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Evaluating Shame Transformation in Group Treatment of Domestic Violence Offenders

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Offender rehabilitation, pitting the rational ability of criminal justice against the seeming irrationality of criminal behavior, remains controversial. Psychology highlights the importance of emotions in mediating individual behavior. Borrowing from restorative justice as a more emotionally intelligent form of justice, this article examines the role of shame and guilt in a domestic violence offender treatment program. The emotions are differentiated and then activated, similar to the use of reintegrative shaming in restorative justice, to promote greater offender accountability and empathy. Using a two-group comparison of male domestic violence offenders, measurements were taken on three sets of scales in assessing the outcome of the shame transformation process. Statistically significant effects were found for self-esteem and empathetic concern. Findings and future research are discussed.

Keywords: *shame transformation; treatment; offenders*

Both rehabilitation and therapeutic treatment of offenders continue to be widely questioned (Bowen & Gilchrist, 2004; Day, Tucker, & Howells, 2004). A range of interventions and approaches has been proposed and studied, yet recidivism remains high (Babcock, Green, & Robie, 2004) and costly to society (Durose et al., 2005). Cognitive–behavioral techniques, currently favored, are designed to address irrational beliefs, correct distorted thinking, and bring about positive consequences through encouraging prosocial behaviors. Although these approaches have been shown to reduce recidivism rates (Dowden & Andrews, 2000; Wilson, Bouffard, &

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Mackenzie, 2005), there seems to be little consensus as to why offenders offend in the first place (Dutton, Starzomski, & Ryan, 1996) as well as which particular psychological factors correlate with offenders' reoffending (Bowen, Gilchrist, & Beech, 2005).

The primary goal in dealing with offenders has been deterrence, with a focus on rational reactions, specifically reliance on the "risk principle" (Lowenkamp, Latessa, & Holsinger, 2006) of adjusting services to crime levels, to address often irrational offenders viewed generally in aggregate rather than individual terms (Andrews, Bonta, & Hoge, 1990). "For three centuries, criminology has tried to make reason, rather than emotion, the primary method of justice. The results so far are modest, blocked by a paradox in social policy: we presume that criminals are rational, but justice should be emotional" (Sherman, 2003, p. 2). This posture reflects a primary difficulty in reconciling psychology and criminology, where the former focuses on understanding individual conduct and the potential for change while highlighting the importance of emotions in mediating individual behavior (Harris, 2003). This has been apparently successful (see Latimer, Dowden, & Muise, 2005) in the field in restorative justice conferencing, where the goal is to repair the harm to the victim as well as avoid repetition of the criminal behavior. According to Sherman (2003, pp. 7-8), emotionally intelligent justice, as illustrated by restorative justice, assumes that the law is rational and the offender emotional. One of the ironies of restorative justice comes from its "greater reduction in repeat offending—and in victim desire for revenge—with samples including violent crimes than with samples of property or less serious crime" (Sherman, 2003, p. 17). This suggests that the emotional dynamics involved in restorative justice interventions actually work better with more irrational, violent offenses than with more premeditated, rational offenses such as robbery or drunk driving. Two sources, John Braithwaite's (1989, 1998) use of "reintegrative shaming" in restorative justice, with the emphasis on the crime rather than the offender and on reintegrating the offender into the community rather than stigmatization, and James Gilligan's (2003) recognition of the paradoxical nature of shame in inciting rather than inhibiting violence have provided much of the inspiration for this project.

Shame, Guilt, and Restorative Justice

Gilligan (1997), after observing violent offenders for more than 30 years, states: "I have yet to see a serious act of violence that was not provoked by the experience of feeling shamed and humiliated, disrespected and ridiculed, and did not represent the attempt to prevent or undo the 'loss of face'—no matter how severe the punishment, even if it includes death" (p. 110). Following up on his first narrative report of his experiences, he links generally accepted social causes of violence, including poverty (especially disparities in wealth), unemployment, caste and age

discrimination, to the emotion of shame as an impetus to violence (Gilligan, 2001). He also views traditional moral and legal approaches that result in ever greater sanctions or punishment (which he believes itself to be a form of violence) as being counterproductive to what he sees as a public health problem. If recast as the latter, official policy would involve "cleaning up" shame-causing social and economic inequities similar to a century and a half ago when it was discovered that "cleaning up the water supply and the sewer system was far more effective in preventing physical disease than all the doctors, medicines, and hospitals in the world" (Gilligan, 2001, p. 99). Braithwaite (1998) describes the central role of shame in restorative justice by remarking that for the offender, "Dignity . . . is generally in need of repair after the *shame* associated with the arrest" and that "dignity is generally best restored by confronting the *shame*, accepting responsibility and apologizing with sincerity" (p. 330, italics added).

