Relational-Cultural Play Therapy: Reestablishing Healthy Connections With Children Exposed to Trauma in Relationships

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Children who have experienced trauma in relationships, such as direct physical or sexual abuse, or who have witnessed crimes or domestic violence, often carry forward symptoms of traumatic stress. Children with posttraumatic stress may become withdrawn or aggressive, clingy or distant with caregivers, oversleep and overeat, or develop insomnia and eat too little (A. Banks, 2006, Relational therapy for trauma, Journal of Psychological Trauma, *Vol. 5, pp. 25–47). These physical and psychological symptoms are further complicated when children have experienced trauma that disrupts their primary relationships. In this article, we will discuss and illustrate a relational–cultural approach to play therapy designed to help children who have experienced trauma in relationships to reconnect to others in healthy and emotionally beneficial ways.*

Keywords: children, trauma, mental health, play therapy, RCT

Knowledge about the effective treatment of abused or neglected children has expanded considerably over the past two decades (Centers for Disease Control, 2012). Recognition of the transmission of traumatic stress symptoms to child witnesses of domestic violence, crimes, abuse, and neglect has encouraged caregivers to bring greater numbers of child witnesses of traumatic events in for counseling services (Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2009). Increasingly, clinicians have begun to explore and

implement developmentally appropriate treatments for young children with post-traumatic stress symptoms, including play therapy (Dugan, Snow, & Crowe, 2010; Gil, 2011). Preliminary research with children who have posttraumatic stress symp-toms supports the effectiveness of play therapy treatment (Baggerly & Exum, 2008; Berson & Baggerly, 2009; Dugan et al., 2010; Schottelkorb, Doumas, & Garcia, 2012). Though the use of other developmentally appropriate interventions has improved outcomes for children with traumatic stress issues, play therapy offers particular promise. Given the specific developmental needs of young children to reestablish feelings of trust and safety after exposure to trauma, and to reconnect them in their safe relationships, play therapy offers a developmentally appropriate approach to helping children reconnect to others after experiencing trauma.

In this article, the authors explore an integration of relational–cultural theory (RCT) and play therapy concepts. This expanded form of play therapy, which is referred to here as relational–cultural play therapy (RCPT), can be applied to children's relational problems in general or to the specific issues following trau-matic relational disconnections. We first review concepts from RCT and relation-ship-focused play therapy models and then align them into a new way of working with children's relational needs. We conclude with a detailed case example to illustrate the practice of RCPT with a young child who experienced relational trauma.

RCT

The goal of human development, according to the creators of RCT, is not individuation or differentiation, but rather the capacity for creating and maintain-ing strong, growth-fostering, and nurturing relationships (Miller & Stiver, 1997). Jordan (2010) states that relational health is characterized as the ability to feel empathy for others and to understand that they, too, can impact others emotionally. Further, Miller describes growth-fostering relationships as having five key aspects, or "Five Good Things," which includes an increase in energy, increased knowledge and clarity about one's own experience, an increase in creativity and productivity, an increased feeling of self-worth, and a desire for more connection (Miller & Stiver, 1997). When people experience these "five good things," they are able to grow fully and develop positive relational images (Jordan, 2010). Conversely, when surrounded by relationships characterized by shaming and uneven power balances, individuals may become withdrawn and develop negative expectations for current and future relationships. From infancy, these relational images inform the assump-tions people make about how they will be treated by others in relationships.

Chronic and acute disconnections occur in all relationships (Jordan, 2010). Acute disconnections occur when two people engaged in a growth-fostering rela-tionship encounter an impasse, or barrier, in the relationship, which is later re-solved. Acute disconnections occur frequently throughout human relational devel-opment and often serve to strengthen existing relationships and the capacity for future relationships. Chronic disconnections occur when the person with less power in the relationship does not feel able to tell the more powerful person that he or she feels slighted or hurt without the relationship dissolving or becoming violent. Often,

the less powerful person begins to either suppress his or her feelings or to pretend to feel differently in an effort to salvage the relationship and pacify the more powerful person. Over time, the less powerful person may begin to withdraw from relationships, to be inauthentic in relationships, and/or to feel incapable of creating growth-fostering relationships (Jordan, 2010).

