"Simply speaking your mind, from the depths of your soul":

therapeutic factors in experiential group psychotherapy for sex offenders

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Abstract

Sex offenders demonstrate heightened levels of negative emotions, traumatic experiences, mental health issues, and emotion disregulation. This study presents a qualitative analysis of interviews with sex offenders concerning helpful experiences in experiential group psychotherapy. Experiential group psychotherapy aims to increase emotional awareness, emotional expression, and reflection on emotions. The data were thematically coded according to Yalom's therapeutic factors for group psychotherapy. The results indicate that Cohesion is reported to be most helpful: when clients trust their peers and feel respected by therapists, emotional engagement in treatment is achieved. Clients report being more capable of focusing on and tolerating their own emotions, which also influences the way they relate to other people (Interpersonal learning). Experiences related to Universality, Instillation of hope, Altruism, and Existential learning were also mentioned as helpful in the treatment.

Keywords: group psychotherapy, experiential therapy, therapeutic factor, sex offender, child molester, client perspective, emotion

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The first and foremost aim of sex offender therapy is the prevention of recidivism. However, we know from general therapy literature that therapeutic success depends on active engagement by both parties, a will to change in the client, the therapist’s skill to get around resistances and an approach based on the client’s needs and strengths (Levenson, Prescott, & D'Amora, 2010; Serran, Fernandez, Marshall, & Mann, 2003; Wampold, 2001). In the field of sex offender treatment, the responsivity principle purports that clients can only respond to treatment if the service delivery matches their abilities to learn from it (Andrews, Bonta, & Wormith, 2011). For this reason, it has been noted that the tendency to overmanualize offender treatment reduces the therapist’s ability to respond to the client’s unique features and therefore decreases the effectiveness (Marshall & Burton, 2010).

The issue of responsivity is a crucial but underexplored area compared to research on risk factors or criminogenic needs. The existing literature confirms the importance of the way in which treatment is delivered to the patient. Jennings & Sawyer (2003) described the importance of group process and the facilitative techniques that will enhance the effectiveness. Strategies for increasing engagement include using a positive, empathic approach that encourages and supports client ownership of change, which may decrease the need for self-protective strategies such as denial (Kear-Colwell & Pollock, 1997). Beech and Fordham (1997) found that therapeutic atmosphere had an important influence on treatment change. Successful groups were cohesive, had effective leadership, produced a sense of group responsibility, encouraged expression of feelings, and instilled hope in members. Levenson & Macgowan (2004) found a strong relationship between treatment

engagement and treatment progress. Their findings suggest that clients who actively contribute to the group, are connected to other members and to the therapist. Clients who are invested in the treatment contract are more likely to progress in treatment than those who are not.

The context of the current study is FIDES (Forensic Institution DEviant Sexuality), a Belgian in-patient treatment centre. Like in many forensic programs, the relapse prevention approach is integrated into a broader rehabilitation model, comparable with the Good Lives Model (Ward & Brown, 2004). What sets the FIDES program apart is its combination of a cognitive approach with an experiential approach. In experiential group therapy, emotional responsivity is targeted by the creation of a safe therapeutic context for speaking about emotions and by stimulating clients to manage their emotions, to get in touch with their emotions, and to label and express them to others (Gunst, 2012). Clients learn to reflect on their inner experience and underlying problems, explore personal difficulties and work through unfinished business. Group psychotherapy with sex offenders – especially newly formed groups – tends to require more structure than group psychotherapy with other clinical populations. Due to poor motivation, defensive reactions and lack of self-reflective capacity, the group does not work on its own. The therapist needs to create and model a working therapeutic environment. The therapist needs to be well trained in order to be able to lead this kind of psychotherapeutic group. He needs to be empathically attuned, authentic, and accepting as well as directive (Gunst, 2012). Creating a safe group climate does not occur automatically, but is a necessary condition for self-exploration. The purpose of experiential therapy is not to develop increasingly sophisticated risk management strategies, but to deepen the experiential self-exploration process and find out what is

underneath this behavior (Gunst, 2012). Experiential psychotherapy offers an important supplement to the cognitive relapse prevention model as it engages clients into the therapy on an emotional level, thereby improving their emotional functioning.

