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## The Promise and Peril of Role-Play in Experiential Treatment

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A member of the Association for the Treatment of Sexual Abusers (ATSA) recently asked for others' thoughts on having adolescents re-enact their sexual offenses as a part of group treatment. Of course, there is some question as to whether group treatment is the preferred modality for work with juveniles, but that is another matter for another post.

For those who may be unfamiliar, some adult programs have indeed used role-play re-enactments of sexual crimes as a means to explore the issues and harm of sexual abuse, although this practice has diminished. At the time, it certainly seemed like a good idea to many professionals. There are probably many reasons for its decreased use, including research attention turned toward cognitive-behavioral therapy.

Experiential work in treatment can certainly deepen its impact. In an era when so much focus is on building clients' responsiveness to treatment, experiential work seems a natural part a larger program that adheres to the principles of effective treatment. Among the helpful resources, John Bergman and Saul Hewish's book, [Challenging Experience](#)(2004), offers many excellent ideas, and Bergman has recently summarized the fascinating history of experiential techniques in a [2012](#) book chapter. I incorporate many of these techniques into my own work. Of course, none of these resources advocates real re-enacting of the client's own crime. Still, experiential techniques can be very powerful tools that only skilled therapists should use.

That said, there are many reasons not to have young people re-enact offense scenes in treatment. In fact, I would be extremely careful about going anywhere near it. Here are a few perspectives:

The first is a clinician's perspective: Young people in trouble with the law often have far more complex/developmental trauma in their backgrounds than we realize. No matter how one looks at it, acting out offense scenes is a high-dose/high-intensity activity that is rife with opportunities for increasing shame instead of understanding. There is no doubt that some kids will gain some genuine understanding from it; however, my concern is that many more will simply acquiesce to it and say that it was an important experience for them while never sharing what they really went through doing it. Many is the young person victimized by an adult who came away saying it was not so bad or that they deserved it. To what extent are these kids truly consenting to experiential treatment activities that may a very public expectation of the provider or the program? When treatment completion is largely dependent on participation – and the adolescent knows that their peers are participating – how easily can they (and their families) weigh the risks against the benefits? Where does pressure offset consent? To what extent are we replicating abuse and abusive environments?

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The net result for adolescents is more likely to be “I’m a bad person” than “I’ve done something harmful.” Further, the highly fragmented experience that results from past trauma makes it far more likely that kids will see this as one more bad experience brought down on them by adults. Many readers might look at this as a challenging experience brought about by caring people who have their best interests at heart. Not so in the world of traumatized teens. Professionals must build, re-build, and maintain must a positive alliance with them every day.

Obviously, it’s not helpful to criticize without offering an alternative. Instead of thinking “let’s give them an experience, so that they will understand the harm of their actions”, why not think in terms of “this is a young man capable of understanding the harm of his actions, and that understanding is in there somewhere. How can I elicit, invoke, or invite that part of this kid to talk to me, thereby having him provide his own experience of understanding? This way, any epiphany is more likely to occur in the way that works for him and on his timetable, rather than through my methods or in accordance with my schedule.

The second is a clinical supervisor’s perspective: Supervisors should ask themselves how confident they are that their clinicians can manage this kind of activity without difficulty? For inpatient settings (which is where these activities typically take place), how will they manage it when their young clients return to their units shaken and upset, experiencing shame and at greater risk for self-harm? It might not happen today or tomorrow, but something will happen eventually. Then there is the “Lord of the Flies” problem, in that many of the kids might feel shame, anxiety, or even gratification from acting out others’ experiences. How certain is the supervisor that he or she knows what the clinician is doing with this high-stakes activity? How will the supervisor respond to complaints by families? After all, in their minds, they signed consent for their child to enter treatment, not another world.

The third perspective is that of an administrator: This is a media event waiting to happen. Eventually, there will be a bad experience and it will make the newspapers. In fact, this has happened in at least one adult treatment program some years ago. Inmates complained that they were being told to re-enact abuse situations. The complaints received all sorts of coverage and there were complaints about tax dollars supporting this, etc. More recently, there was a juvenile program’s use of the penile plethysmograph that led to complaints that appeared in the newspapers across Canada ([Turpel-Lafond, 2011](#)). There are many ways to use experiential exercises, but re-enacting offenses is generally not such a great idea.

Humanitarian perspective: We often have no idea how much power we hold over our clients of all ages. It may be the easiest element to forget when working with people who have sexually abused. We need to be extremely careful how we use it.

## References

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