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The role of affect regulation in the treatment of people who have committed sexual offenses

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ABSTRACT

Affect regulation problems have been found to play an important role in the onset of problematic behavior, such as sexual abuse. The role of emotion and maladaptive coping has become relevant in both research and treatment interventions. Forensic treatments have been strongly influenced by conceptualizations of affect regulation that emphasize the control of emotional experience and expression. For a long time, emotions were treated as less important than cognition. However, the view of emotion as an adaptive resource and meaning system is now emerging in the forensic literature. General psychotherapy research has shown that improved affect regulation and deeper experiencing is associated with better outcomes in psychotherapy. These findings, in combination with the role of emotions in behavioral and relational functioning, are leading to a shift in forensic treatment approaches. In this paper, we review the literature on affect regulation in treatment programs for individuals who have committed sexual offenses. The implications of this work for forensic practice will be considered. Finally, Emotion-Focused Therapy will be presented as a promising therapeutic approach for forensic treatment programs to promote clients' emotional engagement and processing, and to improve treatment outcomes.

Emotions reveal the impact of events and interactions with our environments and show people what they need to thrive. As such, they are crucial to well-being, and act as a guide for pursuing important goals. However, they can also cause problems when people are unable to regulate them and process them in ways that are optimal for their well-being (Elliott, Watson, Goldman, & Greenberg, 2004; Nyklíček, Vingerhoets, & Zeelenberg, 2011). It can be problematic when emotions are suppressed because they are unbearable, or when people ignore or dismiss them. Hyperactivation or deactivation of emotions is often a consequence of past trauma, loss, or attachment problems (Cassidy, 1994; Crittenden, 2008). Both under-regulation and over-regulation of affect have been linked to different forms of psychopathology, such as depression, dissociative disorders and certain personality disorders, such as borderline and narcissistic personality disorder (Elliott et al., 2004; Greenberg & Watson, 2006; Gross, 2014; McMains, Pos, & Iwakabe, 2010; Nicolò et al., 2011; Siegel, 2012; Stewart, Zvolensky, & Eifert, 2002; Watson & Greenberg, 2017) and other problematic behaviors, such as alcohol abuse (Aldao, Nolen-Hoeksema, & Schweizer, 2010), aggression and sexual violence (Day, 2009; Langton & Marshall, 2000).

It has been proposed that affect regulation plays a key role in sexual offending behavior (Gunst, Watson, Desmet, & Willemsen, 2017; Howells, Day, & Wright, 2004) and warrants further consideration in

the treatment of individuals who have committed sexual offenses (ISOs). Sexual offending is a widespread problem that affects communities and society, as well as survivors and their loved ones. It has a psychological impact, possibly including PTSD, eating, mood and anxiety disorders, and also physical and economic sequelae that are high in cost. These consequences highlight the need to improve the psychotherapeutic treatments available for ISOs. Current views on the effectiveness of treatments to prevent relapse are cautiously positive. Meta-analytic studies indicate that the psychological treatment of ISOs significantly reduces general and sexual recidivism. A small but significant effect has been found (Hanson, Bourgon, Helmus, & Hodgson, 2009; Kim, Benekos, & Merlo, 2016; Schmucker & Lösel, 2015) for cognitive behavioral treatments based on Risk Need Responsivity (RNR) principles (Bonta & Andrews, 2007). However, optimism is tempered by the lack of rigorous RCT studies on treatment outcomes in this population (Hanson et al., 2009; Schmucker & Lösel, 2015) and because the effect of treatment is small. Given these small effects, it is important to investigate whether other treatments that have received little attention are more effective (Kim et al., 2016). Ward, Mann, and Gannon (2007) have argued “that the terms ‘treatment’ and ‘therapy’ refer to the process of applying psychological principles and strategies to change the behavior of offenders” (p. 89). Forensic treatment differs in two important ways from other therapeutic programs. Firstly,

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therapeutic engagement is often not entirely voluntary, as it may be a requirement for parole or probation. Secondly, the treatment has a dual purpose in that it is not only provided for the best interests of the client, but also for the protection of society at large (Ward, 2013).

It has been suggested that to improve the effectiveness of therapy in forensic settings, the focus of research and treatment should be expanded beyond cognition (Day, 2009; Gannon & Ward, 2017; Howells et al., 2004). A critical analysis of former treatment models shows that they failed to adequately address existing affect regulation problems that are viewed as risk factors for sexual offending (Howells et al., 2004; Serran & Marshall, 2006; Ward & Beech, 2006; Ward & Hudson, 2000). Recently, the role of emotional states and maladaptive coping has become a relevant topic in both research and literature on treatment interventions for ISOs (Gunst et al., 2017; Howells et al., 2004; McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010; Ward, 2017). Research has identified the maladaptive coping styles that ISOs use when experiencing negative emotions, such as distracting themselves, imagining different outcomes, worrying, or impulsive emotional outbursts (Maniglio, 2011), in addition to more sexualized coping strategies (Whitaker et al., 2008). Nevertheless, in spite of the growing focus on emotion, forensic treatment programs are still influenced by etiological and therapy models that have a negative view of emotions (Ward, 2017). These models see emotions as problems that need to be controlled and managed, due to their potential for disrupting prosocial motivations and actions, and for biasing problem-solving (Ward, 2017). In contrast, other psychotherapeutic orientations emphasize that emotions are biologically adaptive, with a growing agreement on the importance of working with emotions in psychotherapy to enhance treatment outcomes and contribute to lasting change. For example, the third generation of cognitive behavioral psychotherapies, including Dialectical-Behavioral Therapy (Linehan, 2014), Schema-Focused Therapy (Young, Klosko, & Weishaar, 2003), Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 1999), and Cognitive Behavioral Affective Therapy (Fernandez, 2010, 2013) has started to focus more on emotional regulation in therapy.

Other approaches with a primary focus on promoting more effective emotional processing and affect regulation, like Emotion-Focused Therapy, have a growing evidence base for their effectiveness with different populations (Elliott, Watson, Greenberg, Timulak, & Freire, 2013; Paivio & Pascual-Leone, 2010; Pascual-Leone, Bierman, Arnold, & Stasiak, 2011; Watson, Gordon, Stermac, Kalogerakos, & Steckley, 2003; Watson & Greenberg, 2017). In addition, clients' emotional processing and depth of experiencing have been found to be important change mechanisms and are significant predictors of outcomes in different therapeutic approaches, including CBT (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Greenberg & Pascual-Leone, 2006; Watson, Greenberg, & Lietaer, 2010; Watson, McMullen, Meghan, Prosser, & Bedard, 2011; Whelton, 2004).

However, the view that emotions and feelings are an important change factor in the treatment of ISOs is not commonly accepted in forensic psychology and practice. The Safer Society Survey (McGrath et al., 2010) reports that the majority of forensic treatment programs (around 65%) integrate improvement of emotion regulation as a target in treatment because marked deterioration of mood is linked to imminent risk of sexual reoffending. However, the focus is on monitoring and managing emotions, to the detriment of exploring affective experiences as a guide in the individual treatment process to increased well-being. The goal of this paper is to bridge that gap by highlighting the importance of emotional processing styles with respect to sexual offending, and to further our understanding of affect regulation as a treatment target.

