result in suicide involves the therapist's unconscious impulses to kill the patient.

Feelings of countertransference hate may be contained or acted out. The phenomenon of 'malignant alienation' suggests that they may be acted out in indirect but catastrophic ways. The most spectacular and disturbing historical example of the direct acting out of malignant feelings of hate against psychiatric patients has been the deliberate killing of 100,000 severely mentally ill in 5 psychiatric 'hospitals', specially designated as extermination camps for these patients, in Nazi Germany.[4] Evidence of currently ongoing abuse of the vulnerable elderly in institutional settings, and neglect of mentally ill people in the community indicate that this is not just a historical but also a contemporary psychiatric problem.[4]

It is the acting out of feelings of hate that provides the link between the experience of hate in clinical and conflict situations. The ubiquity of feelings of hate in conflict situations is widely known. The following quote, from an authoritative history of the French Revolution, an event of universal significance, underscores its relevance. Schama refers here to the vengeance extracted on counter-revolutionary elements in the region of Vendee during the French Revolution:[7]

> The most notorious massacres were at Nantes, where the representant-en-mission, Jean-Baptiste Carrier, supplemented the guillotine with what he called 'vertical deportations' in the river Loire. Holes where punched in the side of flat-bottomed barges below the waterline, over which wooden planks were nailed to keep the boats temporarily afloat. Prisoners were put in

with their hands and feet tied and the boats pushed into the center of the river to catch the current. The executioner-boatmen then broke or removed the planks and made haste to jump into boats that were alongside, while their victims helplessly watched the water rise about them. At first these drownings were confined to priests and took place almost guiltily, by night. But what the sans-culotte 'Marat Company' conspicuously in the repression humorously called the 'republican baptisms' or the 'national bath' became rutinised and executed in broad daylight, where some witnesses survived to describe them. In some cases prisoners were stripped of their clothes and belongings (always a source of prerequisites for the soldiers) giving rise to accounts of 'republican marriages': young men and women tied together in the boats. Estimates of those who perished in this manner vary greatly, but there were certainly no fewer than two thousand and quite possibly as many as forty-eight hundred.

The historical origins and moral significance of such events have been and continue to be debated by historians[8] but what is not in dispute is their regular recurrence. Indeed events in Nantes, grotesque as they were, seem to pale by comparison to some other historical events, including those described by Thucydides in his discussion of the origins of the Peloponnesian War.[9] Though the war itself may or may not have been of universal historical significance, Thucydides' record of it undoubtedly is of universal intellectual significance:

> When the Corcyreans realised that the Athenian fleet was approaching and that their enemies had gone... they seized upon all their enemies whom they could find and put them to death. They could deal with those whom they had persuaded to go on board ships, killing them as they landed. Next they went to the temple of Hera and persuaded about fifty to submit to trial. They then condemned every one of them to death. Seeing what was happening most of the other supplicants who had refused to be tried killed each other in the temple; some hanged themselves on the trees, and others found other various means of committing suicide. During the seven days that Everymedon stayed there with his sixty ships, the Corcyreans continued to massacre those of their own citizens whom they considered enemies. Their victims were accused of being enemies of democracy, but in fact men were often killed on grounds of personal hatred or else by their debtors because of the money they owed.

Popular support for and engagement in such activities has been complimented by intellectual encouragement by political philosophers. Amongst the earliest to offer such support has been Aristotle. For example, Kerrigan[10] quotes him as stating *"to take vengeance on one's enemies is nobler than to come to terms with them; for to retaliate is just, and that which is just is noble"*. We will return to Aristotle's comments later. Presently it will suffice to state that, although I do not agree with Aristotle on this point, I do not wish specifically to advocate pacifism as an alternative.

Ultimately, it is preferable to leave arguments about the justification or condemnation of vengeance, hate, violence and war to political philosophers, politicians and the general public. It may be, however, that our clinical experience and psychological understanding of hate may illuminate their deliberations and actions. In particular I wish to suggest that an integrated understanding of hate in clinical practice, through a consideration of psycho-physiological, social psychological and ethical aspects of fear and our responses to it may be relevant to the understanding and resolution of conflict. Conversely, as previously indicated, I wish to suggest that ideas of political forgiveness, emerging as they do from consideration of complex situations of conflict and sophisticated and integrated intellectual, emotional and civic responses to such conflict, may enrich our understanding and help support improvement in the practice of psychiatry, when issues of hate arise.