If chronic disconnections persist, a condition Jean Baker Miller (1989) termed *condemned isolation* may develop. In condemned isolation, a person feels so injured by rejection and shame in relationships that he or she no longer seeks out connection but withdraws entirely. People who live in a state of condemned isolation often report feeling that they are not able to express their feelings or thoughts to others without fear of being shamed, rejected, or abused. Miller (1989) theorized that condemned isolation may be the cause of many cases of major depressive disorder. Isolating behavior, similar to what is known as condemned isolation, is also common among children with significant histories of abuse or neglect, and can often be observed in children with reactive attachment disorder (Kagan, 2004).

Tucker, Smith-Adcock, and Trepal (2011) have outlined a way to conceptualize using RCT in counseling children, using the "Five E's": encourage self-empathy, explore relational images, educate about power, explain disconnections and conflict, and expand relational capacities. In this model, the counselor encourages the child's self-empathy, a self-care that provides a therapeutic foundation for examining the child's relationships. This is accomplished through mutual empathy (Jordan, 2010): Therapists allow clients to see that what they are saying impacts the therapist and that the therapist is moved by their experiences. When an atmosphere of mutual empathy is present, counselor and client work to find both negative and positive relational images in the client's life. The history of relationship patterns can be explored with a client of any age.

Educating about power is a way for the counselor and client to examine cultural and personal constructs that may be causing imbalances of power in the client's relationships (e.g., sexism, racism, classism), causing them to feel less important than others in relationships. According to Maureen Walker (2005), culture is an active participant in the development of relationships between people and must be examined in order to see people in context. For children, this may take the form of the power differences that exist between children and adults. The counselor may help the client explore differences between relationships that are characterized by power-over (e.g., dominance) and those that are power-with (e.g., mutuality), as well as how cultural and personal factors contribute to feelings of shame or privilege.

Explaining the occurrence of disconnections in relationships and increasing strategies for connection are also explored. For instance, in what ways does the client withdraw from others? Does he or she walk away during arguments or avoid conflicts by pretending to agree? Does he or she blame others when feeling hurt? The possible origins of these disconnection strategies are also examined, and strategies for disconnection are gradually replaced by effective communication and coping skills. These strategies of disconnection in relationships (e.g., blaming, withdrawing, gossiping) can be understood as part of relationships early on in children's development; however, they can be difficult to explain to children.

Developmentally appropriate ways of helping children understand healthy relationships are needed.

RCT was developed for, and has been primarily used with, adult clients. However, when working with young children, a play therapy approach is more developmentally appropriate than a more abstract, cognitive approach like the one described for RCT. Blending the brain-growth enhancing relational aspects of RCT and the developmentally appropriate methods of child-centered play therapy thus creates a new model for approaching trauma work with children.

RCPT

Therapists working with children have long recognized the healing potential of play for children who have experienced trauma (Axline, 1974; Gil, 1991, 2011). Play therapy allows children to work through complex, often disturbing, memories and experiences using developmentally appropriate media (Axline, 1974; Gil, 1991; Landreth, 2002). In play therapy, children are not asked to express their thoughts and feelings verbally; rather, as Gary Landreth (2012) has stated, "Toys are used like words by children, and play is their language" (p. 12).

Like RCT, most variations of play therapy emphasize the relationship between the therapist and the child client. Axline (1974), who was a colleague of Carl Rogers and Carl Moustakas, implored therapists to form warm, permissive, and nonjudgmental relationships with their young clients in order to help the child develop a sense of mastery and accomplishment in the play room. With children who have experienced trauma, play therapy builds the foundation of a safe, trusting relationship between the child and therapist that is able to contain the difficult therapeutic work of trauma resolution (Gil, 1991, 2011).