1. Affect and affect regulation: conceptual clarification

In the literature on emotion, the term *affect* is defined broadly to encompass stress responses, emotions and moods (Gross, 2015). In this

paper, affect is used to incorporate the holistic experience of the organism. Spinoza (1994/1667, Ethics, Part III, definition 3) described affect as “the modification or variation produced in the body (including the mind) by interaction with another body which increases or diminishes the body's power of activity” (transl. 1994, p.154). This definition fits with the “organismic valuing process” described by Rogers (1959). Organismic experience is a vital source of knowledge that can guide thinking and behavior. It provides information on the experiencing process that is fresh and fluid, and offers a way to understand emotional experience (Gendlin, 1970; Kennedy-Moore & Watson, 1999).

This organismic knowledge or bodily “felt sense” (Gendlin, 1996) is broader and richer than just emotions, which are seen as a subset of organismic experience that involves more specific responses typically elicited from the appraisal of significant events, objects and/or persons. In addition to emotions, the term *affect* also includes undifferentiated feeling states (Gross, 2015; Kennedy-Moore & Watson, 1999) and bodily felt meanings (Gendlin, 1979, 1996) and captures the ongoing partly-unformed stream of inner information called “experiencing” (Gendlin, 1970). People can learn to attend to the flow of experience to access the implicit meaning therein. According to Gendlin, it is the (implicit) meaning of the feeling in a specific context that can be found by listening to the bodily felt sense that is of greater significance than the emotion itself (Gendlin, 1979, 1996). Affective experience carries personal meanings that reveal what is significant for our well-being, stored in affective-cognitive structures termed “emotion-schemes” (Elliott et al., 2004; Greenberg, 2015). Affective experience can provide increased understanding of oneself, better regulation of one's behavior, and enhanced and deeper relationships with others (Kennedy-Moore & Watson, 1999). Organismic experience, including emotions, contains action tendencies to mediate people's needs in their environments (Elliott et al., 2004; Frijda, 1988; Greenberg, 2015; Lazarus, 1991). According to current emotion theory, there is no split between emotion/affect and cognition, as they are highly integrated in conscious experience, and affective experience is seen as an adaptive resource and a meaning system (Colombetti, 2014; Greenberg, 2015).

As affect encompasses a greater range of organismic experience than emotion, the term *affect* will be used throughout. AR is the process of regulating the whole range of feeling states and organismic experience. Emotion Regulation (ER) has been described more narrowly as “the processes and strategies individuals use to influence which emotions they will have when stimulated as well as how they experience and express these emotions” (Gross, 1998, p. 275). Using a broader conceptualization of affect, models of AR provide a more comprehensive perspective, and include different dimensions of regulation. The complexity of affective functioning can be captured only as an interplay between different dimensions. Multidimensional models of AR try to conceptualize the typical or dispositional ways in which individuals understand, regard, and respond to their emotional experience. A good example of such a framework is the *Process Model of Affect Regulation* of Watson and colleagues (Elliott et al., 2004; Kennedy-Moore & Watson, 1999; Watson & Prosser, 2004). According to this model, adaptive AR involves 1) awareness of bodily emotion-feeling states and their symbolization or labeling in conscious awareness; 2) the flexible use of AR strategies to modulate arousal; 3) the flexible use of strategies to modulate the expression of emotion; 4) acceptance of the emotional experience and bodily felt meaning; and 5) the capacity to reflect on emotions and organismic experience to solve problems in living (Watson, 2011; Watson & Prosser, 2004). Other models that use this conceptualization include that of Gratz and Roemer (2004) and Berking and Whitley's (2014) Adaptive Coping with Emotions Model. These different dimensions of AR can be measured with the Observer-Measure of Affect Regulation (O-MAR; Watson & Prosser, 2004) or with a self-report measures like the Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) and the Emotion Regulation Skill Questionnaire (ERSQ; Berking & Whitley, 2014). Although AR and ER

are often used interchangeably, in this paper AR is used to capture the multidimensional process (Kennedy-Moore & Watson, 1999) of regulating emotions, as well as more vague bodily felt experiences.

Despite the divergence in views and definitions of emotion and AR, there is a growing agreement on some key aspects of AR. Firstly, the multidimensional view of AR is currently widely accepted across different theories and therapeutic orientations, in which it is seen as a process of tolerating, differentiating and modulating affective states to promote needs and goals (Berking & Whitley, 2014; Elliott et al., 2004; Gratz & Roemer, 2004; Gross, 1998; Kennedy-Moore & Watson, 1999). Secondly, researchers agree that adaptive AR serves important intrapersonal and interpersonal functions. The key to adaptive AR and healthy functioning is seen to be the capacity to label, modulate, accept and reflect on affective experience. While these processes do not necessarily occur in a sequential fashion, they are all interrelated (Kennedy-Moore & Watson, 1999). Thirdly, theorists posit that emotions reveal the significance of events, such that the meaning in emotions can serve as a guide to needs and goals to promote well-being and survival (Elliott et al., 2004; Greenberg, 2015). Fourthly, the context and the individual's goals must be taken into consideration when determining whether a particular regulation strategy is adaptive or maladaptive (Tull & Aldao, 2015). Finally, all the prominent models of emotion regulation and AR do not view regulation as primarily involved with the elimination, control, or reduction of negative emotion (Tull & Aldao, 2015). Research suggests that efforts to repress or avoid emotions may have paradoxical effects, not only on subjective well-being but also on physical health (John & Gross, 2004). There is a growing consensus that both upward and downward regulation capacities of both positive and negative emotion are essential for adaptive AR (Gross, 2014; Kennedy-Moore & Watson, 1999).

All the different interrelated dimensions of AR (awareness and labeling, modulation of arousal and expression, acceptance and reflection) grow from an interaction between attuned responses by caregivers and constitutional factors (see for an overview Gunst et al., 2017). Impaired attachment relationships and the experience of trauma can lead to the development of AR strategies that may cause problematic bio-psycho-social functioning later in life (Baim & Morrison, 2011). Given that AR problems underlie multiple forms of psychopathology and maladaptive behavior (Gunst et al., 2017; Werner & Gross, 2010), it is important to consider the influence of AR problems on the psychotherapeutic process, and how psychotherapy can enhance AR.

2. AR's role in general psychotherapy

2.1. Level of experiencing and AR capacity

A number of theorists have advocated the need to pay greater attention to the importance of emotion in facilitating client change in psychotherapy (Fosha, 2002; Gilbert, 2010; Greenberg, 2002; Linehan, 1993; Power, 2010). Gendlin, Beebe, Cassens, Klein, and Oberlander (1968) were the first to observe that clients who engage in deeper experiencing during the session benefit more from therapy. To facilitate this process, he and his colleagues developed a performance model, named focusing, that elaborated specific steps that people could follow to become aware of and symbolize their inner subjective experience, including their emotions. A number of studies have found that focusing promotes higher experiencing in clients, and these processes can be increased with training and specific therapist interventions (Hendricks, 2002).

