Rehabilitation or Ruse?

Exploring "Shame-Based" CBT for Domestically Violent Offenders

Zoeanne McCurdy

Department of Psychology, University of West Florida

PSI4930: Psychology, Science, and Pseudoscience

Dr. Jane Halonen

November 20, 2023

Rehabilitation or Ruse?

Exploring "Shame-Based" CBT for Domestically Violent Offenders

Intervention programs for domestic and intimate partner violence (IPV) are a growing focus of the psychological sciences (Murphy et al., 2020). Support services and comprehension of the social problem have progressed over the years, leading to advanced knowledge and therapeutic programs interventions. Offenders are most often court-ordered to complete traditional cognitive behavioral therapy (CBT; Hollon, 1998). However, high rates of recidivism have cultivated interest in improving potential treatment modifications and interventions (Radatz & Hilton, 2022).

Treatment strategies have recently involved incorporating the feeling of shame, prompting shame-focused exploration and training within CBT sessions (Loeffler et al., 2010). As a result, Shame-focused CBT has emerged. Legitimacy concerns regarding the treatment have arisen as well. The purpose of this paper is to evaluate whether shame-focused CBT has empirical support. In this paper, we will examine the nature of intimate partner violence, criminal justice outcomes for offenders, key characteristics of IPV offenders, the role of shame in IPV, if shame can rehabilitate IPV offenders, complications to shame-based CBT, and alternative explanations to determine shame-based CBT's foundation in scientific methods. Shame-based CBT holds potential as an intervention method for domestically violent offenders based on standing literature, related concepts and constructs, and current empirical support.

The Nature of Intimate Partner Violence

Intimate domestic relationships can deteriorate into social conflicts, assault, or violence (Kivisto et al., 2011; Radatz & Hilton, 2022). According to Kivisto et al., men and women perpetrate acts of IPV at similar rates, although women are more likely to experience serious

injury and mental health declines as a result of experiencing IPV. Intervention programs for male-on-female IPV focus on understanding perpetrator characteristics (Gondolf et al., 1997). The researchers analyze the potential connectivity between antisociality and acts of IPV (Kivisto et al., 2011). Their work explores relationships between abusers' personality traits and the transgression of abuse. Current research suggests partner-violent men experience more painful emotions related to self-consciousness, particularly, shame and guilt (Baumeister et al., 1996).

Current treatments have little to no differentiation in outcomes, partly allowing the continuation of IPV (Taft et al., 2003). A limited understanding of the mechanisms of domestic violence and IPV creates a limited knowledge base of treatment mechanisms. The complexity of understanding the perpetuation and continuation of IPV results from it being inherently irrational.

Criminal Justice Interventions Related to IPV

Current intervention practices for IPV involve a variety of approaches. A majority of cases that involve the criminal justice system result in a misdemeanor charge (Price & Rosenbaum, 2009). Misdemeanors are often not conducive of jail time, but instead the completion of an intervention program. Little evidence supports jail sentences possessing any rehabilitative potential, considering they are often short-term.

The criminal justice system focuses on rehabilitative methods as the primary response to IPV. Abuser Intervention Programs (AIPs; Murphy et al., 2020)--formerly known as Batterer Intervention Programs (BIPs; Price & Rosenbaum, 2009)--are rehabilitative programs for batterers. "Batterers" has become a popular piece of terminology for individuals who have been physically abusive to an intimate partner (Loeffler et al., 2010, p. 519). The treatment of offenders with a history of domestic violence varies due to a lack of consistent methods and

applications. Clinicians have made adjustments to current treatment protocol to understand the offender and lower rates of recidivism and dropout.

The specificities of each IPV intervention program vary. No national registry of AIPs or BIPs exists as of 2009, despite the number of programs increasing to indescribable numbers (Price & Rosenbaum, 2009). According to Price & Rosenbaum, the themes and concepts among many programs have been popularized. A preference in terminology for "batterer intervention" persists in the aim to "depathologize battering" and maintain the perpetrator's responsibility to their actions (p. 758). Cognitive behavioral approaches are one of the most popular methods used to treat batterers. Program combinations are popular, as nearly half of respondents described cognitive-behavioral approach methods being used in intervention programming.