Play therapy allows children to have a choice about their actions and words, when, often, they have not had choices in most prior relationships, particularly with adults (Landreth, 1991). Children experiencing relational violence need to have a safe place where they can disclose the violence and trauma they are living with at home (Gil, 1991, 2011). In relationship-focused play therapy, the first task of the therapist is to help the child develop a feeling of emotional safety and rapport with the therapist. The therapist helps the child to feel safe by creating minimal limits, which communicates to the child that although he or she is allowed to express disturbing feelings and thoughts in the playroom, the therapist is capable of handling the material and can keep the child safe (Gil, 1991, 2011). Unconditional acceptance of the child's feelings also is a primary and powerful way to build a sense of safety. Play therapy may allow children to experience a relationship that provides them with a sense of mutuality and wholeness, perhaps for the first time (Landreth, 2002). The support provided through this therapeutic connection can also foster the growth of courage, which is necessary in trauma-focused play therapy. Experiencing mutuality and safety in relationship also produces shifts in the clients' inner experiences, self-statements, and self-image (Jordan, 1991).

Relationships organize children's lives, their life beliefs (e.g., "I am not safe, others are not trustworthy"), and their development in all areas (e.g., cognitive, social, emotional). RCPT is the blending of RCT concepts with relationship-

focused play therapy approaches. This theoretical orientation to play therapy is an extension of Moustakas's (1997), Axline's (1974), and Landreth's (1991, 2002) foundational works, using the core concepts of RCT to further facilitate children's growth-fostering relationships. Thus, the approach allows for a high level of child direction and relationship building, yet considers the need for the therapist to incorporate an understanding of relational and cultural issues that intersect with the world of the child in the context of trauma.

The overarching goal of RCPT is to help the child client expand his or her capacity for connection. This is essentially the same goal RCT therapists have for their adult clients (Jordan, 2010) and is not dissimilar from the basic goals of relationship play therapy. The goals for relationship play therapy include the expression of negative and worrisome emotions, the development of emotional maturity, and respect for other people (Moustakas, 1997). Though the tenets of RCPT are useful for a variety of presenting concerns in counseling children, in the section that follows, we further outline RCPT principles and apply them to counseling children who have experienced relational trauma.

WHY RCPT: THE IMPACT OF RELATIONAL TRAUMA

Unlike most other mammals, human children are unable to survive on their own until several years after birth. For newborn humans, food, water, and protection must come from someone else. Caregivers must also protect children from physical dangers, provide shelter, and care for them if they are injured or ill. Naturally, children are born with the innate need and capacity for building and responding to these nurturing relationships, and when caregiving is sufficient to meet the children's basic relational needs, they develop the capacity to create and maintain healthy relationships throughout the life span (Cozolino, 2010).

Early relationships with adults organize children's lives and their development in other crucial ways. Due to our social and cultural hierarchy, children must also depend on their affiliations with more powerful others to acquire access to resources throughout childhood and into early adulthood (Hare-Mustin, 1987). In this way, children's basic needs are relegated to a dependent relational status in a culture that views dependency pejoratively. Furthermore, formative relationships with caregivers not only provide children with access to basic needs but also inform life beliefs that guide their behavior, impact all areas of development, and help them learn about their world. Children cannot survive, much less thrive, without close emotional and physical connection to a caregiver.

When children experience trauma, development may become stuck across multiple processes, including cognitive, psychosocial, moral, and relational development (Banks, 2006). Relational trauma also subverts the successful completion of conflicts around self-concept, self-efficacy, and self-worth (Banks, 2006). Beyond impacting immediate development, chronic abuse and neglect can cause children to develop survival strategies. These strategies serve them well in abusive situations but often result in behavior problems at school or in other settings. Lying, hoarding (especially food), distrust of authority figures, aggression, hypervigilance, and seeking alliances with the most violent person in any situation are common life

beliefs and patterns seen in children who have been traumatized (Burgess, Groth, Holmstrom, & Srgoi, 1998). Predictably, the very behaviors that grow out of a child's basic instinct for survival within dangerous, and often chaotic, environments are often the triggers for their referral to mental health agencies by school personnel. It is therefore imperative that therapists see these behaviors as indicators of possible trauma history, rather than as simple conduct or attentional problems.