Fear, hate and citizenship

In this and subsequent sections I will assume that often, perhaps always, the roots of hate are in fear, both in clinical situations and in conflict. This may be an oversimplification. Melanie Klein[11] has postulated

envy and greed as fundamental to human destructiveness but the neurobiology of these remains to be worked out to the same extent as the neurobiology of fear. In any case similar principles may apply to the two. Others, of a more religious orientation, may posit evil as the root of hate. This is something I am in no position to support or refute but those of a religious inclination may wish to consider that what is described below are some of the mechanisms through which evil may manifest as hate.

The experimental psychologist Le Doux[12] has summarized elegantly the essentials of what is currently known about the psychophysiology of fear. In particular he has highlighted the significance of two overlapping but distinct neurobiological systems of response to threatening stimuli. The first leads from the perceptual apparatus (say visual) via the thalamus to the (visual) cortex and, then, through the cortical association areas, to thinking and action. The second leads directly from the thalamus to the amygdala and from there to fearful physical reaction (e.g., running away or shouting out or hitting back), prior to clear sensory information reaching the cerebral cortex.

The differences between the two systems are important. The first is associated with clear perception, reflective thinking and a considered behavioural response. It is a slow response system. The second is associated with indistinct perception and instinctive reaction, prior to any considered reflection. This second system is the one that provides a "rough and ready" response. The evolutionary advantages of this second system in the presence of acute physical danger are obvious. It may make the difference between life and death. On the other hand, the system is biased in the direction of action and may lead to unnecessary or wrong action. It may also be associated with maladaptive, extreme or persistent reactions, such as are observed in post-traumatic stress disorder.[13] In the present paper, however, I am not concerned with the diagnostic or psychopathological significance of the psycho-physiological fear system but with its potential relevance to hate in clinical practice and in conflict.

My thesis is that some patients come to be experienced by clinicians as enemies, and thus induce fear. It may be thought preposterous to suggest that the clinician's patient may appear to be an enemy but a close reading of the relevant literature[4,5,14] and careful reflection on one's own clinical experience may suggest that this is indeed the psychiatrist's experience some times. When this is the case the psychiatrist may respond out of fear, through an instinctive reaction, using the "rough and ready" second psycho-physiological system of response. I believe that countertransference hate and malignant alienation in clinical situations often have their origins in fear and may operate through this response system. For example the psychiatrist may fear an aggressive patient who has attempted suicide and terminate an assessment prematurely, before establishing an accurate assessment of mental state or other relevant risk factors. It must be emphasized however that fear in the clinician may be induced not only by aggression but other responses on the part of the patient as well, including poor concordance with treatment plans or simply failure to improve or, indeed, deterioration in health. It is worth considering the possibility that, in fact, fear of dependency may be a more common trigger of malignant alienation and countertransference hate than fear of aggression in clinical practice. Certainly this appears to have been the case in the killing of the mentally ill in Nazi Germany.[15]

Fear induced instinctive responses, in the clinical situation, are likely to be wrong and unhelpful. According to the psychology of cognitive dissonance[16] they are, also, likely to be justified post-facto by the clinician through processes of rationalization. Such processes may start with the feeling of "righteous indignation" that Maltsberger and Bhui identify (in the quote above) as part of the countertransference hate reaction. Lerner[17] has highlighted our need to believe that we live in a just world. By association we need to feel that our actions are just. It is this that gives force to our rationalizations. In the light of this theory it is not surprising that some mental health staff use moral language to justify their "rough and ready" counter-

transference acting out repeatedly. This is then amplified by supportive comments from members of the multidisciplinary mental health team. If I may be permitted to coin a neologism I would use the term *"morationalisation"*, a term intended to combine the meanings of "more than one person" "moralization" and "rationalization", to encapsulate this team/group process of reinforcing unhelpful countertransference reactions.

Hate is a social as much as a psychological phaenomenon. Its origins are in the psychophysiology of fear and pain and the force of its impact, in the first instance, on the individual and his or her behaviour. However, it becomes integrated through attitude change, rationalization and the creation of group cultures and team moral climates. It is my experience that it is the very moral nature of the justifications used by mental health teams staff, that makes malignant alienation and countertransference hate so difficult to reflect on, resistant to change and pernicious in their effect.