However, most treatment programs are associated with high levels of dropout; the current dropout level ranges from 40 to 60 percent within the first three months of treatment (Gondolf, 1997). Those who drop out are the most likely to reoffend and to have more severe acts of IPV on their criminal records. Fewer than 10 percent successfully graduate. The current rates of recidivism for IPV and domestic violence are high. The disparity becomes more apparent through the relapse of partner-violent behavior, as a majority of treatment programs focus on the persistently high rates of recidivism (Radatz & Hilton, 2022).

Between 30 and 56 percent of incarcerated individuals have a criminal charge involving domestic violence (Mennicke et al., 2015). Men who have a history of IPV often are more likely to have both violent and nonviolent crimes in their criminal history as well. Following an arrest involving IPV or the completion of a rehabilitative treatment for an arrest, the recidivism arrest rate ranges from 20 to 30 percent (Radatz & Hilton, 2022).

Individual characteristics of the client potentially play a role in IPV perpetration and the likelihood of reoffense (Radatz & Hilton, 2022). A majority of experimental treatments aim to combat the high recidivism rates by focusing on the offender's behavior and cognitive perceptions (Hollon, 1998). CBT methods, in particular, aim to modify or change the behaviors and perceptions of the offender to reduce the likelihood of recidivism and increase the likelihood of prosocial behaviors.

Characteristics of the IPV Offender

The relationships among psychological traits and instrumental aspects of partner violence present complex interactions. Many partner-violent men present upon treatment intake with traits associated with psychopathological disorders, including antisociality, borderline personality disorder narcissism, and psychopathy (Kivisto et al., 2011; Taft et al., 2004). Nearly half of all men who are seeking court-mandated treatment present with distinct traits indicative of personality disorders. Even when the behaviors do not qualify diagnostically, many more present with relevant features of those conditions. The criteria for each condition are distinct and separate from one another.

Borderline traits involve an insecure sense of self, a lack of emotional regulation, and insecure, yet fervid, intimate relationships (Lawson, 2010). The pathology of borderline personality disorder appears to relate to shame (Schoenleber & Gratz, 2018). Taft et al. (2004) found that borderline traits correlate positively with several measures, including hostile-dominant interpersonal problems and scores reflecting significant interpersonal problems. Individuals with borderline personality disorder are also not as likely to acknowledge problematic behaviors.

Distinct differences exist between psychopathic and antisocial traits, despite these being often conflated (Kivisto et al., 2011). Individuals presenting with psychopathic traits show functional deficits in emotional processing and a lack of empathy for victims. Those presenting with psychopathic traits also have an affinity for using instrumental acts of violence against others. Those presenting with psychopathic traits have difficulty developing a relationship with the therapist (Taft et al., 2004). The lack of empathy and diminished capability of emotional processing results in a struggle to develop a connection between the therapist and client. Psychopathic traits are also related to hostile-dominant interpersonal problems, but not to total interpersonal problems.

Offenders presenting with antisocial traits show similar instrumental patterns of violence (Kivisto et al., 2011). However, those with antisocial traits do not possess the same emotional deficits as those with psychopathic traits. Minimal empirical evidence supports negative, antisocial emotion being a function of IPV by antisocial-presenting individuals, although Kivisto et al. do note that the confusion between the two trait categories could be at fault. Antisociality and feelings of anger in partner-violent men are associated. Research explores the relationships among antisociality in men with a history of partner-violence and common emotions associated with the literature on domestic aggression and violence. Patients presenting with antisocial characteristics are also less likely to acknowledge problematic behaviors (Taft et al., 2004).