In group therapy literature, Yalom's manual on group therapy has been highly influential (Yalom & Leszcz, 2005). There is a considerable body of research on these therapeutic factors in different populations, mainly using the Therapeutic Factors Q-sort (Yalom & Leszcz, 2005; Dierick & Lietaer, 2008). This instrument is used to rank therapeutic factors in order of importance. In outpatient groups, the most important therapeutic factors, from a client perspective, are Interpersonal learning and Catharsis (see the description of the factors in the Results section). The least important factors are the Corrective recapitulation of the primary family group, Imparting information, and Imitative behavior (Yalom & Leszcz, 2005). 'These results all suggest that the defining core of the therapeutic process in these therapy groups is an affectively charged, self-reflective interpersonal interaction, in a supportive and trusting setting' (Yalom & Leszcz, 2005, p. 89). Empirical research demonstrates that the therapeutic process in sex offenders is propelled by almost the same factors as outpatient treatment with psychiatric patients. A number of studies on the client's perspective have demonstrated that for sex offenders, Catharsis, Interpersonal learning and Cohesion are the most valued factors, while Imparting information, and Imitative behavior are the least valued (Riemer & Mathieu, 2006; Reddon, Payne & Starzyk, 1999). It seems that for group treatment to be effective in sex offenders the group should have an atmosphere in which members can work together in a supportive environment and express thoughts, feelings and share stories in such a way that they gain greater self-understanding. Advice

from other group members as well as observation and modeling behavior is experienced as less helpful (Riemer & Mathieu, 2006; Reddon, Payne & Starzyk, 1999).

These findings are in keeping with recent metasynthesis of ten qualitative studies on client's perspectives in sex offender treatment (Walji, Simpson & Weatherhead, 2014). They found that the quality of the therapeutic relationship is a decisive factor in the experience of the clients. The therapeutic relationship in group therapy concerns the clients' relationship with the group as a whole and with the therapist(s). In relation to the group, patients find it helpful to meet others with similar problems as it facilitates understanding of their experiences and reduces feelings of isolation. A necessary condition for group therapy is trust, in order to feel safe and to be able to share and discuss personal details without feeling judged. Furthermore, patients are able to challenge each other in ways that therapists cannot. The clients are often able to confront toxic behavior, attitudes, rationalisations, or minimalisations of sexually offensive behavior in powerful, yet sensitive ways. They know the mechanisms themselves. Therefore, it is stronger and more tolerable if peers give this feedback. If the group's efforts are too harsh or vague, the therapist is always there to help process a difficult interaction (Jennings & Sawyer, 2003). In relation to the therapist(s), patients appreciated therapists who are empathic, patient, positive, genuine, caring, trusting, respectful and authoritative. This therapeutic approach is beneficial for the client's sense of self-worth as they differentiate between their offence and their identity, and internalize a more understanding and compassionate stance towards others. In other words, the process of change is not restricted to attitudes towards the offence and the victim, but implies a broader personal transformation. Participants of the studies developed a new self-concept, 'incorporating acceptance of all aspects of their identity, as well as learning to experience and express emotions previously closed off or denied' (Walji et al.,

2014, p. 324).

The findings of Walji et al. (2014) dovetail with studies using the therapeutic factors of Yalom. The importance of the therapeutic relationship, marked by acceptance, respect and trust is what Yalom called cohesion. This seems to be the primary condition for effective group treatment, and it facilitates other therapeutic factors such as catharsis and interpersonal learning. According to Walji et al. (2014), a crucial aspect of catharsis and interpersonal learning concerns clients' exploration of their own experiences of victimization.

The aim of the current study is to elicit feedback from clients about helpful aspects of experiential group therapy. Most previous studies have focused on cognitive-behavioural therapy within the context of relapse prevention. As the objective of experiential psychotherapy is different, the findings from previous research might not apply to experiential treatment with sex offenders. Thus, the present study offers a client perspective on helpful experiences in the context of sex offender group psychotherapy oriented towards increasing experiential self-exploration.

Method

Sample

In this study, 13 sexual offenders were interviewed. Nine of them were part of the group therapy and four had successfully completed the treatment program. The sample covers all clients who participated in the experiential group during the period from March to September 2012. All 13 participants were Belgian adult men with a mean age of 44 years

(range 32 – 60 years) and were transferred to FIDES within the context of a conditional release from prison. All participants had commited a sexual offence with underage victims and one had an additional adult victim. For four participants the sexual offence was exclusively intrafamilial, for another four the sexual offence was exclusively extrafamilial, and for five participants the sexual abuse was mixed. Using the STATIC-99 (Hanson & Thornton, 2000), seven participants were categorized low risk, two were low-moderate risk, three were moderate-high risk, and one was high risk. This means that our sample is fairly heterogenous in terms of actuarial risk profile.