The impetus for this research comes from a set of observations made in a treatment program that has been working for 20 years with offenders, primarily men charged with domestic violence or anger-related crimes or misdemeanors. These men arrived in treatment claiming frequently to be victims, not because they had not acted out angrily or violently, but because they felt stigmatized by the "system." This made accepting responsibility or accountability (Lerner & Tetlock, 1999), seen as an indispensable first step in involuntary treatment, consistently elusive. What also became clear was their profound confusion about being encouraged to acknowledge guilt ("taking responsibility") for their offenses while simultaneously experiencing shame at being sentenced to treatment as "batterers" or criminals because of what they felt was justified anger, and then being asked (or feeling forced) to speak openly about their behavior in front of strangers. The confusion, consistently noted in the research about these two moral sanctioning emotions, made accountability in a group of men sharing similar negative emotions unlikely and certainly a painfully antitherapeutic process. Citing Erik Erikson, Gilligan (1997) also noted: "He who is ashamed would like to force the world not to look at him, not to notice his exposure. He would like to destroy the eyes of the world" (p. 64). This illustrates how shameful it can be for people to admit shame, a classic therapeutic "double bind," and another paradox inherent in this complex emotional state. Such a contradiction sets up what Hahn (2004) calls a "negative therapeutic reaction," a response that immediately undermines the chances of successful rehabilitative treatment or producing genuine enduring behavioral change.

While anthropologists, psychologists, sociologists, and criminologists have long identified both shame and guilt as central to social control and deviance, the literature presents considerable diversity in characterizing and distinguishing them (Harris, Walgrave, & Braithwaite, 2004; Piers & Singer, 1971). Harris (2003) proposes two primary distinctions: one focuses on the *source* of the bad feelings, the other on the *object* of the emotions. In the first case, shame is said to occur when one experiences disapproval (real or imagined) in the eyes of others, whereas guilt

occurs when one disapproves of one's own actions. This suggests that shame results when one's image is at stake whereas guilt results when one's conscience is disturbed. In the case of the object, shame is felt about the self as a whole, whereas guilt is limited to an action one has undertaken or omitted to take (thus, intentional or accidental). But Harris (Harris et al., 2004) then poses the question: "Can we feel bad for our actions without feeling bad about who we are?" (p. 7). Indeed earlier Braithwaite (1989, p. 57) affirms how developmental psychologists sometimes distinguish between socialization by shaming and by guilt induction, but then points out how the latter always implies shaming by the person(s) inducing the guilt, thus concluding that to induce guilt and to shame are "inextricably part of the same social process." He goes on to state: "If the maturation of conscience proceeds as it should, direct forms of shaming, and even more so punishment, are resorted to less and less. But there are times when conscience fails all of us, and we need a refresher course in the consequences of a compromised conscience. In this backstop role, shaming has a great advantage over formal punishment" (Braithwaite, 1989, p. 72). Having said this, he becomes careful in applying shame not to the offender in promoting the use of reintegrative shame in restorative justice but to the offense itself, recognizing, as does Gilligan, the dangerous nature of shaming as a form of stigmatizing.

Affect theorists (Nathanson, 1992; Tomkins, 1987) argue that both emotions result from the same underlying physiological affect (shame–humiliation) and Harris et al. ultimately question whether there is any need to differentiate shame and guilt or prise them apart. Tangney and colleagues conclude on the basis of considerable research on the impact of shame and guilt that "the dynamics, motivations, and behaviors associated with these oft-confused emotions *move people in very different directions* [italics added]—guilt typically for the better, and shame typically for the worse" (Tangney & Dearing, 2002, p. 8). They distinguish between guilt-prone and shame-prone individuals and believe that those who are shame-prone will cope with failure less adaptively because its intense focus on the self is much more painful and crippling, whereas those with a predisposition to guilt will behave in a more adaptive and reparative manner because their focus is not on the self but on the harm done to others (see Table 1).

Integrating Shame, Guilt, and Restorative Justice Into Correctional Treatment

After sorting through the literature on shame and guilt and on restorative justice, the treatment program mentioned above concluded that there is a practical reason for differentiating these two emotional states in the clinical setting when dealing with involuntary, often resistant, offenders (see Prelog, Unnithan, Loeffler, & Pogrebin, in press). The program sought to find appropriate clinical ways to work, concretely and productively, with the two emotions. The approach was based on presenting

Table 1
Key Differences Between Shame and Guilt

	Shame	Guilt
Focus of evaluation	Global self: "*I* did that horrible thing"	Specific behavior: "I *did* that horrible *thing*"
Degree of distress	Generally more painful than guilt	Generally less painful than shame
Phenomenological experience	Shrinking, feeling small, feeling worthless, powerless	Tension, remorse, regret
Operation of "self"	Self split into observing and observed selves	Unified self intact
Impact on "self"	Self impaired by global devaluation	Self unimpaired by global devaluation
Concern vis-à-vis the "other"	Concern with others' evaluation of self	Concern with one's effect on others
Counterfactual process	Mentally undoing some aspect of self	Mentally undoing some aspect of behavior
Motivational features	Desire to hide, escape, or strike back	Desire to confess, apologize, or repair

Note: Data from *Shame and Guilt* by J. P. Tangney & R. L. Dearing, 2002, New York: Guilford.