If we truly wish, therefore, to respond constructively and minimize the destructive potential of fear and hate we need to respond, in an integrated way, at different levels. It is unlikely that we would wish or could do much to change normal psycho-physiological responses. However good training, good clinical supervision (including, in particular, psychodynamic supervision) and reasonable working conditions, can help through facilitating the use of the more reflective potential inherent in our psychophysiology. In addition and at a different intellectual and emotional level, I have previously highlighted the need to attend to ethics and citizenship, as important instruments in managing the clinical problems of malignant alienation and countertransference hate.[4]

Ethical thinking, in combination with other factors, can help contain inappropriate countertransference reactions and counteract moralizing based on rationalization. In particular I have given central importance to the need to distinguish carefully between virtue ethics and professional ethics. Virtue ethics sets standards for our own conduct and may drive our countertransference reaction towards our patients in hateful directions, when we feel they do not meet our virtue standards. For example our making a virtue of autonomy and independence my predispose us to hate the dependent patient. Professional ethics, on the other hand, demands that we act in the patient's best interests, irrespective of whether their conduct offends our virtue ethics or not.

I have, also, drawn attention to that fact that, if psychiatrists and patients are to meet in a climate of trust, there is a need for a minimum common ethics between us. The existence of a minimum common set of ethics between patient and psychiatrist is not something that can be taken for granted. For example in my daily clinical practice in an international metropolis like London, England, in an era of globalization, I encounter patients from highly diverse ethnic backgrounds and varied, at times incompatible, ethical and religious convictions. A fundamentally important aspect of citizenship is that it provides the necessary basis for ethical discourse in multicultural societies. In the absence of a common commitment to citizenship it is difficult to find a foundation for common ethical discourse, particularly in the absence of shared customs or religious beliefs.

Following De Mare and colleagues,[18] I have drawn attention to the importance of communion between psychiatrist and patient through dialogue in a common language, as fundamental aspects of citizenship. I have concluded, "The conduct between patient and doctor of dialogue in a spirit of fellowship should be the cornerstone of all psychiatric activity". For an example of a practical application of these ideas please refer to "Engaging patients as teachers of clinical interview skills".[19]

In line with the above thinking, it seems to me, that the relevance of clinical experience with hate to conflict and conflict resolution, is that it suggests the need to anticipate and mistrust instinctual reactions in fear situations. Abstinence should be favoured over the fearful gratification of instinctual responses. Processes of "morationalisation" should be identified, resisted and condemned. Emphasis should be placed, in an era of

globalization, on the search for common ethical foundations, though the pursuit of dialogue in a genuine spirit of human fellowship. In the clinical situation I have emphasized the importance of the distinction between virtue ethics and professional ethics in facilitating such dialogue. Similar distinctions need to be pursued in conflict and conflict resolution.

A note of caution is necessary here. I have previously indicated that I do not wish to pursue a pacifist argument in this paper. The reason for this is that it is important to acknowledge that, though dialogue should be prized and pursued as a priority, it has its limits, particularly if it is used for obfuscation, denial or appeasement and not for communication, understanding and conflict resolution.

It is also important to note that dialogue provides an important but not a unique foundation of citizenship. Justice is an equally important foundation. My emphasis on dialogue is because this is an area where a psychiatrist necessarily builds an expertise through clinical practice. We may have something to say about it, therefore, even if it is just to highlight how difficult it is to maintain in some situations. Consideration of issues of justice would allow us to build a more sophisticated picture of the value of dialogue in citizenship, clinical hate and conflict. In subsequent parts of this paper I will touch on aspects of justice, judgment and punishment but a thorough consideration would require a separate paper.

Before concluding this section, it is also important to concede that, important as they may be, ideas of dialogue and citizenship, may not be sufficient to allow us to address fully the more thorny and extreme clinical and ethical challenges posed to psychiatrists in attempting to care for psychopaths or patients with extreme and enduring mental illness or similarly severe learning disability. Ideas of charity rather than dialogue or citizenship may need to be given greater weight in order to address these extreme situations. Consideration of issues of charity would take us further beyond even the outer reaches of political philosophy into theology and I will refrain from such a leap. On the other hand, though issues of charity may be beyond the scope of this paper, another idea commonly associated with theological discourse, namely forgiveness, is not. This is because forgiveness stands in strong relation to hate, through a more or less diametrical opposition to it. Shriver[20] has attempted to look at the Christian concept of forgiveness form a political perspective. Forgiveness, therefore, may be worth exploring here, because it may provide an example of political discourse (and religious discourse) having something to teach psychiatrists that may be useful in our clinical practice.

Hate and forgiveness

The ethical foundations of medical practice remain controversial.[21, Ch. 4] A commonly, but not universally, accepted model is the 'four principles plus scope' approach of Beauchamp and Childress.[22] Gillon[23] has provided a brief and helpful exposition of this model. Gillon's own summary of his paper is both simple and comprehensive:

> The "four principles plus scope" approach provides a simple, accessible and culturally neutral approach to thinking about ethical issues in healthcare. The approach, developed in the United States, is based on four common, basic prima facie moral commitments- respect for autonomy, beneficence, non-maleficence, and justice- plus concern for their scope of application. It offers a common, basic, moral language. Although they do not provide ordered rules, these principles can help doctors and other health care workers to make decisions when reflecting on moral issues that arise at work.