Clients' level of experiencing and emotional involvement in the therapy process can be measured by the Experiencing Scale (Klein, Mathieu-Coughlan, & Kiesler, 1986). Lower levels of experiencing are characterized by an external focus of attention without reference to the subjective experience. At medium levels, clients make reference to their emotions to describe their subjective lives, but are still predominantly focused on external events. In contrast, at higher levels, clients are

turned inward and focus on their internal experience as they attend to vague, bodily feelings and sensations. They search for words that fit to unfold their implicit felt meaning. Good outcome clients score significantly higher on the Experiencing Scale (Klein, Mathieu, Gendlin, & Kiesler, 1969), both early and late in psychotherapy (Gendlin et al., 1968; Watson et al., 2011). Higher levels of experiencing in the session have been found to be beneficial across a range of therapeutic approaches (Castonguay et al., 1996; Hendricks, 2007; Parker, 2014; Watson et al., 2011).

AR and experiencing are different but related constructs that are important in the therapeutic change process, and they impact each other. As AR influences the level of experiencing and emotional processing, so too emotional processing predicts changes in AR capacities. Studies have found that clients' abilities to regulate their affective experience distinguish good from poor outcomes in experiential psychotherapy (Watson, Goldman, & Greenberg, 2007). The emphasis of experiential therapists is on the immediate experiencing of the client (Gendlin, 1973). It has been found that the client's initial capacity for emotional processing and regulation at the beginning of treatment influences their emotional responsiveness and processing later in treatment (Watson et al., 2007). To effectively regulate their affect, people need to be aware of their experience and able to describe their feelings in a differentiated way, with an optimal level of arousal that is neither too high nor too low to effectively process experience. The awareness and understanding of emotions enables people to identify their underlying needs. Thus, it is important to accept and tolerate organismic and emotional experience and reflect on it in an open manner to clarify its implicit meaning in emotional experience. Cognitive exploration and elaboration on the pertinence and meaning of in-session activated specific, relevant emotions is found to be increasingly important for therapeutic change (Greenberg & Pascual-Leone, 2006; Whelton, 2004). Watson et al. (2010) suggest that the role of the cognitive processing of emotion is twofold: 1) to make sense of the emotion; and 2) to help regulate the emotion. It is the combination of emotional expression and reflection on emotion that facilitates the change process (Elliott et al., 2013). Indeed, emotional expression alone is not sufficient for change, but neither is intellectual analysis. Good and poor outcome cases are distinguished by the mix of moderate arousal and meaning construction (Missirlan, Toukmanian, Warwar, & Greenberg, 2005). Increased levels of experiencing and AR have been found to be related to a reduction in complaints and symptoms at the end of treatment (Watson et al., 2007). Awareness and expression in conjunction with reflective processing facilitate the exploration of beliefs and assumptions related to the experience of emotion and the modulation of arousal.

2.2. From fixed to flexible emotion schemes

Clients often seek therapy when some parts of their life processes are stuck. At the beginning of therapy, clients may have a non-experiential mode of engagement, characterized by intellectualization, somatization, and acting out (Elliott et al., 2004). All of these are indicators of low levels of experiencing, and may block the experiencing process. Normally, experiencing is an ongoing process that registers the constant interaction of the self with the environment (Gendlin, 1997), with the self being organized through emotion schemes, constituted by implicit, idiosyncratic aspects of human affective experiences. These internal models are embodied organizations of sets of anticipations and reactions that guide people's reactions outside of awareness. Complete emotion schemes contain a variety of elements, including situational, bodily, affective, conceptual and action elements (Elliott et al., 2004; Greenberg, Rice, & Elliott, 1993). When people are open to present experience, emotion schemes are dynamically reconstructed. This open, interactive process can, however, get stuck due to past experiences such as attachment problems, trauma, or problematic loss. The experience can then become "structure-bound" (Gendlin, 1973), with the present

interpreted in terms of fixed, maladaptive emotion schemes (Elliott et al., 2004; Watson, 2011).

To achieve new outcomes, Siegel (2012) argues that the brain has to listen to the body to know how it feels and to discover meaning. As a pioneer in integrating neuroscience and psychotherapy practice, Siegel claims that consciousness is not necessarily involved with information processing, but rather with discovering new meaning. This is exactly what Gendlin (1973) states, and what experiential psychotherapists pursue. This view also fits with the enactive approach in cognitive science. Gibbs (2006) argues that human psychological functioning and sense of meaning is shaped in fundamental ways by bodily experience (as cited in Ward, 2017). In psychotherapy, especially when clients' process is stuck, they need to be able to focus on the bodily felt sense, to reflect on it and identify the best-fitting words to move forward. Our body implicitly carries the meaning of what we are experiencing, or how we experience a situation, even without awareness (Gendlin, 1997; Hendricks, 2007). Working to facilitate this contact with the body's implicit knowing is crucial in good therapy. Experiential reflection and exploration can create new emotional reactions and new meanings that may subsequently be integrated into and change existing cognitive-affective meaning structures, or emotion schemes.

2.3. Developing AR capacities and self-reflection in therapy

A major premise of the view that emotional processing is crucial to effective therapy is that it is essential to improve adaptive AR capacities in clients. Thus, it is important to develop interventions to move clients from under- or over-regulation of affect to more appropriate levels on all the different dimensions (awareness and labeling; modulation of arousal; modulation of expression; acceptance; and reflection). According to this perspective, a client needs to be aware of feelings and present with emotions, while not being overcome by them. From a reflective stance, clients can learn, together with their therapists, to witness and be compassionate towards their own inner experience and processes. This manner of inner relatedness has the qualities of a secure attachment bond (Cornell, 2013). This self-reflective capacity develops in safe attachment experiences and attuned responses by the caregiver during childhood that allow the child to create a psychological understanding and view of self. Internalization of the caregiver's mirroring responses enables the child to symbolically represent his or her physical state of arousal and to develop the capacity to reflect on the feelings and behaviors of self and others (Fonagy, Gergely, Jurist, & Target, 2002; Fonagy & Target, 1997). Based on this psychodynamic theory, some authors (Baim & Morrison, 2011; Wallin, 2007) have pointed out that the relationship between therapist and client has the potential to remediate and fill in the 'missing' attachment experiences that were not there as they should have been to develop AR abilities.

Within the experiential framework, therapists – as responsive caregivers – also facilitate clients' AR by being emotionally attuned, offering containment, resonating with the organismic experience of the client, and reflecting and searching for words that fit the experience of the client (Elliott & Greenberg, 2007; Paivio & Pascual-Leone, 2010; Watson, 2002). A basic assumption is that the therapeutic relationship conditions are a vehicle for growth and change, and foster a stronger sense of self, helping clients to be more trusting and compassionate with regard to their own experience and perceptions (Elliott et al., 2004; Rogers, 1959), and to improve their relationships with others as well as their emotional processing and regulation of emotions (Watson & Greenberg, 2017). Therapists help clients regulate their arousal levels: for example, when these levels are too intense, therapists can lower the overwhelming experience by means of co-regulation. Like caregivers, therapists can serve as affect regulators by resonating with their clients' experiences, being expressively attuned and offering containment (Siegel, 2012) so that these skills can become internalized. Conversely, when the client is disconnected from his or her inner experience, the therapist needs to empathically attune to the implicit

inner experience of the client and be attentive to clients' non-verbal cues.