guilt as a proactive, prosocial means of promoting acceptance of one's mistakes (something I *did*) and the ability to repair them; shame, on the other hand, was treated directly as the more dangerous and destructive emotion because of its generally recognized global nature involving condemnation of the self as a whole (something I *am*). Thus, guilt is viewed as an active means of stepping up and taking responsibility for one's actions in contrast to shame, which is seen as a passive, forced acceptance of oneself as inherently inadequate or insufficient. This follows Branden's (1983) contention that "guilt always carries the implication of choices and responsibility, or we are not consciously aware of it" (p. 66), whereas Kaufman (1992) argues that "contained in the experience of shame is the piercing awareness of ourselves as fundamentally deficient in some vital way as a human being. To live with shame is to experience the very essence of the self as wanting" (p. 9). Just as Braithwaite reintegrates shame as potential community "shunning" should the offender continue to act out, so too this treatment reintegrates guilt that is often disguised as shame ("I did something so bad I can't talk about it") and even more powerfully reintegrates compassion versus rejection when dealing with acts of shaming or abuse absorbed in one's lifetime ("I wasn't bad; rather, something bad was done to me"), thus fostering a new spirit of honesty and understanding, the foundations for developing the capacity for empathy (Goldstein & Michaels, 1985) and changing antisocial attitudes and behaviors. Based on both restorative justice research and practical use of restorative dialogue techniques in the clinical setting, a Shame Transformation treatment module was developed. Parallels in the application

of these approaches (see restorative justice features described in Sherman, 2003, pp. 10-11) are summarized as follows and represent the operational basis of the therapeutic program studied in this article.

PURPOSE:

Restorative Justice: To repair the harm of the crime under discussion and prevent further crimes by the offenders, victims, or supporters of either.

Shame Transformation: To facilitate the offender's ability to acknowledge guilt as clearly distinct from shame for one's actions, prepare to make repairs through understanding the effect of harmful and abusive behaviors on a deeply personal level, and avoid such criminogenic behavior in the future.

RESPONSIBILITY:

Restorative Justice: Offenders must first accept responsibility for having caused harm and not dispute the factual claim that they are guilty, regardless of whether they formally plead guilty.

Shame Transformation: Offenders must account fully for their actions through acknowledging responsibility; explain what happened without justifying, minimizing, or blaming others; accept the consequences; and prepare to make repairs as able.

METHOD:

Restorative Justice: Any means that can produce reconciliation between victims, offenders, and their supporters, minimizing anger, and leaving all satisfied that they have been treated fairly while justice has been done. (Face-to-face conferences among stakeholders in a crime, led by a disinterested third party, are the most widely tested method.)

Shame Transformation: Begin at intake to prepare a therapeutic program while working within strict state standards based primarily on correctional counseling and a cognitive–behavioral approach. Use a combination of cognitive–didactic working definitions of shame and guilt plus hands-on interactive board work to clearly differentiate and activate the two emotions for clinical purposes. Then introduce intergroup role-play to illustrate the meaning of proactive, prosocial guilt in vivo, with specific life examples. Follow up by using psychodrama to do the same with destructive shame or abuse, again with actual life incidents. With the former, introduce the notion of reintegrative guilt versus guilt previously experienced or hidden as shame; with the latter, facilitate the experience of reintegrative compassion, whereby the shamed person is able to experience compassion for the shamed or abused person he considered himself to be at one time. More details regarding the treatment method are provided below.

DECISIONS:

Restorative Justice: To the extent possible, decisions about what should happen next to repair harm and prevent future crime are made collectively and consensually by all the individual participants in the process who were closest to the crime, as a form of justice ratified or supplemented by decisions of courts.

Shame Transformation: The group ethos and coherence allow the treatment process to achieve realism, with each member (and therapist) able to comment on one's own or another's process. Later, each member will be asked to compose a final "letter

of accountability" to the victim of his case that will be read aloud and commented on within the group before the termination ritual.

EMOTIONAL POWER:

Restorative Justice: The power of the process comes from the engine of emotional engagement of the participants, in contrast to the suppression of participants' emotions in court determinations of guilt.

Shame Transformation: The power of the processes comes from the recognition of the profound affective and practical differences in the working definitions provided in contrast to the confusing and restrictive hidden quality of shame usually felt at the outset of the program. Also, there is relief and a sense of accomplishment in moving through the role-plays successfully encouraged by, rather than experiencing shame from, fellow members.

EMOTIONS TO ENGAGE:

Restorative Justice: Remorse, guilt, shame, empathy, hope.

Shame transformation: Fear, relief, guilt as proactive, shame as transformable, remorse, empathy for the self and others, hope.

EMOTIONS TO AVOID:

Restorative Justice: Anger, humiliation, fear, disgust.

Shame Transformation: Rage, humiliation or shame (per definition used), disgust.