Close relational ties also are critical for brain development (Banks, 2006). Though the emotional centers of the brain begin to develop at 6 months gestation, about half of brain development occurs after birth (Cozolino, 2010). Brain development occurs via an experience-dependent maturation of neuronal systems, otherwise known as synaptogenesis (the birth of synapses; Putnam, 2006). This development is driven by environment-stimulated activity, such as eye contact with caregivers, and by warm, consistent relationships (Putnam, 2006). Trauma in early life, especially experiences that deprive the child of these important and protective relationships, delays or prevents the child's development of the capacity for relational interaction, which is foundational for all forms of development and learning (Cozolino, 2010; Perry, 2006; National Scientific Council on the Developing Child, 2005). In fact, Schore (2002) has suggested that experiencing trauma before the age of 7 years often causes interruptions in brain development that is more detrimental to IQ than eating lead paint. Furthermore, the Center on the Developing Child at Harvard University has documented the long-lasting effects of maltreatment on the cortisol levels of the child's brain, which is particularly evident when the child has symptoms of traumatic stress, and persists even after the child has been moved to a safe place (National Scientific Council on the Developing Child, 2005). These findings have led to an emphasis on early intervention to reduce stress levels and mitigate long-term harm.

Although studies conducted by Harvard's Center for the Developing Child and elsewhere are definitive in terms of the effects of early trauma on children's brain development, many researchers also are pointing to the brain's capacity for self-repair, or neuroplasticity, and research has shown that human beings continue to grow new neuronal connections throughout life in response to their relationships and environment. (Cozolino, 2010; Doidge, 2007; Siegel, 2012). Therefore, early intervention may be only part of the story in helping children heal from early traumatic experiences. In light of recent neurobiology research, another aim of counseling interventions emerges that focuses not only on early intervention but also on providing an environment in which children can experience healthy connection, reorganize relationships through sensory and interpersonal experiences, and thereby facilitate this brain-repair process (Banks, 2006).

RCPT FOR TREATING RELATIONAL TRAUMA IN CHILDREN

Children who have experienced relational trauma, and whose early primary relationships are often based on instilling fear and dependence in order to control them, are particularly in need of developing a sense of self-empathy, personal agency, and positive connection. In her articulation of the "3 R's" of trauma-focused play therapy—reexperiencing, releasing, and reorganizing—Gil (2011) as-

serts that children must feel safe in therapy before the work of trauma resolution can begin. Until the child feels safe, the therapist should focus on developing a secure relationship with the child. This work may even begin before the child is safe at home.

Though a sense of safety and rapport in the therapeutic environment must be present for trauma resolution to take place, the "3 R's" do not necessarily represent distinct phases. Children come and go in and out of these phases, as they need to, while they are healing, and it is the therapist's job to help the child, their caregivers, and workers understand where they are in the process and how to support them until they are ready to move on. According to Gil (1991), reexperiencing involves recalling the details of the event without feeling responsible for the trauma. The trauma memory, as processed with the therapist, will reveal the perpetrator's role as controlling and acting, whereas the child is revealed as not in control. During the releasing phase, the child can begin to understand and feel that the trauma is over, that it happened in the past, and that, right now, he or she is safe. Often, affective symptoms will begin to improve at this time as the child's brain begins to rebalance and properly regulate affect (Cozolino, 2010). The final stage of this part of treatment is the reorganizing phase. During this phase, the child will begin to see the trauma as something that is a part of his or her life story but is not the primary event or events that define who he or she is. At this point, or sometimes during release, the posttraumatic play will stop and the child will begin to demonstrate more developmentally appropriate, or dynamic, play in the therapy room.

The "5 E's" of RCT can be mapped onto the "3 R's" of trauma-focused treatment to provide a specific play therapy treatment approach. Though the integration of these approaches is nonlinear, we have attempted to create an outline that can be followed and adapted by play therapists. The first principle is to pair reexperiencing traumatic events with the establishment of self-empathy and mutual empathy. Though building rapport is always part of the early stage of treatment, an effort to build a mutually empathic relationship is ongoing. Second, releasing or reframing the child's trauma experience is paired with examining the child's relational templates, or mental images, of healthy and unhealthy relationships. Examination of relational templates naturally includes power-over issues and disconnections, both those that are routine and those that are more serious. Lastly, we see the final principle of RCPT as combining the task of reorganizing relationships and expanding relational capacities. This occurs when the child has experienced healthy self-in-relation and can begin to reorganize their relational templates and build new relational skills. In the section that follows, we further outline the concepts of RCPT and trauma-focused treatment. The result is a working model of RCPT that can be used to treat a child who has experienced trauma.