2.4. Focus on affect and emotion in different therapeutic orientations

Bringing feelings and experiences into awareness and integrating them into self-organization through a process of symbolization is the core aim of experiential psychotherapies (Behr & Becker, 2002) and of psychodynamic psychotherapy (Desmet, 2019; Fosha, 2002; Shedler, 2010). The main focus of these approaches is to improve patients' understanding and problem solving by increasing awareness of their inner world and its influence over current and past relationships. The aim is to facilitate deep-seated changes in personality, emotional capacities and organization. Over the last few decades there has been a trend in all psychotherapeutic orientations to integrate more emotional work in psychotherapy. The third wave of cognitive behavioral therapy (Dialectical Behavioral Therapy, Schema Focused Therapy, Acceptance and Commitment Therapy, and Mindfulness) has moved in the direction of improving the level of emotional expressiveness in therapy. In the enactive approach, emotions are considered to be the center of adaptive functioning, actively supporting cognition and behavior. From this perspective, emotion and cognition are no longer seen as polar opposites (Colombetti, 2014). However, forensic therapy lags behind this development, although recently it has started to catch up (Ward, 2017).

To summarize, improved AR and deeper experiencing contribute to better outcomes in psychotherapy, in terms of fewer psychological complaints and less severe psychopathology. The therapeutic relationship can foster these changes as well as improved AR, with specific therapeutic interventions, such as focusing, being useful in enhancing emotional processing. According to the AR models described above, good AR implies: a) awareness of affect; b) the ability to modulate arousal and control impulsive behavior by flexibly using situationally appropriate emotion regulation strategies; c) the modulated expression of affect and emotion; d) acceptance of affective experiences; and e) the ability to reflect and find meaning in affective experiences so they can act as a guide in life to promote needs and goals (Gratz & Roemer, 2004; Watson & Prosser, 2004). It is important to improve these capacities and heighten the experiencing level of the client to promote the change process and help clients benefit optimally from therapy.

3. The role of AR in the treatment of individuals who have committed sexual offenses

Self-regulation, specifically AR, plays an important role in the phenomenology of human aggression and the onset of sexual abuse (Day, 2009; Gunst et al., 2017; Langton & Marshall, 2000). Poor AR is often associated with problematic strategies such as using sex as a coping mechanism and substance abuse on the one hand, and being emotionally numb on the other (Gunst et al., 2017; Gunst & Vanhooren, 2017). Moreover, as described above, AR is an important factor in the process of change in therapy. This suggests that a focus on affect and AR should be an important part of treatment of ISOs. However, forensic treatments and theory have been strongly influenced by narrow views of ER that emphasize the control of emotional experience and expression, and the reduction of emotional experience, as opposed to the broader conceptualizations of AR. Research suggests that the suppression of emotion is a short-term solution that keeps the problem intact or makes it worse (Gross, 2014). Therefore, it is important to broaden the conceptualization of AR and integrate different dimensions of it, as well as less concrete aspects of the affective experience, such as the bodily felt sense.

Although the focus in treatment of ISOs is still primarily on changing cognition and behavior, there are some indications that new insights in AR are leading to a shift in treatment approaches. First, we review the literature on AR training in general treatment programs for ISOs. Then, some implications for forensic therapy from affective

science are considered. Finally, Emotion-Focused Therapy is described as a promising alternative that could be integrated into forensic treatment programs to promote clients' emotional engagement, processing and regulation, and to increase the effectiveness of treatment.

3.1. Affect regulation training in treatment programs for individuals who have committed sexual offenses

Based on the relapse prevention model that high-risk situations and related emotions need to be avoided, many forensic treatment programs integrate emotion regulation training as one part of a larger treatment (McGrath et al., 2010). The emphasis is on improving emotion regulation strategies in dealing with intense negative emotions. The focus is mainly on the regulation of arousal, rather than on improving awareness, modulating the expression of emotion, acceptance and reflection. Historically, most offender programs have addressed anger when targeting negative emotional states related to offending behavior. Although there is evidence that for some ISOs anger may contribute to their offending behavior, there are often many other emotions in play, such as sadness and loneliness (see for an overview Gunst et al., 2017). Nevertheless, the experience and management of other emotions has received little attention in research and practice compared with the study and treatment of anger (Gunst et al., 2017; Yates, 2004). Knowledge of what works in targeting AR difficulties is lacking, and the existing research focuses on coping (Blagden, Lievesley, & Ware, 2017). A thorough literature review on the treatment of ISOs (Serran & Marshall, 2006) reveals that almost all programs, and certainly all cognitive behavioral programs, train clients in the skills necessary to deal with specific problematic situations, but do not show evidence of attempts to modify the general coping styles of ISOs. However, dysfunctional coping (such as sexualized coping and externalizing) is shown to be promising as a dynamic risk factor in meta-analyses (Mann, Hanson, & Thornton, 2010; Whitaker et al., 2008). Serran, Moulden, Firestone, and Marshall (2007) examine changes in both coping skills and coping styles following the treatment of child molesters, in comparison with a waitlist group. In contrast to changes in more task-oriented coping, no change in emotional coping strategies was found (that is, self-oriented responses such as fantasizing, dwelling on the problem, and self-blame), which are linked to poor mental health and a higher risk of reoffending.

In CBT interventions for emotion management, ISOs are typically asked to identify the emotions that put them at risk for sexual offending behavior. An offense chain analysis is used, in which ISOs sequentially delineate the thoughts and emotions that preceded the sexual offending behavior. Many techniques in the emotion management module involve offenders learning mindfulness and behaviorally-based skills to help them cope more effectively with their emotions, to facilitate awareness and modulation of arousal (Moster, Wnuk, & Jeglic, 2008). A good example of a recent CBT intervention for emotion management is the Safe Offender Strategies (SOS) program of Stinson and Becker (2013), based on a multi-modal self-regulation theory. It has a well-developed module of emotion regulation as one of ten modules in the program, which consists of 25 sessions to help clients better understand their emotional experience. This larger goal consists of a series of smaller goals, including understanding the complexity of emotional states, how they interact with thought and behavior, the origin of emotions, and how people learn emotion-related behaviors. In addition, treatment addresses the qualitative features of emotional experience, and the relationship between emotions and maladaptive behavior. Clients also explore the role of risky emotional states (that is, those that are commonly linked to dysregulation and sexual offending) in their own offending behaviors. Clients learn to use a self-monitoring sheet to rate increasing emotional intensity to preventatively employ adaptive coping skills.

Despite the fact that Stinson and Becker (2013) consider both being overly sensitive and being callous and insensitive as indicators of ER

problems, their program manual focuses on more intense emotions rather than the absence of emotions. Emotions that put clients at risk are identified through the process of behavioral chain analysis. Some emotional states are more significantly related to sex offending behaviors, including anger, loneliness, boredom, resentment, defiance, excitement, sadness, and disappointment. After identifying their individual emotional risk profiles, clients must learn what triggers these emotional states (Moster et al., 2008; Stinson & Becker, 2013). The goal of treatment is to help clients learn new strategies that are not only effective but also less harmful to themselves and others. Interventions in SOS are based on the Dialectical Behavior Therapy model (Linehan, 1993), which focuses on developing strategies for AR. This model involves self-monitoring, awareness of triggers, reducing vulnerability to triggers, managing stress, pleasurable replacement activities, distraction, doing something inconsistent with the emotional state, taking a self-imposed time-out, mindfulness, calming activities meant to soothe strong emotions, physical activity, and seeking intense physical sensations. Clients practice these strategies both in the moment and when not experiencing strong emotions in order to become more effective using the skills.