Despite the nature of this work, that is, involving involuntary clients, the challenges of being both therapeutic (providing positive personal regard despite offending behaviors, genuineness, and accurate empathy; Yalom, 2002, p. 18) and firm but fair in applying necessary limits (as well as good modeling, reinforcement, and concrete guidance; Andrews, Bonta, & Hoge, 1990, p. 37) with this population require both vigilance and awareness of the emotional, usually irrational nature of the offenses committed by these men and their general reluctance to engage in the treatment. Therefore, immediately at intake, in the first meeting, two restorative philosophies are stated. These are: "You will be held accountable here for all your actions but, to the best of our ability, you will not be shamed," and "Your offense has jeopardized your relationship with others; here you will learn to build a solid relationship with yourself which will help you in all your relationships with others." Both statements fit common psychological assumptions that human change can best come about in a safe and supportive atmosphere of positive regard.

Treatment Program

Both correctional treatment and restorative justice focus on the victim and the offense. The former demands that the offender accept responsibility without victim blaming while changing behavior; the latter seeks to vindicate the victim's feelings by having the offender, again, take responsibility but also listen to and be able to acknowledge the victim's feelings and then agree, as able, to make repairs. The treatment philosophy applied here takes both approaches into account while recognizing

the danger of dichotomizing criminology's focus on behavioral consequences and aggregate populations versus psychology's focus on behavioral motivations and regard for individual differences. Furthermore, it is considered imperative to find ways for the offender to experience a victim's feelings, without that person being present in the treatment setting. The result requires a combination of clear, consistent guidelines and limit-setting, the "holding accountable" appropriate to correctional treatment, along with the three Rogerian cornerstones to successful therapeutic treatment: positive regard for the person, genuineness, and accurate empathy. Once offenders have experienced both, they are able to undertake the module described above that consists of the following four specific steps (as one core component in the course of treatment sessions).

Session 1. Provide cognitive–didactic working definitions of guilt and shame. Do interactive board work having participants list specific examples of occasions when they have felt guilty versus ashamed to activate the feelings and allow concrete understanding of the specific differences ("something I did" vs. "something I feel that I am"). The goals of this session are to understand practically and begin to understand experientially the distinct differences and significance of both emotions preparatory to moving to experiential phases in Sessions 2 and 3.

Session 2. Set up interactive role-plays enacting exchanges of specific life incidents when guilty of harm to another individual. This enables participants to work through the four steps of accountability: take responsibility; account for and explain behavior without justifying, minimizing, or blaming the victim; accept consequences; and prepare to make repairs. The goals of this session are to deepen understanding on an experiential basis of how to activate the guilt emotion, differentiate it very clearly from shame, and work through the steps of demonstrating full accountability. Role-plays provide greater opportunity to simultaneously experience empathy for the victim played by another group member and thus change antisocial criminogenic attitudes.

Session 3. Set up psychodrama use of "the empty chair," whereby the participating member visualizes the shamed self in the chair, discloses what happened to him at a time of abuse or shaming in his past, how he felt at the time, how he feels now, and what he would have done (use of counterfactual thinking) had he been able to be present at the time of the incident. The goals of this session are to activate the shame emotion by recalling and recounting a shame incident suffered at an earlier, more vulnerable time in life, demonstrate clearly where the guilt lies, and elicit deep compassion for the victim of the shame incident as a means of developing self-empathy and consequently empathy for others. Again, the overall goal is ultimately change in criminogenic attitudes and behaviors.

Both Sessions 2 and 3 represent corrective emotional experiences, which, as emphasized by Yalom (1985, p. 26), are often more likely to occur in a group setting.

Paradoxically, group members are also usually able to do this kind of deep, transformational work better in a group setting than in individual psychotherapy because of both the common bonds created (group cohesiveness) and the lack of the explicit power differential experienced in one-to-one individual treatment.

Session 4. Return to a series of cognitive exercises designed to consolidate lessons from the three previous sessions. Group members are prompted to write up and share how they would recognize, then halt both self-shaming (easily internalized by many in this population) and shaming experienced at the hands of others without resorting to old defensiveness or violent retaliation. The goals of this final session are to process the experiences and allow cognitive recapitulation as a means of ensuring deeper understanding and ability to implement the anticriminogenic lessons learned in a practical, everyday sense.

Research Design and Method

Following several years of developing this treatment philosophy and the parallel restorative process within the clinical setting, the treatment program commissioned a study to evaluate and learn how the shame transformation process works and affects participants. The premise was that similar to restorative justice conferencing, when offenders are enabled to express themselves clearly and consciously, and then experience the pain their offense has caused, they can be moved to make repairs, change their criminogenic attitudes, beliefs, and rationalizations, and not reoffend. Given the difficulties involved in tracking both the offenders and their victims longitudinally, the study team realized that recidivism, although an ideal (see Rosenfeld, 2008, for an alternative view) measure of the effectiveness of the treatment, would be extremely difficult to acquire data on. We opted for an interim approach. This called for measuring common indicators of change—self-esteem, locus of control, and empathy—likely to result in lower recidivism down the road and specifically facilitate a greater predisposition to listening and internalizing the ongoing program units designed to further inhibit and change criminogenic factors. Thus, the testing premise became the following:

> If an offender feels better about himself (through a new self-awareness, including understanding guilt to be different from shame and thus becoming able to release the shame and claim the guilt), move from an external blaming to an internal responsibility-taking locus of control, and experience greater empathy, then he is much more likely to be able to hear a victim's feelings, make repairs for his actions, and not reoffend.