Data collection and analysis

We collected data through semi-structured interviews. The Q-sort would have generated more readily interpretable results in terms of a hierarchy of therapeutic factors. However, we were interested in participants' experiences about the group. The interviews were conducted in a separate room in the institution and consisted of four parts, each composed of several questions. Participants were given freedom to steer the interview in their own direction and give spontanious feedback. In that way, they had the opportunity to broach topics that are not included in Yalom's model, thus alleviating one of the shortcomings of Yalom's Q-sort that participants must make a forced choice. The interview started with introductory questions on the length and the progress of their treatment that were intended to put the participant at ease. In the second part of the interview, the theme of the therapeutic factors was broached in a general way: 1) What do you think about group therapy as opposed to individual sessions? 2) How do you feel in the group? 3) What do you think the other members of the group think about you? 4) What do you think about the therapists? How do they behave and respond in general? In the third part of the interview,

the interviewer asked about the therapeutic factors specifically: 5) Does the therapist sometimes explain things during therapy, based on theory? If yes, what do you think about that? 6) Do you have the feeling that the therapy helps you? 7) What do you consider the most important part of the experiential group psychotherapy? 8) Do you have difficulties with certain aspects of the psychotherapy? 9) Do you ever hear about other group members having had similar experiences to your own? If so, how does that affect you? 10) What is it like for you to share personal things with the other participants? 11) How do they react to your story? 12) Do you feel supported by the other participants during the therapy? If so, when? Do you feel supportive and helpful towards other participants during the therapy? 13) Do you think that you learn more about how to relate to other people during the therapy? 14) Do you ever get emotional during a session? Do others? What happens then? The fourth part of the interview consisted of closing questions to expand on their previous answers or to discuss helpful experiences they didn't mention before. The interviews were audio-recorded and lasted for 63 minutes on average (range 20 tot 120 minutes).

In the interviews, all of the questions were asked of every participant. However, soms of the questions were more often glossed over or given only a brief answer. For example, while several participants indicated that sessions were emotionally taxing, only a few described what could be called a cathartic experience (question 14). On the other hand, participants talked at lenght about the importance of the group format (questions 1 and 2) and the role that trust played in their levels of openness and perceived progress (question 7). Most subjects that participants spontaneously spoke about, related to the therapeutic style of the group leaders. Several described discrete incidents where a specific intervention of a group leader was helpful to them. Most of these related to empathic interventions, not to confrontational interventions.

The interviews were transcribed and passages in which clients talked about helpful experiences were selected in the transcripts. These passages were caterorized according to Yalom's description of the therapeutic factors. The results are organized according to the eleven therapeutic factors.

Results

Installing hope

Instillation of hope is encouraging a sense of optimism and the attainability of change by the therapist or by seeing other group members change and grow in the course of treatment (Yalom & Leszcz, 2005). Yalom's concept includes both the sense of change being possible and strategies for encouraging it. During the interviews, clients usually expressed the notion that the group could help them achieve their personal goals. Often clients had difficulty pinpointing the origin of their sense of hope. Several clients mentioned the positive environment as a likely contributor, but had difficulty articulating the process through which change was achieved. In those cases where interviewees did articulate the things that made them hopeful about change, two mechanisms were noted. First, clients said they noticed change in themselves. Often, favourable comparisons were made between themselves and newer clients.

> 'Certain people change too; they can see what they've been through. [You] mirror yourself on them, at the beginning [of the therapeutic process]. They reflect all the phases you're ahead of […] and the guys who have been through all of the phases already, […], they see themselves in us, or in me, how they used to be when they first got here.'

Secondly, clients recounted examples of overt encouragements and interventions by therapists and group members alike. One client told us he routinely told the “newbies” about his own therapeutic progress, hoping to motivate them.

Finally, the more spontaneous examples of hopeful cognitions concerned personal change or interpersonal goals, like “breaking out of my cage,” or “finally being open to my family.”

Universality

Universality is the patients’ realization that he is not alone in his situation and others wrestle with similar problems (Yalom & Leszcz, 2005). A sense of universality diminishes shame and insecurity. In our data set, several people spoke about the lessening of feelings of shame. The concept of shame and its ill effects is perhaps more relevant to an offender population.