Narcissism, on the other hand, involves an "artificially inflated egotism" (Baumeister et al., 1996, p. 13). Narcissism results in a general disregard for others. Having too much self-esteem has connections to narcissism and elements affiliated with an inflated ego and superiority. An overabundance of self-esteem has associations to aggression, as well as positive correlations to hostility, dominance, and grandiosity. Despite the difficulties of identifying key

components of the personalities, beliefs, and dynamics of abusive and violent behavior (Gondolf, 1997), the complexity and nuances of persistent abuse still require more intense research to clarify the interplay of those variables.

The Role of Shame in IPV

Shame and self-esteem are related; shame involves scrutinizing the nature of the self, resulting in profound emotional pain (Tangney, 1996; Yelsma et al., 2002). Shame affects other emotional components as well. Shame functions as a self-centered emotion that focuses on a negative judgment of the self, leading to devaluation and feelings of anger (Eisikovits & Enosh, 1997). A similar need for coping mechanisms for shame-inducing events also exists.

Nathanson's (1992) Compass of Shame illustrates a multidirectional model of four shame-centered coping styles, which has empirical support (Elison et al., 2006). The coping styles include Attack Self, Withdrawal, Avoidance, and Attack Other. Yelsma et al. (2002) examines the Attack Other coping style and connections to research on anger, shame, and domestic disputes. The researchers established a significant correlation between Attack Other and the externalization of shame. Shame relates to the externalization of emotions onto others, possibly as a means to cope. Externalization reflects outward blame and functions to enable the individual experiencing shame to rationalize their own behavior or actions that caused the experience.

Gillian (2002) observed that the emotional experience of shame motivates the individual to mask the event or action that induces it, supporting the rationale behind externalization. For those who engage in externalization tactics to cope with the shameful experience, feelings of shame often result in anger, behavior rationalization, and domestic disputes.

The defining constructs of guilt and shame are often confused (Tangney, 1996). Whereas shame entails a negative evaluation of the entire self, guilt involves a negative evaluation of the action or behavior that has been perpetrated by the individual (Lewis, 1971). In other words, shame focuses on the impact on the self concept, whereas guilt focuses on the consequences of the action or behavior. The identity or self concept of the individual experiencing shame has no current associations with guilt.

Guilt also relates to feelings of regret, remorse, and reparative action (Tangney, 1996), an effort to repair damage or harm done as a result of the damaging action or behavior. Tangney suggests that guilt can be construed as a prosocial emotion and shame as an antisocial emotion. She argues that shame and guilt are just as likely to be experienced in private as in public, countering initial preconceptions that shame is a public emotion whereas guilt is private.

Yelsma et al. (2002) describes shame as impeding positive emotion, an affective component of self-esteem. Low self-esteem positively correlates with greater levels of aggression and more shame (Velotti et al., 2017). Greater experiences of mental suffering and hostility correlated with the presence of diminished self-esteem and the presence of shame. Additionally, self-concept and self-esteem pose a complex relationship with shame and violence. Experiencing shame results in the "death of the self" (Gillian, 2003, p. 1153), leading to humiliation, aggression, and violence.

Tangney (1996) argued that shame encourages aggression and dysfunctional anger. However, Velotti et al. (2017) countered that the direct connection between shame and aggression lacks in-depth exploration. They argued that the relationship between shame and aggression involves the potential for shame to pause violence in some cases; consequently, not all forms of shame are maladaptive. Violence and aggression may eliminate the experience of

shame in the case of perpetrators of IPV (Gillian, 2003). By ridding oneself of shame, a different, more positive, emotion may be experienced. In the case of batterers with a history of IPV, for example, pride has been posited as a potential emotion. Ultimately, the redirection and replacement of shame with another emotion, particularly a prosocial one, could reduce instances of IPV.