Self-esteem is often cited and its deficit correlated with partner aggressiveness in interpersonal relationships. "Attacks or perceived attacks on an individual's

self-concept have been viewed as an important source of aggressive behavior" (Goldstein & Rosenbaum, 1985, p. 425). Research on male aggression in partner violence confirms that "enhanced self-esteem is associated with reduced perpetration of intimate partner violence" (Murphy, Stosny, & Morrel, 2005, p. 208) and a reduction in recidivism (Goldstein & Rosenbaum, 1985).

Locus of control in this research is a proxy for measuring accountability as it is important in the attribution process of crime (Blatier, 2000) and relevant in therapeutic settings when offenders have to account for their actions and take responsibility for changes in behavior and attitude (Lee, Uken, & Sebold, 2004). Regarding attribution between genders, Real (2002) states, "Men are socialized to externalize distress; they tend not to consider themselves defective so much as unfairly treated" (p. 81). This includes the externalization of blame, notably blaming the victim, and minimization of actions. By fostering an internal versus external locus of control in the offender, the therapist aims to increase both understanding of behavioral motivations and accountability for one's actions, past, present, and future.

Finally, if an offender can view his or her actions as harmful to another, the assumption is that he or she will be less likely to offend in the first place. Gilligan (1997, p. 183) states categorically, "A lack of empathy sets anyone on the path to violence." Speaking of how boys are raised, Real (1997) asserts: "The fact that empathy has traditionally been conditioned out of boys facilitates their obedience to leaders who order them to kill strangers" (p. 177). "Learning to empathize with others can be viewed as the culmination of the treatment effort," according to Bateson (1991). "The development of empathy helps group members address relationship issues [and] learn fighting-fair strategies of assertive but not aggressive communication" (VanWormer & Bednar, 2002, p. 563). The development of empathy in offender populations is considered "unlikely when confrontive or shaming techniques further undermine the batterer's already precarious self-esteem and leave him feeling helpless" (ibid.). Research findings regarding empathy and offending support the notion that low empathy and violence are highly correlated (Jolliffe & Farrington, 2004). Furthermore, it must be noted that empathy is not a one-dimensional construct. Davis (1983, 1994) illustrates that empathy can be construed as perspective-taking, empathetic concern, fantasy, and feelings of personal distress when others are harmed.

The treatment program believes that "freeing up" an offender from expectations of further shaming in treatment is likely to increase self-esteem, which in turn will manifest itself in greater accountability. Furthermore, it is believed that the more individuals express responsibility or accountability for their actions, the more likely they are to move from an external blaming ("There's nothing I can do") to an internal responsibility-taking ("I can do something") locus of control. Finally, it was hypothesized that the more one possesses self-esteem plus a robust sense of personal control, the more likely one is to become self-tolerant and, consequently, the more likely it will be for one to experience tolerance or empathy for others. Thus, the

present study was designed to evaluate the effectiveness of the Shame Transformation component in increasing levels of self-esteem, internal locus of control, perspective-taking empathy, empathetic concern, and lowering personal distress. In summary, it was specifically hypothesized that the Shame Transformation component would reduce the offender's shame and consequently increase his positive view of self, thereby reducing the likelihood of repeat violence (through domestic or stranger violence) by increasing self- and other-directed empathy.

Study Method

The study involved six different treatment facilities and their facilitators (generally master's-level counselors trained in psychology, social work, or general counseling) conducting domestic violence therapy among involuntary offenders primarily ordered by courts to undergo the same. In Colorado, therapists offering domestic violence treatment must have at least a bachelor's degree in a field related to human services, including a total of 200 hr in domestic violence dynamics, such as intimate partner abuse, intergenerational violence, sociocultural issues, such as the role of patriarchy, understanding criminal behavior, sexual abuse as a control technique, effective use of community resources, and other counseling-related areas. They must follow treatment guidelines based on cognitive–behavioral approaches specified by the state and be approved providers (Colorado Domestic Violence Offender Management Board, 2005). The control groups were led by their respective regular on-site therapists whereas the experimental groups were treated by one trained therapist, also an approved provider and licensed clinical social worker. Use of one therapist to administer the experimental therapy was done to ensure consistency of treatment applied throughout. The goal was to evaluate the effectiveness of the Shame Transformation treatment with these offenders and to determine whether and how the Shame Transformation component affected offenders differently than customary cognitive–behavioral treatment in terms of (a) self-esteem, (b) locus of control, (c) empathetic concern, (d) perspective taking, and (e) personal distress.

Settings and Participants

The study was conducted in a large city in Colorado, during mandated weekly sessions for domestic violence offenders at their specific treatment agencies. Six different geographical locations were used in the city and its suburbs. Both the experimental and control (i.e., cognitive–behavioral) treatments were carried out in group therapy settings of comparable size at each location. Each paired set of treatment and control groups was involved in activities lasting four sessions across a 4-week time period. Data were collected from each group in four 4-week phases across a period of 4 months.