> ‘Well, it makes you feel, look, you're not alone. You're not the only one that a lot has happened to; these guys are the same. And so I'm like, see? We *are* here to help one another. And that really started to hit me.’

Recognisable stories were generally experienced as both positive and negative. Hearing similar or recognisable experiences of other group members was felt to be helpful insofar as clients gained a more moderate perspective of their own troubles and gained new insight into their issues. Helpful remarks were also considered applicable to their own situation.

> ‘That's an excellent safety net. It's a better safety net than the staff sometimes. Because they have the theory – unfortunately, we have the praxis. It's not just about

> the crimes, it's about your *past*. I think there are few therapists who have a past where they were punched and beaten with belt buckles and kicked off a staircase and being made to stand outside in your underwear when you were a little kid. That's just a couple of things. (…) Things like that... (sighs). Err, and if the other guy talks about something similar, we can discuss it pretty well.'

Imparting information

Yalom narrowly defined *Imparting information* as explicit advice by the therapist or group members, as well as the psycho-educative efforts of the therapist (Yalom & Leszcz, 2005). Whereas FIDES' experiential group does not include any psychoeducation, participants did note a slight psychoeducative component to the sessions. They pointed out, for example, that the therapist would normalize an experience by one group member that others were sceptical about. Our interviewees appreciated the acknowledgement of their feelings, which made them feel safer in the experiential group.

Specific advice by other members of the group was considered very helpful by most of our participants. However, for many of them, the content of the advice was less important than the care shown to them by their peers. Clients didn't necessarily want the others to agree with their opinion or point of view, although one client was mostly pleased when others agreed with his way of thinking. In the majority of cases, clients didn't mind disagreement so much as disengagement. Most clients wanted their peers to be interested in their problems and to try and help out. Yalom and Leszcz (2005), note that explicit advice in itself isn't therapeutically valuable, but that the sense of being cared for and appreciated is usually quite helpful.

Altruism

Altruism is one of Yalom's broader concepts, and includes any and all support given or received, the reasoning being that contributing to another's welfare is in itself a healing process that demonstrates the client's worth (Yalom & Leszcz, 2005). In the interviews, Altruism was often coded as support, frequently from the client to his peers. The following excerpt was double-coded with Group cohesion.

> 'We'll help him, won't we? If we try to feel like him and help him to process things and give ideas and options – in sofar as solutions exist for some problems. And, most importantly, give him a lot of support... […] and be very clear about one thing: "look, man, if something ever bothers you, call one of us and talk. We're here for you." '

Clients noted feeling valuable to the group when capable of helping other group members.

> 'At those times I was proud of myself. Why? Because partly, it helps me, but also because I can help them. (Quiet) I was proud of it then. I can feel... (laughs) I'm feeling that warmth again now.'

A number of clients support Yalom and Leszcz' (2005) assertion that altruism generated by the client creates a healthy distance from their own issues and problems. In addition, our participants frequently mentioned being able to empathize deeply with others' stories, despite urgently felt problems of their own. This, too, is part of what Yalom and Leszcz (2005) described in the conceptualisation of the Altruism factor.

> '[when I feel personally touched by someone else's story because it is so recognisable] I try to push it away for a while. I'll set it aside and try to listen. Then when he's done talking, I'll take it back.'

Corrective recapitulation of the primary family group

The *Corrective recapitulation of the primary family group* is about correcting modes of engagement that stem from childhood through new interpersonal experiences (Yalom & Leszcz, 2005). This factor was barely mentioned in any of the interviews. We suspect the abstract nature of the concept makes it less likely for participants to spontaneously mention it. One client told us about how the trust within the therapeutic relation was a new interpersonal experience to him, an experience he didn't know from his parents.

Development of socializing techniques

As opposed to Interpersonal learning, this particular factor is rather narrowly conceived as the learning of specific behaviors, such as framing criticism in terms of its effect on oneself rather than as an integral part of the other. For Yalom and Leszcz (2005) and in our own analysis, socializing techniques (e.g., learning to communicate one's own opinion and labeling it as an opinion: "According to me, you are wrong") is more productive than expressing one's opinion to a peer as an absolute fact (e.g., "What you're saying is wrong."). Several clients told us their own interpersonal styles was rather brusque and straightforward and that they had changed this because of their experiences in experiential therapy.