Reexperiencing: Encouraging Self- and Mutual Empathy

During the reexperiencing phase, it is common for children to play out the traumatic event, either as a direct retelling using toys as actors or metaphorically. Posttraumatic play is very different from typical developmental play (Gil, 1991, 2011). Children in this phase of therapy might play out the same scenario over and

over, without any apparent relief or joy. The therapist's job during this early phase of treatment is to bear witness to the child's literal or metaphoric telling of their trauma story. To acknowledge the child's experience, limits should only be set to keep the child and therapist safe, and should be communicated in a matter-of-fact manner, rather than with emotion or judgment (Landreth, 2002). In addition to setting basic, and consistent, limits, the therapist can help the child build a sense of safety by being congruent in tone, manner, and predictable in scheduling the place and time of therapy appointments. It is important to children that the same play materials are available for each session, so the therapist should avoid removing any toys or materials from the playroom, even if they are broken. For example, the first author has observed children use animals with broken limbs to represent a visible example of their internal pain and feelings of brokenness. The availability and use of these broken toys can be empowering to children who have had their life experiences minimized or denied. However, to ensure the safety of the child, which also is a critical therapeutic factor, when broken toys are a safety hazard, it is imperative to immediately replace them with the same or similar items.

It is also the responsibility of the therapist to recognize when it is time to step into the play and encourage the beginnings of the release stage of treatment. A child's readiness to move away from repetitive posttraumatic play and into release varies greatly among individual children. Whereas many authors (Gil, 2011; Greenwald, 2005; Kagan, 2004) recommend actively helping children move away from what Gil (2011, p. 159) calls "stagnant" posttraumatic play, many play therapists fear intervening in the child's play. However, when working with traumatized children, play therapists must be alert to the appearance of stagnant play, which may, in fact, cause further damage to the child.

In RCPT, when the therapist observes repetitive, joyless, rigid play, particularly if symptoms worsen outside of session, it is time to actively help the child move into release by asking, "who can help," thus introducing the self-in-relation idea that relationships with caring others aid in resolving trauma. Shifting from stagnant to dynamic play may be done very subtly, perhaps by asking the child to give the play a new ending. By asking, "Who can help the baby dinosaur from the angry T-Rex this time?" the therapist may break the spell of stagnant play and allow the child to begin to consider new relational outcomes, which includes the help of others. Children revise the trauma story, learning that they can make things happen, that they can engage with safe others to help them, and that, together, they can act on the world in meaningful ways.

Releasing: Exploring Relational Templates
(Including Power and Disconnections)

Once a child has reexperienced the trauma, a release phase of treatment is possible and stagnant posttrauma play will disappear. Often, this is a sudden shift and can occur within a given session. Stagnant play can then develop into what Gil (2011, p. 159) calls "dynamic play." Witnessing also helps the child to feel less isolated in his or her experiences. It is also important for the therapist to highlight the child's strengths and survival skills as they appear in the play. This should be

done descriptively rather than evaluatively. For example, the therapist might say, "You got away from that bad guy by not giving up. You kept yelling until somebody heard you." A more evaluative statement is, "You did a great job getting away from that bad guy." Descriptive recognition of strengths validates the child's learning and empowers the internalization of these attributes and increases self-empathy.

Dynamic posttraumatic play is characterized by greater range of themes and affect, and may be followed by the appearance of fatigue or relief in the child. During the early days of this phase of treatment, symptoms may briefly worsen and then will generally decrease rapidly as the child builds a greater sense of mastery and control. Once dynamic posttrauma play begins, the therapist may begin introducing new ideas into the play about relationships. Relational templates may be explored within the play by asking the child questions such as, "What are mommies supposed to be like?" or "How does a friend act?" These types of questions allow the child and therapist to explore the child's current expectations about relationships and over time, and begin to think differently about them. If a child client answers the question about mommies with a list of negative attributes, it can be helpful to say, "Do all mommies act that way or just some mommies?" Rather than to directly confront or correct the child's ideas and expectations, the therapist should gently and empathically offer other ideas. Part of the shift in the child's relational templates about adults will occur over time as they experience a healthy, positive relationship with the therapist.