The experimental and control groups included domestic violence offenders ordered into treatment for crimes against persons and property. Because Colorado

Table 2
Background and Demographic Characteristics of Domestic Violence Offenders Under Study

	Control Group (n = 63)	Experimental Group (n = 52)
Age		
M	36.82	30.25
SD	11.846	8.183
Gender, *n* (%)		
Male	63 (100)	52 (100)
Female	0 (0)	0 (0)
Ethnicity (%)		
African American	5.1	6.4
Asian or Pacific Islander	1.7	4.3
Caucasian	35.6	36.2
Hispanic or Latino	57.6	51.1
Other	0.0	2.1
Education (years)		
M	11.49	12.00
SD	3.489	2.828
Estimated annual income (US$)		
M	30453.49	25282.86
SD	23799.443	13783.462
Location of treatment, *n* (%)		
Location A	7 (11.1)	8 (15.4)
Location B	7 (11.1)	6 (11.5)
Location C	28 (44.4)	17 (32.7)
Location D	7 (11.1)	7 (13.5)
Location E	7 (11.1)	6 (11.5)
Location F	7 (11.1)	8 (15.4)
Language spoken at home (%)		
Bilingual	0.0	4.2
English	62.3	72.9
Spanish	36.1	20.8
Other	1.6	2.1

does not recognize domestic violence ipso facto, decisions are made by the courts as to whether the crime fits the characteristics of domestic violence, that is, generally involving any past or current intimate partner. Participants for the study were selected according to their availability during agreed treatment times, location, and willingness to participate. The demographic composition of the sample for both the treatment and control groups can be viewed in Table 2.

All participants in both groups were informed of the study, its goals, and design and their cooperation sought. The overall goal stated to participants was “to move from a negative to a more positive outlook.” The design was equally simplified: All participants were told they would be given a pre- and posttest survey to track

movement, so as to minimize bias. Participants were assured of personal confidentiality and given the option of either participating or declining to do so. Participants who refused to participate were placed in the control group but were not evaluated or included in data collection. Although the experimental groups were led through the structured 4-week Shame Transformation process outlined earlier in this article, control groups followed their regular standardized cognitive–behavioral treatment during the same time period.

Design and Measurements

Participants were assigned to either experimental or control groups based on their availability at each location during the treatment times agreed with the selected group's regular on-site therapist (and not randomly, as would have been ideal). Both groups were administered a pretest–posttest Likert-type scale survey at the first and last session. Three well-known measurement scales were used in the surveys. Measures used include the Rosenberg (1979) Self-Esteem Scale, viewed as the "most widely used measure of global self-esteem" (Heatherton & Wyland, 2003). This scale uses 10 items related to "the evaluation which the individual makes and customarily maintains with regard to him/herself; it expresses an attitude of approval and indicates the extent to which an individual believes him/herself to be capable, significant, successful, and worthy" (Coopersmith, 1967, pp. 4-5). The internal consistency of this scale (alpha = .88) is considered adequate for research purposes (Robins, Hendin, & Trzesniewski, 2001). The Levenson (1974) multidimensional Locus of Control Scale was used in part, using the scale for internality, defined as a "continuum of beliefs as to whether one's outcomes are a result of internal control" (Ward, 1994). Internal consistency of the scale for internality (alpha = .82) was likewise considered adequate for research purposes (Ward, 1994). Finally, the Davis (1983) Interpersonal Reactivity Index scales for perspective taking, empathetic concern, and personal distress were used. The perspective-taking scale is designed to evaluate "the tendency to spontaneously adopt the psychological point-of-view of others" (Davis, 1983, pp. 113-114). The empathetic concern scale is designed to assess "other-oriented feelings of sympathy and concern for unfortunate others" (ibid. p. 114). Lastly, the personal distress scale "measures 'self-oriented' feelings of personal anxiety and unease in tense interpersonal settings" (ibid., p. 114). Internal consistencies for these scales (alphas ranging from .71 to .77) were considered adequate for research purposes (Davis, 1983).[1]

To determine the effects of treatment, analysis of covariance (ANCOVA) is used as it is designed for testing between-group differences in linear trends and allows for identifying more refined treatment effects (see Kerlinger & Pedhazur, 1973). By using ANCOVA, researchers can control for these differences and adjust for the differences between nonequivalent groups (Pedhazur & Pedhazur-Schmelkin, 1991). Specifically, these differences included the difference in means for the pretest

Table 3
Treatment and Control Group Means (and Standard Deviations) for Pretest and Posttest Scales

	Sample (n = 115)	Control Group (n = 63)		Treatment Group (n = 52)	
Measure	Pretest	Pretest	Posttest	Pretest	Posttest
RSE	21.17 (4.301)	22.17 (4.309)	21.90 (4.138)	19.96 (4.005)	22.33 (4.747)
LOC	36.50 (4.762)	37.75 (4.084)	37.59 (3.662)	35.00 (5.118)	36.15 (4.864)
PT	12.87 (2.597)	12.65 (2.444)	13.19 (2.868)[a]	13.13 (2.773)	13.65 (2.619)
EC	13.63 (2.977)	13.32 (3.100)	13.00 (2.793)[a]	14.02 (2.804)	14.35 (2.956)
PD	8.97 (3.061)	8.78 (3.410)	8.44 (3.097)[a]	9.19 (2.590)	8.73 (3.056)

Note: RSE = Rosenberg self-esteem; LOC = locus of control; PT = perspective taking; EC = empathetic concern; PD = personal distress.
a. n = 62.

scores.[2] A review of this method can be found in Pedhazur and Pedhazur-Schmelkin (1991, chaps. 12 and 21).