Empirical Evidence Supporting Shame-Based Interventions

Standard cognitive behavioral therapy focuses on altering the behavioral and cognitive processes of the individual enrolled in the program by the guidance of a professional (Hollon, 1998). Cognitive behavioral therapy draws from cognitive theory, which argues that erroneous beliefs and dysfunctional cognitive processing are at fault for psychological dysfunction. CBT posits that two aspects cause IPV: a cognitive warping of the relationship between oneself and one's partner and inadequate skills in emotional expression (Lawson, 2010).

Current cognitive-behavioral approaches focus on group-treatment practices (Murphy et al., 2020). Murphy et al. used CBT strategies in group treatment practices resulting in less recidivism than individualized treatments. However, the researchers did have a particularly small sample size ($N = 42$), which may reduce the potential for generalization. Throughout the treatment process and follow-ups, those in the group treatment condition show distinctly fewer instances of physical violence than those in the individual treatment condition. Many participants prefer individual therapy to avoid the experience of public embarrassment or even out of fear of other individuals in group treatment. Alternatively, the forced experience of public embarrassment could lead to group cohesion and peer influence, enhancing positive behavioral change.

CBT includes many variations since many clinical experiments explore potentially efficacious treatment forms for unique populations (Tolin, 2010). The emotional content associated with shame and the dynamics of CBT draw from several subdisciplines in the psychological sciences. Beyond clinical psychology, Alex and Farisha (2021) observed connections between shame and positive and existential psychology. Methods for managing shame stem from these disciplines, including compassion-focused therapy, mindfulness empathy, and internal versus external shame.

Connections to affect theory and self psychology analyze the functions of domestic violence in itself and in the scope of shame (Brown, 2004). Both affect theory and self psychology argue that shame could very well be an underlying condition to violence. Self psychology stresses the importance of attachments throughout the lifespan while affect theory views emotional regulation as key.

For experimental purposes, shame-focused CBT addresses shame because of its affective function to emotion dysregulation (Loeffler et al., 2010). Shame moderates many of the emotional components that are present in emotion dysregulation. In the case of domestically violent offenders, shame-focused CBT recentralizes the focus from the self onto the transgressed action or behavior. During recentralization, the offender must acknowledge the feelings of and impact on the victim. Refocusing emotional cognition while incorporating traditional CBT practices aims to create more lasting treatment effects, subsequently reducing recidivism.

Experimental treatments utilizing a shame-focused dialogue exist, although the designations used vary (Loeffler et al., 2010). Naming differences in shame-focused therapeutic interventions makes exploring the diversity of methods possible. Shame-focused CBT

intentionally serves batterers by incorporating dialogue to acknowledge and interact with the experience of shame. Three shame-based approaches will be examined.

Shame Transformation CBT

Loeffler et al. (2010) integrated the concepts of shame and guilt into an experimental treatment plan, referenced as "Shame Transformation" in the protocol (p. 5). Shame Transformation focuses on channeling the feelings of shame into guilt to reform the batterer's emotional experience. The treatment focuses on the offense and the victim instead of the perpetrator. Shame Transformation treatment elicits a greater shift in self-esteem and empathetic concern. Shame Transformation factors in restorative justice because of the similarities in emphasizing empathy for the victim's experience and reparative action between the two. The practice of restorative justice focuses on the emotional nature of the batterer in tandem with the logical nature of law and order. The use of restorative justice results in reduced recidivism and a dampened desire for retribution for victims in crimes that involve irrational, violent acts.

Although self-esteem and empathetic concern are two features that affect batterers, some challenges exist in the success claimed by Loeffler et al. (2010). There was little to no effect on locus of control, perspective taking, or personal distress, according to the researchers. The absence of controlled conditions on group assignment causes concern, even though condition randomization would be difficult. The findings are suggestive and emphasize the need for additional rigorous research to further investigate the potentials for shame-focused CBT alterations before positive treatment outcomes for Shame Transformation can be endorsed.