Towards the end of Stinson and Becker's SOS treatment program, in module eight, clients learn to cope with the past. Important goals for this module include familiarizing clients with the relationships between traumatic experiences, dysregulation and self-regulatory deficits; helping them recognize that dysregulation is related to stressful or traumatic life events; describing the impact of trauma or harmful behaviors on victims; and helping clients come to terms with and accept their own behaviors. Notwithstanding SOS's focus on emotion, it does not specifically address trauma. The SOS treatment manual targets different dimensions of AR, such as awareness, modulation of arousal and expression, and reflection. The structured approach, with a focus on skills training and cognitive exploration, might, however, overlook the importance of emotional deepening and processing.

3.2. Implications and recommendations for forensic treatment

Improving the underlying deficits in self-regulation and AR is important for forensic treatment programs. In spite of a growing focus on the management of emotions, changing unwanted or risky emotions, and training clients in more adaptive coping strategies, their underlying needs are not yet addressed adequately. Ward (2017) argues that the fragmentation of treatment programs into discrete modules maintains the focus on problem areas rather than processes for facilitating deeper and long lasting change. The training and teaching modules usually involve cognitive group discussions, but do not promote emotional deepening.

3.2.1. Activation of emotion

A pitfall of the emphasis on skills training is that clients learn how to manage maladaptive emotions without finding meaning in the underlying adaptive emotions and needs. Talking about emotions without being in contact with emotions in the moment limits its usefulness and impact, as in the moment processing in psychotherapy is important for contributing to change on a deeper level. More experiential work could contribute to more long-lasting changes, as demonstrated by recent studies in psychotherapy (Elliott et al., 2013; Shedler, 2010).

Another reason why emotions need to be activated in treatment is linked to the observation that the thoughts and attitudes of the client will differ when he or she is in a calm and rational state from when he or she is angry or depressed (Marshall et al., 2003). Emotional and interpersonal schemas (such as attitudes to women or beliefs about children's sexuality) that arise from a fusion of emotions and cognition cannot be addressed when emotions are not present in therapy.

3.2.2. Emotional engagement

The only study that investigates emotional engagement of ISOs in

therapy is a study of Pfäfflin, Böhmer, Cornehl, and Mergenthaler (2005) comparing ISOs to neurotic clients in the application of the Therapeutic Cycle Model (TCM). TCM was developed to measure two change factors in verbal psychotherapies, which are related to emotional and cognitive regulation. Although the ISOs in Pfäfflin et al.'s (2005) study used emotional words in conjunction with abstract expressions, overtly expressed feelings were lacking. In contrast, the neurotic patients in the control group seemed to show a more genuine integration of emotional expression and the abstract expression of understanding.

Promoting the ability and willingness of clients to emotionally engage in treatment remains a major challenge to improving treatments. The extent to which ISOs are able to engage in treatment is determined by affective factors (Blagden et al., 2017; Howells & Day, 2006). Offenders who are emotionally inhibited have difficulties engaging in therapeutic activities. It is not their level of distress that drives them to therapy; instead, most clients enter treatment as an obligation, or to get an earlier conditional release from prison. At best, they are ambivalent about change and engaging in treatment. Integrating Motivational Interviewing (Miller & Rollnick, 2012) can contribute to more emotional responsiveness. The authors define Motivational Interviewing as “a collaborative, person-centered form of guidance to elicit and strengthen motivation to change” (Rollnick & Miller, 1995, p. 325). A number of studies have shown that motivational interviewing has been effectively used to supplement or enhance treatment engagement, progress, compliance, and adherence in offender populations in prisons and community probation agencies (Stinson & Clark, 2017). Evidence seems to suggest that reassessing the personal impact of the client's problems can be helpful to sufficiently increase their distress to enhance their motivation to participate in treatment (Cain, 2016). The core of Motivational Interviewing involves the therapist's willingness and ability to establish a collaborative relationship with the client, to work in an evocative manner by listening closely to how the client is experiencing a situation, and to support the client's autonomy (Prescott & Porter, 2011).

To successfully engage in treatment, offenders, like other clients, need to experience and accurately label their emotional states as well as disclose their experience to others in order to reflect on it. Research has found that clients' willingness to self-explore and process emotion is essential to successful therapy (Castonguay et al., 1996; Greenberg & Pascual-Leone, 2006; Whelton, 2004; Watson et al., 2010; Watson et al., 2011). Working in a way that brings emotional experience alive and enables effective processing in the session will help therapists to clarify why clients become fearful or aggressive in different situations; it will also illuminate why they feel lonely, even if they are not able to verbally express their reasons at first (Greenberg, 2015; Ward, 2017). In this way, both therapist and client can become more aware of the latter's triggers, as well as of alternative ways of handling their emotions.

3.2.3. AR capacity

To improve emotional responsiveness, lessons can also be learned from treatments developed specifically to target AR. In particular, evidence suggests that acceptance-based Emotion Regulation Group Therapy, or ERGT (Gratz & Tull, 2011) may efficiently and effectively improve AR among patients with heightened AR difficulties (Gratz, Weiss, & Tull, 2015). Affect Regulation Training, or ART (Berking & Schwarz, 2014; Berking & Whitley, 2014) may also be effective. Both approaches conceptualize AR as a multidimensional construct, involving: (a) awareness, understanding, and acceptance of emotions; (b) the ability to engage in goal-directed behaviors, and inhibit impulsive behaviors, when experiencing negative emotions; (c) the flexible use of situationally-appropriate strategies to modulate the intensity and/or duration of emotional responses, rather than to eliminate emotions entirely; and (d) the willingness to experience negative emotions as part of pursuing meaningful activities in life (Gratz & Roemer, 2004). Rather than equating regulation with the control of *emotions*, emphasis is

placed on the control of *behavior* when emotions are present.

In addition to AR training, we believe that treatment of ISOs could benefit from more relational psychotherapeutic work. While treatment providers often seek a clear set of strategies and techniques that can be learnt within the treatment context (Blagden et al., 2017; Ware, 2011), the development of AR capacity, as described earlier, actually occurs through co-regulation and systematic empathic responding of an attuned other.

Furthermore, interventions that explicitly aim to increase emotional and bodily awareness may also have an important role to play in offender treatment by increasing emotional responsiveness (Day, 2009; Day, Bryan, Davey, & Casey, 2006). Byrne, Bogue, Egan, and Lonergan (2014) investigated a short-term alexithymia-specific intervention comprising both mindfulness and mentalization-based treatment components. This preliminary study shows positive results in terms of increasing emotional awareness in ISOs.