Analysis and Results

The demographic characteristics of both groups are shown in Table 2. The experimental group is younger, has more individuals of Asian and Pacific Islander origin, fewer Hispanics and Spanish speakers, and is poorer in terms of household income.[3] Both groups consist entirely of males, are similar in education level, and contain comparable proportions of Caucasians. Treatment and control group means for both pre- and posttests are listed in Table 3.

The findings from this analysis are presented in Table 4. The data were analyzed using SPSS 14.0 General Linear Model, Univariate Analysis of Variance. The posttests were treated as the dependent or outcome variables. Fixed factors were specified as experimental or control and the covariate was the score for the pretests.[4] The calculation for effect size or the magnitude of the impact of the independent variable on the dependent variable used the group difference indexes (d; Kline, 1998, p. 97). Cohen (1988) set the conventions for this statistic, where values less than .2 constitute a small effect size, values lying between .2 and .8 are denoted as being of medium effect size, and values above .8 constitute a large effect size. Eta squared (η^2) is reported as the correlation ratio or the amount of variance explained by the model (see Table 4). In addition, partial eta squared is also reported as the estimated variance explained by the specific independent variables within the model (see Howell, 2002).

Table 4
Analysis of Covariance for Shame Transformation Therapy, Test of Between-Subjects Effects

Source	SS	*df*	MS	*F*	*p*	Partial η^2
Self-esteem (η^2 = .378)						
Treatment	92.080	1	92.080	7.478	.007[a]	.063
Error	1379.162	112	12.314			
Total	58361.000	115				
Corrected total	2215.948	114				
Locus of control (η^2 = .567)						
Treatment	5.590	1	5.590	0.689	.408	.006
Error	908.138	112	8.108			
Total	159014.000	115				
Corrected total	2096.574	114				
Empathetic concern (η^2 = .381)						
Treatment	25.252	1	25.252	4.657	.033[b]	.040
Error	601.825	111	5.422			
Total	21102.000	114				
Corrected total	973.018	113				
Perspective taking (η^2 = .420)						
Treatment	0.373	1	0.373	0.083	.774	.001
Error	497.440	111	4.481			
Total	21338.000	114				
Corrected total	857.439	113				
Personal distress (η^2 = .558)						
Treatment	0.001	1	0.001	0.000	.991	.000
Error	470.497	111	4.239			
Total	9437.000	114				
Corrected total	1063.939	113				

a. Significant at the .01 level.
b. Significant at the .05 level.

Two results stand out in the ANCOVA. Analyses of linear trends found significant effects of treatment for both the measures of self-esteem and empathetic concern while controlling for the pretest score, indicating that the Shame Transformation component is significantly more effective than standard cognitive–behavioral treatment in increasing participants' self-esteem and empathetic concern as defined by our measures. There were significant effects of treatment on self-esteem, $F(1, 115) = 7.478$, $p < .05$, for the measure of self-esteem with a medium effect size (d) of .551. Analysis of linear trend found significant effects of treatment, $F(1, 114) = 4.657$, $p < .05$, for empathetic concern with a small effect size (d) of .110.

The analysis did not provide sufficient evidence to reject the null hypothesis for the measure of locus of control (LOC) internality, $F(1, 115) = 0.689$, $p < .10$, or perspective taking $F(1, 114) = 0.083$, $p < .10$. In terms of personal distress, it should be noted here that we were looking for a *reduction* rather than an increase in this subscale. As

Tangney and Dearing (2002) note, "proneness to shame is negatively or negligibly related to other-oriented empathy and positively related to personal distress" (p. 81). Analysis of linear trend provided insufficient evidence to reject the null hypothesis for the measure of personal distress (PD), $F(1, 114) = 0.000$, $p < .10$.

Discussion

Our main findings show that Shame Transformation treatment, compared with standard treatment, is better able to promote a shift in two major characteristics affecting domestic violence offenders: self-esteem and empathetic concern. This suggests that incorporating such a process into standard involuntary treatment aimed at changing antisocial attitudes and behaviors can improve both the self-esteem of and empathetic concern in domestic violence offenders. However, the Shame Transformation treatment module had no significant divergent effects on measures of locus of control, perspective taking, and personal distress.