> 'I do usually share, you know, I say what I think, but I need to learn – that's a big one for me – to chew on things before tossing them out there. I'm one of those – I think of something, bam, it's out and it's usually correct, but I say it the wrong way. It comes off as way too hostile. And I need to learn to not do that as much. If I'm personally touched by the subject, I'll have an easier time talking about it because I'm learning to speak about myself and my own feelings now. Before, it was like (laughs) bam, out with it, and now I think about it for a bit first.'

Imitative behavior

According to Yalom and Leszcz (2005), Imitative behavior occurs whenever a client imitates specific behaviours of either their peers or the therapist(s). For example, copying therapeutic language would be an imitative behavior, as would be experimenting with a counseling or supportive role. Some clients, generally the ones who were already participating in the after-care program, or those who were due to finish up the program soon, told us they took on a counseling or facilitating role in experiential group therapy. Others described a transference of the therapist's behaviour and role to their home and their relationships. Another client said that seeing emotional sharing and self-revelations modeled by experienced members of the group made him reveal more about his inner self.

> 'In general, what you often hear is that someone who's been there longer brings up a subject in a genuinely emotional way, and that the newer, younger members of the group will then bring up something serious and important of their own within the next couple of weeks. And that's just because they feel safe about it, so they're like "I'm allowed to talk about this and it's okay if there's emotions involved". So, that's because of experiential therapy... from an "older one" who's been there longer, that they go "hey, it's okay for me to bring this stuff up." '

More experienced clients also mentioned efforts to monitor the group climate and actively promoted a warm and accepting group environment.

Interpersonal learning

Interpersonal learning is the correction of negative interpersonal experiences by exposure to, and comparison with, interpersonal and social beliefs displayed by other group members (Yalom & Leszcz, 2005). Interpersonal learning occurs naturally as a result of being in a therapeutic setting with others. Interpersonal issues automatically come to light and are (hopefully) corrected through group feedback and exploration. Interpersonal learning

consists both of emotional expression and a reframing of belief around emotional expression: clients experience that expressing negative affect at a time of friction and tension in the group has no disastrous effects as previously feared. Yalom and Leszcz (2005) describe this factor as being the equivalent of insights and progress in individual therapy. Over the course of the interviews, participants stressed the importance of focusing on and accepting emotions, which is a central therapeutic aim in experiential group psychotherapy.

> ‘That's where I learned to connect. Like now, now I've been outside for almost a year. But it's a lot easier now, like when someone tells a story I make connections immediately, which I never did before. Before, I didn't know what that was like. Or I didn't think about it at all. But now, well, it's much more emotionally gripping than before, but you do feel it and, well, you understand it and you feel what they feel.’

For many clients, changes in their interactions with other group members are due to the experiential therapy. Empathy and openness are mentioned often, as well as increased listening skills. In the following excerpt, a client describes how making the distinction between his own point of view and a fellow group member freed his mind to pay more attention to the person's story and process. This is a good example of how the experiential therapy promotes clients’ mentalizing capacity.

> ‘At first, err, a door closed, for me. At first a door closed. I was like, to put it bluntly, fuck it. And the other one would be like “I've had it. I'm done with this.” And then of course she [first therapist] comes along, to pick at the whole thing until... they always find the heart of the matter in some way. After a while you learn to understand that the other guy's feelings about something are just that […] And I have my way of seeing something and he has his. So at some point I was like “yeah, that's how he sees that, that's how he feels,” and I get interested in where he's coming from.’

The following excerpt was double-coded with group cohesion. It details the kind of experience many of our participants warmly extolled as being the most valuable change in their therapeutic process: a feeling of being less distrustful and isolated.

> 'A sense of trust. A feeling I never really had with people before, because, yeah, when they used to – I never actually had a lot of contact with people. I tried to be alone as much as possible: working alone, going out alone. And I never, never have been used to having a lot of people around me. And I never had a lot of interaction with people. And I didn't trust people very much. And here that did work out because you get to know about that thing called "trust." So then you know what trust is, and it feels really really good and warm.'