When working with adults, RCT therapists may spend multiple sessions on the next task—explaining disconnections. Adults often have long-term, entrenched patterns of using the same strategies of disconnection (passive–aggressive behavior, walking away during arguments, using violence, etc.) to end painful encounters (Jordan, 2010). Children's strategies for disconnection are less well developed but can be equally entrenched, especially when their early relationships included exposure to victim grooming by perpetrators and/or fear of primary caregivers. When children have experienced severe disconnections in relationships, for example, they often develop a sense of worthlessness. Over time, these negative experiences can be ameliorated by experiencing positive, growth-enhancing relationships. Children can also be taught to recognize healthy relationships, such as the "Five Good Things," and contrast these components with power-over dynamics and dominance (e.g., manipulation or neglect).

Depending on the severity of the behaviors the child uses to avoid connection with others, additional strategies may be needed in addition to play therapy. Psychoeducational groups that include direct instruction on positive behaviors and role playing can be beneficial, as can filial therapy and other parenting supports. Collaboration with the school counselor is often critical to help meet the relational needs of children. For example, Brown, Brack, and Mullis (2008) recommend school counselors provide the following strategies for *reconnecting* children who have experienced relational trauma: group counseling for communication, assertiveness, and other relational skills or pairing children with an adult mentor, all with careful consideration of the child's individual healing process and coordination of school-based activities with any outside treatment. Classroom interventions may also be needed if symptoms are expressed at school. Some school-based trauma-focused interventions have

been described that can be provided as an adjunct to RCPT (e.g., Jaycox et al., 2009; Thompson & Trice-Black, 2012).

Reorganizing: Expanding Relational Capacity

During the final phase of trauma treatment, the child moves away from trauma-based play and begins to play more like a nontraumatized child, using developmentally typical themes. In this final stage of treatment, the child expands his or her capacity for healthy connections, begins to develop new and positive relational templates (e.g., "I am safe, others can be trusted"), and increases self-empathy and empathy for others (Jordan, 2010). The task of this stage is to experience and practice healthy relationships (i.e., "Five Good Things"). Furthermore, at this point, the child's brain is capable of building new neuronal connections and new neuronal maps to allow greater regulation of affect to occur (Cozolino, 2010) and, consequently, the development of new relational images (Banks, 2006).

It is not unusual at this stage of treatment for a child to announce to the therapist that he or she is finished and would be okay with no longer coming to see the therapist every week. Other children are subtler and will gradually disengage from the intense play of earlier phases. Ending therapy can be difficult for both child and therapist, who have built a bond over the course of therapy. It also presents an opportunity for introducing the child to healthy, positive goodbyes. Prior to the last few sessions, the therapist can engage the child about new adventures, hopes for the future, and wishes for positive relationships in the future. This may be done symbolically within the metaphors of play or more directly at the end of play sessions.

When possible, planning for termination in advance gives the child a sense of control and safety about the ending of the powerful relationship between him/herself and the therapist. There are many creative ideas for last sessions. Whatever sort of celebration or summation the therapist and child choose for the final session, the child should leave knowing that the therapist, or someone like him or her, will be available in the future, if needed, and that the child can now use his or her new skills to cope with any challenges the future may bring.

CASE EXAMPLE: LANE

Lane, age 8, came to therapy with a diagnosis of posttraumatic stress disorder (PTSD) due to parental neglect and sexual abuse. Lane was born to a single mother who struggled with drug addiction and alcoholism throughout Lane's life. From birth to 10 months of age, Lane and her mother lived with Lane's present guardian, who was Lane's primary caregiver. Her mother then moved out of state, taking Lane with her. During her second year of life, her father came back into her life but died that same year of unknown causes. Life with her mother was unstructured and chaotic. There were many people in and out of the home at various times. Lane's guardian believes that sometime between the ages of 3½ and 4, Lane was sexually

abused. The guardian witnessed her engaging in sexualized play with dolls during a family visit. At age 4½, Lane's mother abandoned her; she left her with a neighbor and did not return. Lane's mother was subsequently arrested and lost custody of Lane because of neglect. At the time Lane entered treatment, her mothers' parental rights had been terminated and Lane was living with her guardian.