These findings suggest several implications for treating domestic violence offenders. First, understanding the critical differences between guilt and responsibility, and shame and inadequacy, is a major cognitive step forward. Second, experiencing the emotional release of denial or hidden shame, either masquerading as guilt or endured and suppressed as shame, frees up the offender's ability for honest self-expression and restores some of that individual's lost dignity (Braithwaite, 1998). This permits them to participate better in restorative justice measures such as apology, restitution, mediation, and conferencing (Bazemore & Schiff, 2001). The combination allows for more open and receptive treatment and for individual offenders to benefit from it. Breaking through shame barriers, cognitively and experientially, in an interactive setting may result in individuals who feel better about themselves and who consequently are more likely to view and treat others favorably as well as benefit from prosocial treatment. This experience may provide one path to the accountability (or taking responsibility) demanded of domestic violence offenders by both retributive and restorative justice. By extension, this shift can be viewed as a promising predictor of constructive change and potential treatment success.

At the same time, our findings should be interpreted as suggestive rather than conclusive, given the relatively small sample size and possible bias due to the nonrandom assignment of participants into treatment and control groups. True randomization was not possible because of the court-mandated structure of treatment location and time. Additional shortcomings may include the use of one clinician to administer all of the Shame Transformation treatment sessions. However, this may be a positive attribute of this research in that the experimental treatment was standardized throughout the different phases of the study. Other difficulties encountered in carrying out this research included working with open-ended groups where members' consistent presence was questionable. Thus, during the study period, some participants might

complete their required treatment, be terminated, or miss sessions, for a variety of reasons. Often the on-site therapist's presence or involvement was inconsistent: he or she might sit in on the group, usually in the role of a silent observer; sometimes he or she was a volunteer participant. Education, fluency in the language, and literacy were also a concern, requiring the therapist to read them the questions before answering. Abstract reasoning and the ability to imagine hypothetical situations were another concern, and so the therapist had to be very clear and concrete in presenting the material and balanced in encouraging participants' engagement in the experiential exercises. Cultural concerns and views about the meaning of shame and honor, and guilt and redemption, were also an issue. So too was the time of day when the groups were conducted; certainly, late evening groups were likely to include even less motivated participants than usual because of fatigue. Considering all this, it is conceivable that the positive results obtained may have improved further in a more stable testing situation. Future research should seek to randomize or control these limiting factors and situational characteristics. In addition, following up with those who underwent the Shame Transformation process and comparing them with individuals who underwent other treatments, over a longer period of time, is important. This should be done using not only the psychological scales used here but also valid measures of recidivism.

Finally, it can be considered fairly commonsensical that shame and guilt must be treated differently in various offender populations to induce greater accountability and victim empathy. However, questions remain as to how best to carry out the treatment described here, among offenders who may have committed crimes other than domestic violence, and are of variable motivation, education, and ability to participate. For example, when should such a component be introduced into standard cognitive–behavioral treatment of offender populations? It may make sense to do so at the beginning of treatment, but with open-ended groups, there is no common beginning because each member is at a different stage of treatment. Furthermore, should the philosophy underlying shame transformation be integrated into the intake evaluation, as demonstrated by the two questions stated earlier in describing the process? The concept after all reflects a treatment philosophy as well as a module of specific steps. If the therapist holds the notion that shame represents an effective sanction or conveys such an attitude, then the philosophy and the module become moot.

Research on shame and guilt forces us to recognize the deleterious effects of the former. Targeting shame as a universal precursor to violence (Gilligan, 2003) and a barrier to effective rehabilitation (Braithwaite, 1998; Hahn, 2004) may be an important addition to the cognitive–behavioral therapies currently favored. The positive effects of the shame transformation process on domestic violence offender self-esteem and empathetic concern found here indicate to those who sentence and treat offenders for a variety of offenses that they should consider incorporating these ideas into their work.

Notes

1. The pretest was analyzed to determine if similar alpha levels were observed in the sample as were reported in other populations. The alpha values seemed reasonably similar with the exception of that for LOC: RSE, .808; LOC, .562; EC, .720; PT, .643; and PD, .706 (LOC = locus of control; RSE = Rosenberg self-esteem; EC = empathetic concern; PT = perspective taking; PD = personal distress).

2. Independent samples *t* tests were performed to determine if the between-group differences in age, income, ethnicity, and education were systematic. Difference in age ($t = –3.228$, $df = 101$, $p < .002$, two-tailed) was systematic, whereas income ($t = –1.138$, $df = 76$, $p > .05$, two-tailed), proportion Caucasian ($t = 0.061$, $df = 104$, $p > .05$, two-tailed), and years of education ($t = 0.768$, $df = 91$, $p > .05$, two-tailed) were not.

3. See Note 2 above.

4. Additional analyses controlling for ethnicity, income, age, and education were performed and have been left out of the article as their usefulness is restricted by the limitations of nonresponse, which affected the degrees of freedom detrimentally, and thus the ability to generalize findings. Further analyses were also performed for each scale using ordinary least squares regression to control for the effects of demographic variables on the treatment outcome and are not presented here for reasons of space. Both sets of analyses, which are available on request, provide little evidence that treatment effects were the result of systematic bias in the samples.

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