Group cohesion

Like Interpersonal Learning, Group Cohesion is one of Yalom's broadest concepts, being a proxy for the therapeutic alliance in individual therapy settings (Yalom & Leszcz, 2005). On the one hand, group cohesion refers to the feeling that the group is a "good environment." On the other hand, group cohesion refers to a sense of belonging to the group. These two components don't necessarily overlap: it is possible for clients to feel that the group is good and supportive, but still think that they themselves don't really fit in or belong in the group, or vice versa. However, for group cohesion, both components are important. Most interviewed clients described the experiential group as a warm and accepting environment. Many clients detailed the process of opening up in therapy, and the importance of the initial realisation that their peers were unlikely to judge them as long as they were honest and open. A frequently recurring opinion was that trusting the group and trusting that others would be accepting was a precondition for therapeutic work.

> 'Yes, and then the whole thing with my father, that was... shh... case closed, but still. Still, sometimes I do feel that urge. I closed it off, seems like, but still I... you're so

> comfortable and I sometimes feel like, I need to talk about it now. And I do, and it does help, I think.'

Trust, several clients noted, correlated highly with the confidentiality of the experiential sessions. Almost all the people we interviewed told us how essential it was to be confident that the personal issues they talked about in experiential therapy didn't leave the room. Most of them had to learn to trust others.

> 'The simple fact that I've dared to take that step. That I started talking about a certain subject, and how the others responded to it. That that was a very positive thing to me, that I experienced that as a very positive thing. And that nobody hurt me because of it. That's what made it safe for me. Doing it once and seeing that, oh yeah, it does work. You see, it's... it's taken seriously and again the second time and again the third time and that builds trust. Yeah, I think that's what it comes down to in the end. Because there are people in that group that I wouldn't feel safe around normally.'

As we mentioned in the method section, FIDES operates with a semi-open group system, where clients leave at the end of the process and leave room for new clients. Occassionally several clients will finish the program at once so that a number of new clients can join the group at the same time. Participants generally agreed that the group could easily absorbe one new member at a time, but they aknowledged the impact of a series of new arrivals. The before-after process of absorbing more than one or two new clients at a time was described by several of our interviewees as constituting two entirely different groups. With the presence of new clients, trust issues emerge automatically, especially when they are slow to understand the purpose and key concepts of the experiential treatment.

Clients seemed to view therapists' attitudes towards them as something seperate from the group climate. Most clients appreciated their therapists' warm and accepting attitude. One client described a non-superior attitude as essential to him.

> ‘You can just say things like that to her – that's a sign of, how's she's on the same level as you are […]. So she doesn't, like, place herself above you, even though they are, in a way, of course – but also, you can just talk to them and have friendly banter.’

Several clients mentioned how important is was to them to feel that the therapists “really respect[ed] your boundaries” and “take us into account.”

> ‘They do redirect the session sometimes, but steering the conversation? I've never seen either of them say “we won't be talking about that. We'll talk about this instead.” […] Never tell anyone “that was a wrong thing to say and we'll be talking about this other thing now.” That doesn't happen. I think it would be very – I mean, the point is that everybody feels safe to say their piece and being restricted in that way might make you hold back the next time.’

Catharsis

In Yalom and Leszcz’ conceptualization (2005), *Catharsis* entails experiencing and expressing both positive and negative feelings, and reflecting on the experience. The expression of feelings may or may not come with relief. Many of the clients we interviewed told us about highly emotional moments during therapy, although many failed to say whether this was ultimately a relief to them. Several clients spoke of “bombs that had to go off.” Some described a cathartic experience as crucial to their therapeutic process.

> ‘There are certain things that you go through in your life. You used to bottle it all up, and when you get here you learn – you teach yourself – to talk about it. They can only tell you “look, do with it as you like, but it's still *you* and you still need to want to talk about it.” And so I started talking about what I'd gone through in the past, with my grandmother and my parents, and the bottled-up emotions that are inside me which came back subtly. But on the other hand – how do I put this – it was kind of a relief. Immediately, it's like the brick in your stomach that just crumbles. And that meant a lot to me.’

Not all of the people we spoke to experienced the release of pent-up emotion as a relief. For example, the following client had a somewhat ambivilant attitude towards the expression of emotion (i.e., it is sometimes an overwhelming experience followed by feelings of shame).