The relevance of principles of respect for autonomy, beneficence, non-maleficence and justice to the practice of psychiatry is obvious. In this sense the clinical practice of psychiatry falls squarely within the scope of application of Beauchamp and Childress' model. My concern is not whether it provides foundations for the ethical practice of psychiatry, which it does, but whether such foundations as it provides are strong enough to see us through the more

challenging clinical situations. More specifically, the abstract philosophical principles of autonomy, beneficence, non-maleficence and justice seem, sometimes, not to measure up to the emotional force of fearful and hateful countertransference reactions, driven as they are by wired evolutionary neurobiological instinctual circuits.

Most, if not all, clinical supervisors will probably have had to deal with junior trainees whose countertransference hate leads them to question the applicability of any conventional ethical clinical consideration to their particularly challenging patient. It is important to acknowledge that such reactions as we observe in these trainees are the same as we might expect in many lay people should they become familiar with the history and conduct of the patient. In common with the trainee such lay people would ask in the face of perversion, aggression, abuse or sadistic murder why this individual should benefit from a clinical ethical approach that puts beneficence at its center. They might be inclined to seek vengeance or rejection instead.

In my view the only response that is both consistent with current professional medical ethics and takes the facts of any particular case into full account is one that puts forgiveness at its center. To put it another way, psychiatry and conflict resolution share the need for an explicit and conscious ethical commitment to forgiveness if they are to be successful in overcoming fear driven hate. Though an attitude of forgiveness is necessary for the practice of medicine and surgery in general, it is particularly important in psychiatry. This is because we specifically focus on our patients' thoughts, intentions and actions and some of these, as previously stated, may on occasions offend our sense of virtue, sometimes severely. In psychiatry, therefore, I would suggest, forgiveness needs to be adopted explicitly as a principal ethical foundation, of equal importance to respect for autonomy, beneficence, non-maleficence and justice.

The Christian origins of the centrality of the concept and practice of forgiveness[20, Ch. 2] will enthuse some and put off others. Though the concept of forgiveness is particularly associated with Christian teaching I believe its relevance extends beyond any specific religious convistion or affiliation. Shriver,[20] a Christian theologian with a history of engagement in the civil rights movement of Martin Luther King in the United States in the 1960s, has done much to both take into account the Christian heritage of the concept and to move it firmly in the arena of political conflict. In exploring "forgiveness in politics" he examines issues of "vengeance and forbearance" in relation to the German-American conflict and issues of "enmity and empathy" in relation to Japanese-American conflict during the 2nd World War and its aftermath.[20, Ch. 4 & 5] He also explores issues of "justice and forgiveness" in what he calls "the long road to equal citizenship for African Americans".[20, Ch. 6]

Shriver appears to have two fundamental starting points. First he writes approvingly that Thucydides "would adduce the Athenian-Spartan collision at Corcyra as proof of the conclusion that 'anyone who moved through those years without understanding that man produces evil as a bee produces honey, must have been blind or wrong in the head'".[20] He then affirms "if we believe that the preservation of our neighbour's life is the first rule of politics, we might contribute to a new politics of life by accurately recollecting what the politics of death did to them or their ancestors".[20] This life affirming stance is one that should be favoured by all doctors, including psychiatrists. It is also the one most compatible with the contemporary philosophy of human rights[24] and, clearly, contrary to classical Aristotelian conceptions of political ethics, including the glorification of vengeance.

Shriver places forgiveness in opposition to vengeance. Where vengeance leads to retaliation, vindictiveness and terror, forgiveness leads to judgment, forbearance, empathy and renewed community. Forgiveness is not about "forgiving and forgetting". Neither, however, does he favour remembering for the sake of it. Rather, I think, his attitude is one which is consistent with the following conceptions of psychotherapy:[25]

«An analyst once had this experience when treating a mentally handicapped man. The patient was aged 33 and went each day to a sheltered workshop where he performed the most menial tasks. The analyst and some of the staff believed that he had a mental capacity that was capable of higher-grade work. In the sessions these words would some times dribble from the corner of his mouth:

— I am 33 years old and is that nothing?

And a moment later:

— Can you give me a picture of who I am?

The analyst said:

— The fact that you feel they have been thirty-three years of emptiness, waste and nothingness is so painful it is better to have people's picture of you than to face this ghastly nothingness.