Lane presented with depressed and restricted affect, poor peer relationships, angry acting out, oppositional and overcontrolling behavior with adults and peers, highly disruptive school behavior, lack of empathy for others, an inability to play and professed disdain for play, and recent sexual acting out with peers. She had seen a therapist previously for about 6 months. The former therapist primarily utilized a cognitive–behavioral play therapy approach, but her guardian felt that progress was superficial, saying, "She played card games and told the therapist what she thought she wanted to hear but nothing really changed. She is still difficult and hard to live with."

Reexperiencing: Encouraging Self-Empathy and Mutual Empathy

Her new therapist utilized RCPT to facilitate building safe, trusting relationships; reexperiencing, releasing, and reorganizing her traumatic experiences directly and in the metaphor of her play; and then experiencing and practicing the components of healthy relationships as part of her reorganizing her trauma.

Lane was initially resistant to the new therapist, telling the therapist that she "didn't play with kid toys," but she readily engaged in drawing. With open-ended questions and story prompts, Lane was able to give stories to her drawings. In her first session, she drew herself with no arms, hands or face, evidencing a feeling of being invisible and helpless due to her neglect and abuse. The therapist began the discussion by asking, "Tell me about your picture?" Lane replied, "It's just me getting a picture taken." The therapist then said, "Just pretend this was someone else; who would it be?" to which she replied, "It's an invisible girl." The therapist then began a story, "Once upon a time there was an invisible girl who lived. . ." Then Lane began to fill in where the invisible girl lived and how she lived by herself and got to do all the things that grown-ups do, describing a fun-filled fantasy about her early life, until the therapist introduced conflict by saying, "But then one day. . ." At this point, Lane's story became less idealized. She had the character being stuck in a basket in an elevator and no one could help her because she was invisible. In storytelling about her picture, she told about "an invisible girl who feels pretty powerful and can use her power to do all kinds of grown up things but she gets stuck and no one can see her to help her." Lane commented on feeling invisible with her mother and with the relative with whom she now resides.

In the stories that followed, Lane began to find the control she needed by pretending she was an art teacher and the therapist was her assistant. Initially she would "call security" whenever the therapist spoke; the therapist obeyed "the rules" by raising her hand or whispering, but would often be told, "Can't you see there are cameras and everyone is listening?" Lane needed extra assurance that everything was private and confidential in order to trust the therapist. After this, she began to count to 10 whenever the therapist spoke, but she did so with more

humor. Finally, in the fifth session, Lane asked the therapist to join her in making something, with Lane giving directions. This allowed Lane the control she needed as she began to grow in the relationship and move toward expressing her trauma. Lane frequently struggled to do things on her own, and when she did, the therapist reflected, "You don't trust adults to be there for you," and Lane agreed, saying, "No, not my mom and not my [guardian]."

Unfortunately, as Lane was growing in connection, she experienced the loss of a teenaged family member in her guardian's home when the teen became unruly and drug-addicted and was removed from the guardian's home. This was the loss of another relationship for Lane, but more than that, it triggered her fear that she had done something bad and could lose her safe home if her guardian learned of her sexual abuse. Lane saw her guardian as "perfect" and said, "Without her I would be dead." Though Lane idealized her caregiver, it was soon learned that her guardian also called her names and told Lane and others that she did not like children. At this time, Lane began to draw pictures that were calming, keeping some for herself and giving others to her guardian, as if to appease and connect with her and calm her as well.