Self-Acceptance Group Therapy (SAGT)

Self-Acceptance Group Therapy (SAGT) acts as an alternate shame-focused coping style that entails psychoeducation, cognitive and behavioral understandings of shame regulation, and comfort skills, all to promote self-acceptance (Schoenleber & Gratz, 2018). CBT foundations are a part of SAGT but are not the sole influencing treatment method in the treatment style. SAGT focuses on a range of psychopathological disorders and characteristics, not limited to domestically violent offenders. The treatment posits that targeting the experience of shame would be beneficial due to maladaptive adjustments to shame with which many patients present.

Schoenleber and Gratz (2018) utilized a transdiagnostic outpatient approach in SAGT. The open study design resulted in a small clinical sample size ($N = 24$; Schoenleber & Gratz, 2018, p. 80). The referral methods of the population mark an additional difference between this study and that conducted by Loeffler et al. (2010). Loeffler et al. received patients through court-mandated treatment referrals while Schoenleber and Gratz (2018) received patients through self or clinician referrals. The results of SAGT hold to be positive for individuals, although nearly half of participants reported that more sessions would be beneficial. SAGT promotes self-acceptance by focusing on shame, connecting it to treatment applications used in other shame-based CBT methods. However, future iterations of SAGT must include more men with a history of committing IPV in their sample to help with generalization about the potential of treatment effectiveness with this population.

Shame Resilience Theory

Shame resilience theory offers another shame-focused method to cope with such a negative emotion (Alex & Farisha, 2021). Shame resilience theory involves recognizing and comprehending the triggers of shame, practicing critical awareness, informing the support

network of one's story, and discussing the experiences of shame. Shame is primarily acknowledged through either the transformation of the emotion or the development of resilience (Alex & Farisha, 2021). In contrast to Shame Transformation, shame resilience theory prioritizes shame management and discusses several theoretical frameworks meant to manage and overcome the experience of shame.

Shame resilience theory focuses on developing a hardiness to the experience of shame (Alex & Farisha, 2021). Through the development of shame resilience, empathetic emotional practices also develop. Shame resilience theory involves theoretical methods, such as confronting and creating resilience to shameful experiences. Brown (2006) initially proposed the strategy as a new approach to understanding the experience of shame.

However, shame resilience theory cannot be defined as a therapeutic intervention on its own (Brown, 2006). Brown proposed shame resilience theory as a method to better understand the experience of shame, specifically among women. Drastic differences in the population of interest in this literature review and the work of Brown are present. Additional research should be conducted on shame resilience theory and shame-resilience building tactics. Shame resilience theory can, however, be recognized as a potential alternative to the transformative methods utilized by Loeffler et al. (2010).

Challenges for Shame-Based CBT

The absence of empirical evidence makes it difficult to critically evaluate shame-focused CBT interventions, leading to credibility concerns. Without more definitive determinations of validity and efficacy, questions are left unanswered. The gaps in empirical support mean limited confidence in treatment efficacy claims.

Loeffler et al. (2010) focuses on Shame Transformation, a style of shame-based CBT. The research provides the most compelling evidence for treatment efficacy through its focus on offenders with a history of IPV, shame-focused styles, and CBT intervention practices. In this framework, relationships based on shame take precedence. The majority of the supporting iterations of shame-focused styles and interventions come with limitations. The sample used in SAGT is not representative of the population of interest in this literature review (Schoenleber & Gratz, 2018). The researchers focusing on SAGT involved a dynamic sample, not limited to male batters. There are connections among emotional constructs like shame, self-esteem, and aggression throughout each treatment variation. The connections among these constructions create the strongest piece of evidence for shame-based CBT due to a lack of empirical data.

Countless intervention programs exist to date and exhibit diversity in intervention methods (Price & Rosenbaum, 2009), which complicates drawing broad conclusions about the efficacy of shame-based approaches. Group therapy approaches are one of the few consistencies in AIPs. The rate at which clients are referred to AIPs as well as key functions of the programs vary. Intervention protocols that differ vastly include the number of sessions, duration of the program, intervention style, and ethical guidelines. Program inconsistencies lead to additional complications during attempts to identify the total number of programs. No national or state registries for AIPs exist as of 2009. The lack of registries leads to deficits in empirical data and allows the inconsistencies among programs to persist. Obviously, future outcome studies need to clarify how these variables might affect treatment efficacy.