3.2.4. Trauma-focused work

Although many of the modules in forensic treatment assist clients to self-monitor and manage problematic emotions and reactions, the narrow and rigid focus on sexual offending and other maladaptive behaviors can prevent real change. While the problematic AR and poor emotional functioning that underlie sexual offending often arise from traumatic experiences (including abuse, neglect and loss) and poor attachment, few attempts have been made to integrate findings from trauma and attachment research into treatment of ISOs (Creeden, 2009). In contrast, trauma-focused work is often seen as beyond the scope of treatment of ISOs (Stinson & Becker, 2013). Other authors (Baker, Beech, & Tyson, 2006; Creeden, 2009; Maniglio, 2011; Gunst & Vanhooren, 2017), however, promote the integration of elements of trauma-focused and attachment-based approaches. Maniglio (2011), for instance, claims that a fantasy management approach may not be sufficient in the treatment of ISOs. Once clients have been taught skills for managing strong emotional arousal or have learned to be aware of and accept their inner experience, therapy should deal with the identification and processing of the traumatic past experiences that play a role in their ongoing symptoms, including sexually deviant behavior, in order to sustain and support change. People who have been traumatized can get stuck in the ‘same old story’ and fixed maladaptive emotion schemes that are related to negative views of the self and others, and repeated patterns of maladaptive behavior. Traumatic experiences can only be processed if they can be worked through in order to construct more adaptive meaning and coherent narratives regarding the self, others and traumatic events (Paivio & Angus, 2017).

To conclude, the treatment of ISOs would benefit from a focus on promoting AR in several different dimensions, rather than exclusively focusing on improving strategies to deal with negative emotions and intense arousal. More recently there has been a shift towards making clients more aware of their emotions. In addition, progress can be made by stimulating clients to attend to their emotional and bodily experiences and learn to accept them in order to explore the implicit meanings that they convey. Searching for meaning together with the therapist and other clients can reveal the need evident in the emotion, which can guide clients' actions in a pro-social direction. Therapists can encourage offenders to access and reflect on their affective experience to clarify and modify their blocked emotion schemes and their pathways to offending. Therapists act as models by attending to their own experiences and empathically attuning to the experience of their clients. This is the foundation of experiential psychotherapy. Emotion-Focused Therapy, which is rooted in this tradition, will be described in the following section as an example of how emotional engagement and responsiveness in forensic treatment can be enhanced.

3.3. Emotion-Focused Therapy as an example of an approach to improve AR

3.3.1. EFT: the process-experiential approach

EFT views *experiencing* as central in the change process, and emotional change as the key to enduring cognitive and behavioral change (Greenberg, 2015). The primary focus is on promoting more successful AR and emotional processing in order to effect change. Clients need to gain the tools required to deal with their problems and live in better harmony with themselves and others (Elliott et al., 2004). The emphasis in this approach is not on techniques to teach or modify, but rather on facilitating the client's moment-by-moment affective/cognitive process in order to facilitate shifts in meaning, to facilitate improvements in clients' emotional regulation and processing, and to change behaviors (Greenberg et al., 1993; Greenberg & Watson, 2006; Watson, 2011). Emotions are fundamental to organizing experience, and emotional experience is synthesized into emotion schemes that contribute to the development of a sense of self (Watson & Greenberg, 2017). Emotion schemes synthesize and process a variety of cognitive, affective, and sensory sources of information to provide a sense of personal meaning (Greenberg et al., 1993). In EFT, the body is a guide in which previous experiences are stored in the form of emotion schemes that activate gut feelings and drive our behavior. When these emotion schemes are maladaptive, they are important targets for therapeutic change (Greenberg, 2015).

3.3.1.1. Focus on affect regulation. Problems occur when clients have AR difficulties and are unable to find meaning in their experience. Affect dysregulation, including under-regulation as well as over-regulation, is often rooted in problematic or poor attachment histories and/or traumatic experiences (Elliott et al., 2004; Greenberg & Watson, 2006; Gunst & Vanhooren, 2017; Watson & Greenberg, 2017). Maladaptive emotions, like shame, fear and distress, can become disorganizing and resistant to change, especially when they were experienced often and/or intensely early in life (Greenberg, 2015; Watson, 2011; Watson & Greenberg, 2017). Thus, an important aspect of treatment is to work with clients to develop and enhance different AR capacities. From an EFT perspective, positive change occurs in psychotherapy when people can make sense of their emotions through awareness, expression, modulation, acceptance, and reflection, and are able to transform maladaptive emotion schemes into more positive and adaptive ones. EFT therapists facilitate clients' AR by resonating with the affective, organismic experience of the client, offering containment, and collaboratively searching for words that fit the experience of the client (Watson, 2002). It is proposed that a relationship characterized by empathic understanding and acceptance is the basis for a corrective emotional experience (Elliott et al., 2004; Watson, 2002; Watson & Greenberg, 2017).

3.3.1.2. Specific interventions. EFT has a number of different intervention strategies, referred to as *tasks*, to work with clients' difficulties in intrapersonal and interpersonal functioning. Therapists' empathic attunement using reflections and focusing instructions are the two primary interventions to let the client attune to, become aware of, and symbolize their bodily experience. In addition, EFT therapists work with two-chair dialogue for negative treatment of self, such as self-blame and self-interruption (Watson, 2011), with empty-chair dialogue for attachment injuries with significant others, and systematic evocative unfolding for intense reactions that clients experience as problematic (Elliott et al., 2004; Greenberg et al., 1993). A complete overview of these tasks can be found in *Learning Emotion Focused Therapy: The process-experiential approach* (Elliott et al., 2004).

3.3.1.3. Effectiveness. A large meta-analysis by Elliott et al. (2013) on person-centered and experiential psychotherapies has shown large pre-post client change with an effect size of 0.93 (standardized difference of

the means) and a large controlled effect size (0.76) compared to waitlist controls. In general, experiential therapies have been found to be clinically and statistically equivalent to other therapies (comparative effect size = 0.01). Furthermore, Elliott et al. (2013) have found that clients in person-centered and experiential therapies maintain and slightly improve their gains over early and late follow-ups.

Experiential/emotion-focused intervention principles have been shown to be effective in addressing the underlying and dysfunctional processes for many psychological problems and disorders, including depression (Watson et al., 2003), anxiety (Watson & Greenberg, 2017), and complex trauma (Paivio & Pascual-Leone, 2010). While experiential and emotion-focused therapy has been integrated into forensic therapy (Cornish & Wade, 2015; Gunst, 2012; Gunst & Vanhooren, 2017; Vanhooren, Leijssen, & Dezutter, 2015), there is little research evaluating its effectiveness (Paivio & Pascual-Leone, 2010). One study (Pascual-Leone et al., 2011) examining intimate partner violence has found that participants who attended an EFT group abstained longer from violently reoffending. Recidivism rates for the treatment group were consistently between one-third and two-thirds less than those of the weight-matched controls. Thus, it seems important to further explore the effectiveness of EFT for forensic treatment.

3.3.2. Integrating EFT with forensic treatment

There are several possible ways to integrate EFT into treatment programs for ISOs. Firstly, EFT could be integrated into the general forensic treatment approach in all kinds of treatment interventions and modules. Secondly, EFT interventions or tasks could be integrated in specific treatment modules. Thirdly, EFT could also be added as a separate but interconnected track in treatment.