He replied:

— Well, if you won't give me a picture what do I come here for?

The analyst stood up, placed himself alongside him and said:

— It is like this. There in front of us is thirty-three years of waste, nothing and emptiness. It is like sitting in a train and opposite sits a man with a wounded and diseased face and it is so horrific that you have to hold pictures up in front of you because it is more than you can bear. But the reason you come and see me is that perhaps there is just a possibility that if you have me beside you then you can look at it.»

Conclusion

Feelings of hate are present and may be acted out in clinical practice and civil and international conflict. The containment and working through of hate in clinical practice and conflict resolution may be best achieved through considering the implications of a sophisticated model which integrates psychobiological, social and ethical views of human nature and conduct. As a result, the pursuit of dialogue in a spirit of forgiveness has been advocated in this paper as fundamentally necessary to both clinical practice and conflict resolution.

Dialogue has its limits both within clinical practice and politics. Dialogue may be practically impossible or be misused for denial and appeasement rather than engagement in communication, understanding and conflict resolution. In such cases it may need to be suspended (or complimented by other activities) and resumed (or enhanced) later at the earliest possible opportunity, when circumstances are more favourable. Any suspension (or diminution) of dialogue, however, should be viewed with alarm, as a situation that increases the risks of acting out feelings of hate, and should be seen as a measure of last resort.

Forgiveness may or may not have its limits within conflict and conflict resolution but not within clinical practice. Within a framework of citizenship and professional ethics, forgiveness is an absolute principle in the relationship of the psychiatrist with his/her patient. At times the psychiatrist may need to refer patients to relevant civil authorities for judgment and justice,[26,27] but this is not inconsistent with maintaining an unfailing and consistent attitude of forgiveness in relation to any actual continuing care of the patient. Forgiveness may need to be complimented with the pursuit of justice, including, where parliament determines, punishment through properly constituted judicial and law enforcement authorities. Punishment is a matter for these authorities and not a matter for psychiatrists. An attitude of forgiveness will best prepare the psychiatrist to deal with feelings of hate that might give rise to impulses to retaliate or punish.

For an example of a political conflict where the themes explored in this paper were considered and resolved along the lines suggested please see Jonathan Glover's account of the Cuban Missile Crisis.[28]

Dedication

This paper is dedicated to my mother, Danae Ikkou-Papadimitriou, formerly Associate Professor of Paediatric Cardiology, National and Kapodistrian University of Athens Medical School, and her family, who having survived as refugees from the "Mikrasiatiki Katastrophe", struggled and prospered.

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Μίσος και συγχώρεση

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Η εμφάνιση συναισθημάτων μίσους είναι συχνή τόσο στην ψυχιατρική πρακτική όσο και στις πολιτικές και διεθνείς συγκρούσεις («συγκρούσεις»). Ο συγγραφέας αναπτύσσει ένα ολοκληρωμένο ψυχοφυσιολογικό, ψυχοδυναμικό και κοινωνικό – ψυχολογικό μοντέλο της γένεσης και των επιπτώσεων του μίσους σε δύσκολες κοινωνικές καταστάσεις. Το μοντέλο αυτό μαζί με συνειδητή δέσμευση για διάλογο με τον ασθενή, ως ηθική αξία, και με την ταυτόχρονη αναγνώριση της κοινής ιδιότητας με τον ασθενή ως ισότιμοι πολίτες της ίδιας κοινωνίας, μπορεί να συμβάλει στην πρόληψη καταστροφικών εκδηλώσεων του μίσους στην κλινική ψυχιατρική γενικά, και ιδιαίτερα στις σύγχρονες εξελισσόμενες πολυπολιτισμικές κοινωνίες. Μαζί με αυτά, η συνειδητή αναγνώριση της σημασίας της ηθικής αξίας της συγχώρεσης, σε συνδυασμό με την κατανόηση της πρακτικής της συγχώρεσης, ιδιαίτερα όπως μπορεί να εξασκηθεί σε καταστάσεις «συγκρούσεων», μπορεί να στηρίξει περαιτέρω τους ψυχιάτρους να εφαρμόσουν αποτελεσματικά στην κλινική πράξη το μοντέλο που προτείνεται εδώ. Η έννοια και η ηθική αξία της συγχώρεσης προτείνεται ως θεμελιώδης για την κλινική πρακτική γενικά και την ψυχιατρική ιδιαίτερα.

Λέξεις ευρετηρίου: *μίσος, σύγκρουση, κλινική πρακτική, πολίτης, συγχώρεση.*

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