> ‘Coming here, I let it all hang out and didn't bottle anything up anymore. There are times when it's too much, when I say, I need to start repressing this stuff again. Although that's not good either, they say, but yeah, at long last I start to be ashamed again doing that in front of... And besides, I'm not the only one out of the six of us who is ashamed of it. They'll say “it makes me ashamed, I'm so embarrassed.” It's just too much after a while. “Men are allowed to cry,” they say, you know, but when you're here, when you're here in this facility and getting treatment... we can't... you can't stop the tears. You have to let them out. Otherwise, when you speak from a repressed feeling, it'll burst out eventually, and then it might be an inappropriate moment.’

Yalom and Leszcz (2005) stated that the simultaneous occurrence of emotional expression with a cognitive moment of learning is what makes catharsis therapeutically valuable. Clients in our data set did not comment on the cognitive component at work when they reflected on emotional experiences during therapy.

Existential learning

Existential learning concerns existential subjects such as the inevitability of death, the insight that life is unfair, and realizing that we are all alone in this world (Yalom & Leszcz, 2005). Acceptance of these existential themes results in a more honest and grounded attitude. Additionally, it is crucial that individuals take responsibility for their life choices. In the interviews, this factor was mostly coded for instances in which clients described gaining insight into the fact that they themselves were the only ones capable of making change happen in their own lives. Clients often described initially feeling like it was the therapists'

job to change their lives for them (as well as provide a name for their inner discomfort during sessions). Taking responsiblity for their therapeutic process was noted as a key change.

Self-determination being the only significant existential factor in our data set differs greatly from Yalom and Leszcz' (2005) assertion that acceptance of mortality and going through life alone are crucial. In this target population, acceptance of responsiblity of one's own process and quality of life seems to be of higher importance.

> ‘And now I've started to see – all because of experiential therapy – that it all has to come from you, that you're the one who has to find the answers. And that [therapist’s name] doesn't have to do that for you.’

None of our participants spoke of other existential factors or insights. We had expected that the lack of control and autonomy that comes with being on parole would play a part. However, this was not the case. Other themes, such as dealing with the past, accepting or healing family bonds, and dealing with guilt and shame emerged frequently and spontaneously.

Conclusion

The aim of the current study was to investigate helpful experiences in experiential group psychotherapy for sex offenders. Through interviews with clients who were in treatment or finished treatment, we found that Yalom’s 11 therapeutic factors for group psychotherapy emerge in varying degrees for sex offenders’ self-reported experience in experiential group psychotherapy. Group psychotherapists working with sex offenders need to take into account that the three most prominent therapeutic factors to which clients refer

are Interpersonal learning, Cohesion, and Catharsis. This is the conclusion of our study, and it is in accordance with previous research (Riemer & Mathieu, 2006; Reddon et al., 1999). Interpersonal Learning is a broad factor that refers to gaining insight through interaction, understanding how relating to others elicits certain responses and vica versa. Our results indicate that group psychotherapist should engage sex offenders into a process of learning from interactions with others. Clients emphasized that they were more capable of focusing on their emotions, accept their emotions and express them to others. This corresponds to the therapeutic aim of experiential group psychotherapy (Gunst, 2012). According to the clients, this increased emotional awareness and expression has an impact on their relationships with others: they report feeling more empathy and openness towards other people's experiences, as well as improved listening skills. Furthermore, many clients reported that the most valuable change in their therapeutic process was a feeling of being less distrustful and isolated.

Group psychotherapist working with sex offenders should also know that, from a clients' perspective, trust in the other clients and in the therapists is a precondition for therapeutic work. Trust seems to have a double meaning in this context. On the one hand, trust refers to the confidentiality of what is said during the experiential sessions (strong boundaries with regard to the outside world). On the other hand, trust refers to the certainty that other members of the group will be respectful towards what they say in the group (openness within the group). In terms of Yalom's therapeutic factors, trust is part of Group cohesion, i.e. the client's positive attitude towards the group and the feeling of belonging to the group. Cohesion is a proxy for the therapeutic alliance in individual therapy settings. Most clients said that they had to learn to trust the others and this trust was tested each time someone completed the treatment and was replaced by a new client: such

moments of change pose a challenge to group cohesion. Nevertheless, the experiential group was experienced as a warm and accepting environment and most clients spoke about a gradual process of opening up. The therapists' attitude was also considered important in this process in that most clients appreciated their therapists' accepting and respectful attitude.