The populations referred to AIPs vary as well; to date, intersectional variations have not been well represented. Both men and women perpetrate IPV and are frequently court-mandated to complete a course of treatment (Price & Rosenbaum, 2009), but the majority of research has

focused on male perpetrators. A disproportionate number of men who are a racial or ethnic minority are referred to AIPs by the criminal justice system. Primarily cultural minorities are convicted of IPV in the criminal justice system. Consequently, existing research may not account for majority perpetrators.

The educational background of therapists and group leaders of AIPs also vary (Price & Rosenbaum, 2009). The education level that group leaders possess ranges anywhere from a master's degree or a master's in social work to a doctoral degree. The variability in standard practices leads to complications when determining the efficacy of available AIPs. The persisting concerns demonstrate a need for the treatment protocol or provider standards to be clarified further.

Alternative Explanations to Shame-Based CBT

Potential alternative explanations for effective IVP treatment exist despite the element of shame having an affective component to behavior and the perpetration of IPV: other variables separate from shame demonstrate relationships to IPV as well (Taft et al., 2004). The working alliance between the client and therapist acts as an alternative affective factor in the treatment of batterers. The working alliance represents the bond between the therapist and client, founded on mutually set goals for therapeutic outcome. According to Taft et al., positive working alliances promote reductions in abusive tendencies.

The nature of psychopathological characteristics and the relationship to the working alliance's quality with treatment outcomes has not received as much research. Taft et al. identified factors that promote a positive working alliance including, high motivational readiness to change; higher income; being older; marital status; self-referral status; and presenting with fewer interpersonal problems and traits associated with psychopathy and bipolar personality

disorder. The researchers added that the working alliance appears to have no association to ethnicity or minority group status.

Of the contributing factors Taft et al. explored, motivational readiness to change warrants additional attention. Establishing a positive working alliance with clients presenting with antisocial traits, psychopathic traits, or even a history of substance abuse may be difficult. Most clients seek treatment due to a court mandate. Many feel little motivation to change their behavior upon intake as a result. Clients presenting with psychopathological characteristics are less likely to want to actively engage in behavioral change.

According to Taft et al., research on interventions for substance abusers poses an additional support in motivation to change as a factor in outcome research on shame-based approaches. Treatments for substance-abusing individuals have found motivation to change as an important factor in the intervention process because of its associated post-treatment adherence. Substance abusing clients that present with more motivation to change upon intake are less likely to recidivate and more likely to adhere to the positive treatment goals and outcomes. The similarities in the lack of motivation to change and the strength of motivation to change's prediction of post-treatment adherence between both create direction for future research. The commonality in motivation to change's prediction of post-treatment adherence also point to a strong affective relationship and impacts on recidivism. There are clear population differences in the criminal history between substance-abusing and domestically violent clients. The comorbidity of these conditions in relation to one another or emotions like shame have not been investigated in depth.

Attendance rates and homework compliance add another consideration for research design (Taft et al., 2003). Homework in the treatment of IPV generalizes and develops desirable

skills promoting adherence to treatment goals. Effortful behavioral change can develop further through homework compliance since it covers more desirable skills than most time-sensitive treatment programs are able to on their own. The rate at which a client complies with homework assignments acts as a facet of treatment adherence. Compliance with homework and attendance can also be construed as evidence of a positive working alliance.

Additional research must be conducted to understand the factors involved in treatment adherence and the working alliance (Taft et al., 2003). The direct interactions between treatment adherence and working alliance also requires more intense research. Currently, an affective relationship between the two appears to exist. An understanding of the key mechanisms involved in the rehabilitative process can be understood through current research.

Conclusion

Based upon the present literature and the role of shame in the perpetration and intervention of IPV, shame-based CBT methods hold potential for treatment effectiveness. High recidivism rates make the need for treatment modifications evident and implicate current methods as ineffective (Taft et al., 2003).