3.3.2.1. Integrating EFT principles and interventions in general forensic treatment. The first option outlined above is to integrate the two predominant kinds of EFT interventions, namely empathy and focusing. As psychotherapy research has shown, treatment effectiveness is related to higher levels of empathy in the therapist and deeper levels of experiencing in the client. Despite the fact that empathy has been incorporated into all psychotherapeutic orientations for some time, it is only during the last decade that the benefits of an empathic approach have been recognized and stressed in forensic literature, in contrast to more confrontational approaches (Marshall, 2005; Marshall et al., 2003; Stinson & Clark, 2017). In working with offenders, it is often hard to persist in being empathic, and therefore therapists need to receive intensive training, supervision, and support. It is important to support therapists to integrate and maintain empathic resonance and reflection in their treatment modules. Research has shown that empathy is important to build a good therapeutic relationship, and is in turn responsible for 25 to 35% of the change in general psychotherapy (Elliott, Bohart, Watson, & Greenberg, 2011; Wampold & Imel, 2015; Watson & Geller, 2005), and up to 40% in the forensic field (Marshall et al., 2003).

Lessons should also be learned from psychotherapy research concerning the experiencing level of the client in therapy. Except for Marshall's review of relevant process variables in the treatment of ISOs, emotional responsivity is barely mentioned in the forensic literature. Some authors (Blagden et al., 2017; Day, 2009; Howells et al., 2004; Pascual-Leone et al., 2011; Ward, 2017) have recently emphasized the importance of attending to emotions, as well as to affective and bodily states, in forensic treatments. Howells and Day (2006) argue the need for rehabilitation providers to assess and respond to the affective readiness of violent offenders, and to equip clients with affective skills in order to benefit from treatment.

Like other therapies, forensic treatment could be improved by more sensitivity of the therapist to clients' feelings, levels of experiencing and moment-to-moment progress in the session, as described in the Experiencing Scale (Klein et al., 1986), and on integrating focusing instructions into therapy (Pascual-Leone et al., 2011). The therapist

needs to continuously help the client to attend to, explore, and make sense of their implicit bodily felt senses by a process of attention and reflection. To be able to do so, an adaptive level of AR must be reached (see below for more specific interventions). Integrating the often unconscious affective experience is crucial in the process of meaning making, developing a coherent self-narrative, and live in closer harmony with themselves and others.

3.3.2.2. Integrating EFT principles and interventions into specific treatment modules. The second way of integrating EFT into forensic treatment is to incorporate some of the tasks into specific modules, such as emotion regulation training or empathy training.

3.3.2.2.1. Emotion regulation training. In addition to the regulation of arousal and expression, more emphasis on the other dimensions of affect (awareness, acceptance, and reflection) can broaden and deepen emotion regulation training. It is important to coach clients to find an adaptive level of AR, to make it possible to tolerate and examine their experience in order to make sense of it. Emotions should not be seen as problems to eliminate or control, but as useful information to guide behavior. Empathic attunement and reflection can be very helpful to deal with emotions that are too overwhelming, or with emotions that the person is over-controlling. In the last case, focusing instructions can be beneficial in teaching the client to attend to his or her bodily feelings and experiencing. Interventions like “how does your body feel when you are saying this?” or “what is your body saying right now? Can you stay with that for a moment?” are useful to direct the client's attention inwardly. Clients who are disconnected from their affective experience can benefit from empathic guessing, modelling experiential search by therapists and other group members, expressive art, emotional writing, and more evocative techniques such as chair work. In case of overwhelming experiences, therapists should offer empathy and containment in order to co-regulate the client's experience. Finding words to symbolize the experience is also helpful to downregulate arousal. Simply venting emotions is not productive for change. Catharsis can be useful as a means of draining emotional energies (Strupp, 1967) and completing old, blocked expressions (Gendlin, 1991), but the expression needs to be combined with or followed by an inward movement and reflection in order to make sense of the experience (Elliott et al., 2013).

3.3.2.2.2. Empathy training. Based on the Safer Society Survey (McGrath et al., 2010), victim empathy has been a target of most North American treatment programs for ISOs (75–94%). This approach may be dropped, based on the limited evidence that lack of empathy increases ISOs' risk of recidivism (Barnett & Mann, 2013) or that increased empathy for victims results in reduced reoffending rates (Day, Casey, & Gerace, 2010; Mann & Barnett, 2013). However, these results should be carefully considered because of conceptual and methodological problems, the fact that empathy is context- and situation-dependent, and the way in which empathy training is delivered (Gunst, 2015). Research findings may be biased by a focus on the cognitive aspect of empathy in both measurement and treatment, whereas empathy is a multidimensional construct comprising both affective and cognitive components (Cox et al., 2011). It might be difficult to measure empathy failure when people are not affectively aroused. In fact, research has shown that mentalizing capacity drops when the attachment system is triggered and AR fails (Luyten & Fonagy, 2015). The same might hold true for empathy. More research is needed to gain insights into the process of deterioration of empathic capacity at the moment of abuse.

It is difficult to learn empathy without lived experience. As with developing AR strategies, developing empathy is a growth process through empathic interactions with others. If clients are to become more empathic and responsive to themselves and others, it is important that they internalize their therapists' empathy, acceptance, regard, and congruence (Barrett-Lennard, 1997; Watson, 2002; Watson, Steckley, & McMullen, 2014), especially if this way of being with themselves was

not nurtured in early childhood environments. The internalization of empathic attunement builds empathic capacity for the self and others. Empathy training should therefore rely heavily on empathic attunement of the therapist to the affective experience of the client, rather than on psycho-education. Only when therapists can respond empathically to the inner (often traumatized) world of the client can a space be created for the client to attune to the experience of their victims. If this step is skipped, only false cognitive perspective-taking may be achieved.

To become empathic to others, people first need to differentiate their inner and outer experiences, and, second, differentiate themselves from others. This process of differentiation is vital to the well-being of the individual and those with whom they interact (Watson, 2011). To become more empathic to their victims and differentiate their viewpoints and experiences, role reversal is a powerful technique (Gunst, 2009; Pascual-Leone et al., 2011). The task of empty-chair dialogue for addressing unfinished business (Greenberg, 2015) can be reversed. The client can be asked to put him or herself in the victim chair and express his or her experience with the support of the therapist and other clients. This can provide clients with the opportunity to see the harm they may have caused, accept the needs and boundaries of the victim, express their responsibility, and take the blame away from the victim.

It has been suggested that when offenders' empathic capacity is increased and they become more compassionate, they become more conscious of the harm they have caused their victims. As this, in combination with acceptance of responsibility, can result in a host of negative emotions in offenders, such as shame, extremely harsh self-blame, and self-punishing behaviors (Cornish & Wade, 2015), it is important that clients develop ways to moderate these behaviors. At the same moment, attunement to the felt experience of clients, when they are deeply realizing the harm they have caused, is necessary to work through clients' feelings of shame and guilt. Otherwise, empathy training may be more harmful than helpful in preventing recidivism, which has been signaled in recent studies (Mann & Barnett, 2013). To overcome severe self-blame that might hinder the person from moving forward, Cornish and Wade (2015) have developed an intervention strategy to promote victim empathy and self-forgiveness for interpersonal offenses. This EFT-based intervention could easily be implemented in empathy training. The way people respond to having hurt others can vary from blame-shifting (denying their own responsibility for the offense) to self-loathing (becoming stuck in shame and self-punishment). Being in one of these two extreme positions would indicate chair work. When clients have trouble accepting appropriate responsibility for their actions, therapists can suggest two-chair dialogues between the part of them that says “it's not my fault” and the part of them that feels guilty and ashamed. Two-chair dialogue can also be used for clients who are struggling with shame and self-condemnation, to allow the self-loathing part to interact with the side that needs self-acceptance in the face of wrongdoing. In addition, attempts to repair the harm caused – directly, indirectly, or symbolically – are incorporated into the intervention in several ways (Cornish & Wade, 2015). These EFT-based interventions to promote self-forgiveness might alleviate some of the negative effects of empathy training as a result of repeated confrontations with the harm caused.