Releasing: Exploring Relational Templates
(Including Power and Disconnections)

As Lane began to more directly share about her neglect and abuse by her mother and about her sexual abuse, the therapist normalized her feelings and actions, given her experiences. The therapist also integrated age-appropriate education about both trauma and addiction into Lane's treatment, and in consultation with her guardian. This helped Lane to not feel so different or bad ("or invisible") and helped her guardian to better meet her emotional needs. When Lane shared about how lonely she was and how much she wished she had friends in her neighborhood, the therapist was able to advocate for her by helping her guardian structure needed safety precautions so that Lane could have friends in the neighborhood while being protected from further sexual acting out. This advocacy built further trust and connectedness between Lane and her guardian.

In the fourth month of treatment, at the end of one session, Lane asked the therapist to bring the puppets she had originally refused to play with in the first session, saying, "I might play with them." The therapist brought the puppets, with an array of other toys, and laid them out appealingly. Lane promptly announced, "I don't play with toys." The therapist acknowledged sadness that Lane was robbed of playing as a child and had to be like an adult when she lived with her mom. The therapist added that she hoped that one day Lane might feel safe enough to be able to play. Lane slowly began to examine the toys, first choosing the doctor kit, pretending that she was the doctor, and stated, "Someone comes to me who has something that not a lot of people have but you can get better." It was her first expression of hope for her healing.

During this same time, Lane began to show anger and sadness over missing sessions with the therapist over holidays or when there was testing at school. She would evidence this by regressing and becoming controlling and angry again, but

when the therapist reflected with empathy for her feelings as initially expressed (e.g., "You're mad you missed an appointment and you want me to remind me you're in charge."), Lane would move to more direct expression of her feelings. When she missed her session because of achievement testing, she asked, "Where were you last week? I was done with my tests early and I waited and waited for you." She readily acknowledged the therapist's reflections of feeling sad and abandoned. With mutual empathy expressed between the therapist and Lane, Lane was able to shift between her need for control and her desire for connection, seeking rapprochement and deeper relationship. Her affect became less anxious and angry. She evidenced more smiles and an emerging sense of humor. Her special education teacher reported observing her acting with empathy for another student.

Reorganizing: Expanding Relational Capacity

With the onset of dynamic play, Lane began to actively use play metaphor to express and master her feelings from her neglect and abuse, and to reorganize her life beliefs. She began an ongoing story in which she was a mother to the baby doll who discovers her husband "is drinking and doing drugs and hurt the baby," just as her mother had. She had the therapist act as a police officer "who can ask about stuff and help keep the baby safe." Within this metaphor, she was able to express her feelings of anger, sense of betrayal, sadness, concern over guilt, and to know that "it wasn't my fault or the baby's fault." She expressed warmth, nurturance, and protection for the baby as her self-object, thus practicing the healthy components of relationships.

In subsequent play sessions, Lane further practiced safety, nurturance, and mutuality in relationships when she began to make the baby talk. When the therapist commented that the baby was talking and letting us know how she felt, Lane proudly exclaimed, "I taught her that."

CONCLUSIONS AND IMPLICATIONS

In this article, we have outlined an innovative approach to working with children who have experienced trauma in their primary relationships. RCPT blends the empathic, empowering RCT work of the Jean Baker Miller Institute with the instinctive, relationship-focused play therapy outlined by Moustakas (1997), Axline (1974), and Landreth (1991, 2002, 2012) to create an innovative new mode of treatment. This blended approach also aligns the newest research from the field of neurobiology with Gil's (2011) trauma-focused play therapy to forge a potent amulet against posttraumatic stress symptoms.

Implications for the use of RCPT go beyond play therapy with children. When RCPT is expanded to other expressive interventions, such as art and music, this approach can be used as a way to heal traumatic experiences with adolescents and adults with developmental disabilities, as well as adults who have experienced early, preverbal trauma. Further implications include school-based and filial-based interventions. For example, the first and fourth authors have used an RCPT filial

approach with foster parents to increase parenting capacities. The second and third authors have used RCPT in school settings. Involving school counselors, teachers, families, mentors, and other caregivers creates a relational community, in which children who have experienced relational trauma are kept safe but can also maintain and develop mutually empowering relationships. Although there is strong anecdotal support for this approach, what is needed next is empirical evidence of its effectiveness.

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