The constructs involved in shame-based CBT potentially provide an understanding of the mechanisms behind abuse and IPV. Shame and self-esteem appear to interact with anger, aggression, and violence, fueling the challenges predictable in domestic disputes. Seminal literature (Lewis, 1971) describes how shame can be transformed into guilt or other prosocial emotions. However, future research needs to address many variables to substantiate claims of effectiveness for shame based therapy of IPV.

To date, the literature focuses on male-to-female IPV perpetration and the intervention of male offenders rather than providing a broader understanding of the scope of the problem.

Available AIPs are vast and lack documentation through a registry despite their preference by the criminal justice system. The protocols within AIPs vary greatly due to registration failures. Very few employ clear, replicable methods. Developing a registry that could monitor and maintain information regarding AIPs could be beneficial to the criminal justice system and clinicians alike.

Gathering persuasive empirical evidence for shame-focused CBT depends on the potential to replicate conditions. However, replication may be nearly impossible due to the current variability in conditions. The collection of valid empirical data for shame-based CBT requires clearly defined and replicable protocol. Additional research that carefully delineates the interplay of relevant variables must be conducted to determine the efficacy and validity of the experimental treatment more definitively. The complexity of the perpetration of IPV necessitates a unique intervention approach. Future research should prioritize using replicable and consistent methods focusing on shame-focused CBT interventions with a sample of physical batterers. Future research should also focus on the direct relationship of the experience of shame and acts of aggression to clarify the connections between shame and the perpetration of IPV.

References

Alex, A., & Farisha, A. T. P. (2021). Overcoming shame: A positive psychology perspective. In

    Shame 4.0 (pp. 177–191). Springer International Publishing.

    https://doi.org/10.1007/978-3-030-59527-2_10

Baumeister, R. F., Smart, L., & Boden. J. M. (1996). Relation of threatened egotism to violence

    and aggression: The dark side of high self-esteem. *Psychological Review, 103*(1), 5-33.

    https://doi.org/10.1037/0033-295X.103.1.5

Brown, B. (2006). Shame Resilience Theory: A Grounded Theory Study on Women and Shame.

    Families in Society, *87*(1), 43–52. https://doi.org/10.1606/1044-3894.3483

Brown, J. (2004). Shame and domestic violence: Treatment perspectives for perpetrators from

    self psychology and affect theory. *Sexual and Relationship Therapy, 19*(1), 39-56.

    https://doi.org/10.1080/14681990410001640826

Eisikovits, Z., & Enosh, G. (1997). Awareness of guilt and shame in intimate violence. *Violence*

    and Victims, 12(4), 307-322. https://doi.org/10.1891/0886-6708.12.4.307

Elison, J. (2006). Investigating the compass of shame: The development of the compass of

    shame scale. *Social Behavior and Personality, 34*(3), 221-238.

    https://doi.org/10.2224/sbp.2006.34.3.221

Gillian, J. (2003). Shame, guilt, and violence. *Social Research: An International Quarterly,*

    70(4), 1149-1180. https://doi.org/10.1353/sor.2003.0053

Gondolf, E. W. (1997). Batterer programs: What we know and need to know. *Journal of*

    Interpersonal Violence, 12(1), 83-98. https://doi.org/10.1177/088626097012001006

Hollon, S. D. (1998). What is cognitive behavioral therapy and does it work? *Current Opinion in*

    Neurobiology, 8(2), 289-292. https://doi.org/10.1016/S0959-4388(98)80153-0

Kivisto, A. J., Kivisto, K. L., Moorse, T. M., & Rhatigan, D. L. (2011). Antisociality and

    intimate partner violence: The facilitating role of shame. *Violence and Victims, 26*(6),

    758-773. https://doi.org/10.1891/0886-6708.26.6.758

Lawson, D. M. (2010). Comparing cognitive behavioral therapy and integrated cognitive

    behavioral therapy/psychodynamic therapy in group treatment for partner violent men.