3.3.2.3. Integrating EFT as additional treatment track. A third possibility to integrate EFT is to add a specific experiential group or individual therapy to the forensic treatment program (Gunst, 2012; Gunst & Vanhooren, 2017). Using EFT could improve clients' AR capacity, facilitate the reprocessing of trauma and attachment issues, and help the client to discover needs and wants to promote well-being. Experiential group therapy has been found to be very helpful by clients. A qualitative study by Willemsen, Seys, Gunst, and Desmet (2016) identified a number of factors that offenders found helpful in experiential group psychotherapy, with group cohesion and interpersonal learning being particularly important. In addition,

clients also observed that they learned to listen to their emotions, which, although difficult and painful, was ultimately helpful.

To reach an adaptive way of using emotions and implicit experience as a guide in life, deep emotional work is often needed to free the client from maladaptive emotion schemes. Deeply entrenched maladaptive emotion schemes and associated traumatic experiences, attachment injuries, and unresolved losses must be worked through in order to resolve and change them (Gunst & Vanhooren, 2017; Watson & Greenberg, 2017). Thus, it seems essential that experiential group therapy for offenders provides the opportunity to work through maladaptive emotions and traumatic experiences to unblock the process and enhance functioning. EFT has proven to be effective in working with complex trauma (Paivio & Pascual-Leone, 2010).

In experiential group therapy, clients learn to connect to their bodily experience and bring whatever bothers them to the group for exploration and attention (Gunst, 2012). As described above, EFT-therapists empathically attune to their clients' experience and focus on clients' feelings as they share their narratives. In this way, therapists help clients to deepen their experiencing level and to find new meaning in their experience. Unfolding experience often leads to new experience, and brings the needs of clients to light. Attending to clients' inner experience and working through fixed, maladaptive emotion schemes often requires an intense and lengthy process, especially with high-risk offenders and clients with more severe personality disorders.

In addition to empathic responding and experiential listening, but without leaving this therapeutic stance, there are several ways to deal with anger, shame, fear, and overwhelming sadness, and to coach clients to work through these feelings (Greenberg, 2015). A client can, for example, acknowledge his or her fear of connecting with adults due to past trauma. He or she can work through these feelings using empty chair work to express unmet needs to a significant other or perpetrator, engage in two-chair dialogues to overcome his or her shame, and access new behaviors to soothe his or herself when distressed. Indeed, awareness of underlying needs combined with an accepting stance of self-care gives clients more opportunities to fulfill their needs in a prosocial way.

In summary, EFT could be beneficial to forensic treatment by creating a workable distance from core emotions that were previously blocked, avoided, or too overwhelming to cope with. Empathic attunement, focusing on bodily experience, and exploration through enactment can all help to modify fixed emotion schemes that disturb intrapersonal and interpersonal functioning. In this process, clients can find new ways to fulfill their authentic needs.

4. Conclusion and recommendations for future research

AR difficulties are shown to play a role in the etiology of sexual offending, and are linked to dynamic risk factors, such as sexualized coping (Cortoni & Marshall, 2001; Gunst et al., 2017; Serran & Marshall, 2006). Both hyperactivation and deactivation of emotion are linked to multiple forms of psychopathology and problematic behavior. Nonetheless, research investigating AR problems in ISOs is scant. In forensic research and treatment, emotions were overlooked in favor of cognition, or seen as something to eliminate or downregulate through the use of reason. More recently, a conceptualization of emotion as an adaptive resource and a meaning system has been emerging in the forensic literature. In line with that development, Ward (2017) encourages the integration of the enactive approach in forensic treatment. The enactive approach refutes a split between cognition and emotion, and states, in accordance with experiential psychotherapy, that meaning lies in the body's felt experience (Gendlin, 1996), and that the associated body-wide systems should be incorporated in treatment (Ward, 2017). The current lack of focus on a broader conceptualization of emotion or affect in forensic treatment is a gap that needs to be addressed with a focus on AR.

Today, emotional processing and depth of experiencing have been

shown to be significant process predictors of outcomes in different therapeutic approaches (Castonguay et al., 1996; Greenberg & Pascual-Leone, 2006; Whelton, 2004; Watson et al., 2010; Watson et al., 2011). These findings, however, have not yet been transferred to forensic treatment. Treatment effectiveness could be optimized if ISOs' AR capacities were fostered, as these are often poor due to attachment problems or past trauma (Gunst et al., 2017). People can learn that their organismic experience holds a vital source of knowledge that reveals their needs and can guide their thoughts and behaviors. There are several ways to integrate the enhancement of AR into forensic treatment. Firstly, an empathic therapeutic relationship has the potential to remediate the lack of attuned responses in childhood in order to develop AR abilities. Secondly, specific AR training modules can be implemented in forensic treatment programs. Thirdly, treatment approaches that focus on emotional experience and influence AR can be integrated into treatment programs.

Future research is needed to investigate the emotional engagement of offenders in therapy and its influence on outcomes. Most research in the forensic field is focused on cognitive and behavioral change and restricted to outcomes, to the detriment of investment in the process of change. Studies generally use purely quantitative self-report measures. The validity of self-report measures, however, is always limited, since they are subject to a variety of biases (e.g., Schwarz, 1999). An incorporation of physiological and neurological indices of AR is recommended in examining AR in treatment, both as a mechanism and as an outcome (Gratz et al., 2015). The addition of other measures such as observer instruments (e.g. the Observer Measure for Affect Regulation, Watson & Prosser, 2004) would offer a major contribution to the quality of research. Single case studies can contribute to a better understanding of the change process (Molenaar, 2007) and of individual variation in treatment effectiveness, as studies examining emotional problems in ISOs that average the scores of the participants may mask important variations within the group, particularly considering the fact that both the presence and absence of affect may be criminogenic (Howells et al., 2004).

Regarding the improvement of AR in the treatment of ISOs, most studies examine the impact of treatments that either do not target AR directly, or target AR as part of a larger or more comprehensive treatment. This kind of research precludes conclusions about the precise interventions necessary and sufficient to improve AR, and is limited in terms of improving interventions to facilitate adaptive AR (Gratz et al., 2015). Gratz et al. (2015) conclude their review article on AR in psychological interventions with the recommendation of a more systematic and regular examination of mechanisms of change in treatments, both those that focus on emotional experience and that influence AR (e.g. EFT), and those developed specifically to target AR (e.g. ERGT and ART). Considering AR as an important factor in the treatment of ISOs, such research seems extremely beneficial for the forensic field.

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