The therapeutic factors of Installation of hope, Universality, Altruism, and Development of socializing technique were mentioned as being helpful in experiential treatment. Being able to tell their story and to hear recognizable stories by other clients ameliorates feelings of loneliness and shame. Clients reported being able to empathize deeply with others' stories, despite having intense problems of their own. Being able to support their peers induces a sense of value. The clients feel that the group can help them achieve personal goals and that the group is a good place to work towards these goals. Clients mentioned goals such as dealing with the past, accepting or healing family bonds, and dealing with guilt and shame. Based on these results and based on Walji et al. (2014), we suggest that group psychotherapists acknowledge that the process of change in sex offenders is not restricted to changing the attitude towards the actual offence or the victim, but involves a broader personal transformation. It seems that the clients go through a process of gradually taking more responsibility for their own therapeutic change.

The results with regard to the therapeutic factor of Catharsis were more ambiguous. Most clients reported emotional engagement in the experiential treatment and emphasized that they were more able to focus on, accept, and express their emotions to others. However, the interview data indicated that intense emotional moments are not always followed by relief, as stipulated by Yalom in the Catharsis factor. The interview fragments that were coded for the factor Catharsis refer to strong and uncontrollable emotions:

'bombs that had to go off,' 'bottled-up emotions,' and 'it'll burst out eventually.' Moreover, clients also reported feeling ashamed of their emotions. Having the feeling that emotions are uncontrollable and shameful is an obstacle to approaching emotions and to tolerate being in touch with emotions (Greenberg & Pascual-Leone, 2006). These difficulties in emotional engagement probably reflect affective disturbances and a history of trauma in many clients. Indeed, many sex offenders report a history of childhood victimization, including neglect, physical maltreatment, emotional abuse and especially sexual abuse (Maniglio, 2011; Whitaker et al., 2008). As a result, many sex offenders have problems related to emotion regulation and mental health. We can assume that clients who report uncontrolable emotions were still in the middle of their therapeutic process. Clients can take much time in accessing their emotional life or finding a good distance from their emotions, often shifting from 'too far' to 'too near.' In experiential psychotherapy, trauma-related emotions are managed by helping the client to *be with their emotions* and not to *be their emotions*. This is necessary for them to be able to reflect on their inner life. Psychotherapy research finds that for therapeutic change to take place, it is important that clients not only learn to express their emotions, but also learn to reflect on their experience and find meaning in it (Elliott, Greenberg, & Lietaer, 2004). This can be extremely difficult for offenders with a history of victimization, emotion regulation difficulties, and mental health issues. From this perspective, it is unsurprising that clients are ambivalent towards moments of intense emotional outbursts during the therapeutic process. Modelling and support of other group members and therapists is needed to overcome the fear and shame. The feedback from the clients in this study learns that – although it is tough work – they value working with and through their emotions. The study shows that if there is a safe space in treatment, and if therapist interventions support clients to experience and accurately

label their emotional states, offenders are able and willing to disclose themselves to others. As emotional engagement is important for clients to benefit from treatment (Howells & Day, 2006), it seems important to make this safe space in the treatment programs for offenders to learn and experience how emotions can guide their life.

The present study does not allow us to determine whether experiential group psychotherapy with sex offenders produces positive outcomes and is effective in terms of improving their capacity for emotional processing. Future studies should focus on the variability in emotion regulation in sex offenders. Evidence suggests that cognitive behavioral treatment for sex offenders does not succeed in reducing ineffective emotion-focused coping (Serran, Moulden, Firestone, & Marshall, 2007). We expect that experiential group psychotherapy is able to change different levels of emotional processing: emotional awareness, emotion regulation and negative emotions. However, this remains to be proven. Other limitations of this study have to be considered alongside our findings. The total sample is limited to 13 clients, all with underage victims. However, the data collection covers a long stretch of therapy in 2012, and consists of semi-structured interviews with patients in various stages of their treatment. This increases the trustworthiness of the data, as perspectives from clients at the start, middle and end of their treatment are included.

We conclude that experiential group psychotherapy succeeds in stimulating the emotional responsivity of sex offenders: participants were able to focus on, accept and express their emotions to others. However, strong emotional outbursts seemed to be experienced with an air of ambivalence. In general, the therapeutic process is facilitated by experiences of self-reflective interpersonal interaction in a trusting and cohesive group. In this respect, the therapeutic process in experiential group psychotherapy for sex offenders is

similar to other types of group treatment for sex offenders (Riemer & Mathieu, 2006; Reddon et al., 1999) as well as outpatient non-forensic groups (Yalom & Leszcz, 2005)

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