    Psychotherapy Theory, Research, Practice, Training, 47(1), 122-133.

    https://doi.org/10.1037/a0018841

Lewis, H. B. (1971). Shame and guilt in neurosis. International Universities Press.

Loeffler, C. H., Prelog, A. J., Unnithan, N. P., Pogrebin, M. R. (2010). Evaluating shame

    transformation in group treatment of domestic violence offenders. *International Journal*

    of Offender Therapy and Comparative Criminology, 54(4), 517-536.

    https://doi.org/10.1177/0306624X09337592

Mennicke, A. M., Tripodi, S. J., Veeh, C. A., Wilke, D. J., & Kennedy, S. C. (2015). Assessing

    attitude and reincarceration outcomes associated with in-prison domestic violence

    treatment program completion. *Journal of Offender Rehabilitation, 54*(7), 465-485.

    https://doi.org/10.1080/10509674.2015.1076103

Murphy, C. M., Eckhardt, C. I., Clifford, J. M., LaMotte, A. D., & Meis, L. A. (2020). Individual

    versus group cognitive-behavioral therapy for partner-violent men: A preliminary

    randomized trial. *Journal of Interpersonal Violence, 35*(15-16), 2846-2868.

    https://doi.org/10.1177/0886260517705666

Nathanson, D. L. (1992). *Shame and pride: Affect, sex, and the birth of the self*. W.W. Norton &

    Company.

Price, B. J., & Rosenbaum, A. (2009). Batterer intervention programs: A report from the field. *Violence and Victims, 24*(6), 757-770. https://doi.org/10.1891/0886-6708.24.6.757

Radatz, D. L., & Hilton, N. Z. (2022). The Ontario domestic assault risk assessment: Predicting violence among men with a police record of intimate partner violence in the United States. *Criminal Justice and Behavior, 49*(3), 371-388. https://doi.org/10.1177/00938548211035816

Schoenleber, M., & Gratz, K. L. (2018). Self-acceptance group therapy: A transdiagnostic, cognitive-behavioral treatment for shame. *Cognitive and Behavioral Practice*, *25*(1), 75–86. https://doi.org/10.1016/j.cbpra.2017.05.002

Taft, C. T., Murphy, C. M., King, D. W., Musser, P. H., & DeDeyn, J. M. (2003). Process and treatment adherence factors in group cognitive-behavioral therapy for partner violent men. *Journal of Consulting and Clinical Psychology, 71*(4), 812-820. https://doi.org/10.1037/0022-006X.71.4.812

Taft, C. T., Murphy, C. M., Musser, P. H., & Remington, N. A. (2004). Personality, interpersonal, and motivational predictors of the working alliance in group cognitive-behavioral therapy for partner violent men. *Journal of Consulting and Clinical Psychology, 72*(2), 349-354. https://doi.org/10.1037/0022-006X.72.2.349

Tangney, J. P. (1996). Conceptual and methodological issues in the assessment of shame and guilt. *Behaviour Research and Therapy, 34*(9), 741-754. https://doi.org/10.1016/0005-7967(96)00034-4

Tolin, D. F. (2010). Is cognitive-behavioral therapy more effective than other therapies? A meta-analytic review. *Clinical Psychology Review, 30*(6), 710-720. https://doi.org/10.1016/j.cpr.2010.05.003

Velotti, P., Garofalo, C., Bottazzi, F., & Caretti, V. (2017). Faces of shame: Implications for self-esteem, emotion regulation, aggression, and well-being. *The Journal of Psychology*, *151*(2), 171-184. https://doi.org/10.1080/00223980.2016.1248809

Yelsma, P., Brown, N. M., & Elison, J. (2002). Shame focused coping styles and their associations with self-esteem. *Psychological Reports*, *90*(3), 1179-1189. https://doi.org/10.1177/003329410209000320.2