Establishing Safety and Stabilization in Traumatized Youth: Clinical Implications for Play Therapists

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The relevance of a phase-based treatment approach has recently been discussed in the youth complex trauma literature. In this approach, the first phase emphasizes safety and stabilization, which is often revisited throughout treatment. Clients can present with any number of safety concerns, including poor self-care, high-risk behaviors, revictimization, and dissociation. These issues can impede treatment if play therapists fail to understand them. The authors of this article aim to highlight the safety and stabilization stage of complex trauma treatment, discuss the significant role of safety and stabilization in treatment, and provide play-based interventions for this first phase of treatment.

A phase-based approach to treating complex trauma has been discussed in the adult (e.g., Courtois, 1997; Herman, 1992), and more recently, youth trauma literature (Cohen, Mannarino, Kliethermes, & Murray, 2012; Green & Myrick, submitted). In this approach, treatment involves three phases, including (a) stabilization and safety, (b) trauma processing, and (c) reconnection/reintegration. Although described separately, authors note that these phases rarely occur in a linear fashion (Courtois, 1997). Furthermore, many therapists frequently revisit issues of safety and stabilization throughout all stages of complex trauma treatment (Brand et al., 2012). Indeed, the first phase of treatment is crucial, as it includes (a) developing increased control over symptoms, (b) engaging in skill-building to improve affect and impulse regulation, (c) receiving psychoeducation, (d) developing a positive therapeutic relationship, and (e) increasing understanding of the role that trauma plays in self-destructive behaviors (e.g., Chu, 2011; Courtois, 1997; Herman, 1992).

In this article, the authors aim to provide a brief outline of safety- and stabilization-related concerns exhibited by complexly traumatized youth and to

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highlight several play-based interventions for use in the first phase of treatment. For the purposes of this article, the term "youth" refers to children ages 5–17, and "complex trauma" is defined as "both children's exposure to multiple traumatic events, usually of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure" (National Child Traumatic Stress Network [NCTSN], 2007, p.34). Case examples will be used to further demonstrate the importance and value of play therapists establishing safety and stability with youth affected by complex trauma. In these cases, all clients' identifying information has been altered to protect confidentiality.

SAFETY CONCERNS AMONG YOUTH AFFECTED BY COMPLEX TRAUMA

Complex trauma has been associated with poor self-care, high-risk behaviors, dissociation, and revictimization, although severity and outcomes occur on a continuum. While some complex traumas are confined to one stage of development, others occur over multiple developmental periods, and youth who experience long-standing traumas that stretch over several critical times in development may demonstrate severe symptomatology (English, Graham, Litrownik, Everson, & Bandiwala, 2005).

Poor Self-Care

Youth affected by complex trauma may demonstrate difficulty in the area of self-care. Some were never taught to care for their bodies through cleanliness, healthy eating, sleep-hygiene, exercise, and routine medical and dental care. Others struggle to respect their bodies due to the types of abuse they experienced. For example, Henry told his therapist that if he had been stronger, he could have avoided the abuse; thus, he blamed his body for the trauma he endured. Maggie blamed her body for inviting the sexual abuse she experienced; her abuser often told her that she was beautiful.

Feelings of safety and security are often compromised in situations where chronic abuse is present, and vulnerability during nighttime and sleep is intensified. Thus, youth affected by complex trauma may struggle with *sleep issues*, including difficulty falling asleep or staying asleep. Authors of a longitudinal study of childhood sexual abuse found that abuse accounted for sleep difficulties in adolescence above and beyond co-occurring depressive and posttraumatic stress disorder symptoms (Noll, Trickett, Suzman, & Putnam, 2006). Other researchers found that sexually abused children admitted to an inpatient psychiatric unit demonstrated better sleep quality once they were in the secure, predictable inpatient environment (Sadeh et al., 1995). Nightmares are frequently reported by youth who have experienced trauma. Although nightmares are a part of typical development and experienced by many youth (e.g., Sandoval, Krakow, Schrader, & Tandberg, 1997), researchers have found that trauma-related nightmares are associated with more impairment than typical nightmares (Davis et al., 2011).

Deprivation and failure to develop healthy self-care can lead to *disordered eating.* Children who have been removed from their home due to abuse or neglect may demonstrate excessive eating, eating or drinking from unhealthy sources, and maintaining food through hoarding, stealing, or hiding (Tarren-Sweeney, 2006). Furthermore, some authors have theorized that obesity serves as a defense mechanism against sexual predators (Ray, Nickels, Sayeed, & Sax, 2003). *Substance misuse* in adolescents has also been associated with trauma (Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997). Researchers have suggested that both food and substances serve to self-medicate against low mood, intrusive and anxious symptoms, and somatic complaints (see Brewerton, 2011; Garland, Pettus-Davis, & Howard, 2013).

High-Risk Behaviors

Self-Injurious Behavior

Nonsuicidal self-injury (NSSI) has received a great deal of attention in the childhood trauma literature, with mixed findings in terms of causality. Some studies (a) support a direct link between sexual abuse and NSSI, others (b) suggest that the relationship between sexual abuse and NSSI is mediated by dissociation or comorbidity symptomatology, and still others (c) conclude that the relationship is too complex to be convincingly supported by research (see Lang & Sharma-Patel, 2011 for review). Research findings generally support an association between physical abuse and NSSI (e.g., Yates, Carlson, & Egeland, 2008), while the relationship between neglect/emotional abuse has received less attention and support than either sexual or physical abuse (Lang & Sharma-Patel, 2011). NSSI has been conceptualized as an act that incorporates experience-based (e.g., trauma), intrapersonal (e.g., poor affect tolerance and expression), and interpersonal (e.g., poor communication or problem-solving skills) features and is maintained by internal and external reinforcement (Nock, Prinstein, & Sterba, 2009).

Suicidality

Suicidality rates are especially high among youth who have experienced complex trauma (Thompson et al., 2012). Suicidal behaviors appear to increase in frequency through adolescence before decreasing in adulthood (Vander Stoep, McCauley, Flynn, & Stone, 2009), and authors of a randomized, multisite study of adolescent suicide attempters found that history of physical or sexual abuse was associated with attempts at a younger age (Brent et al., 2009).

Running Away

Youth who experience physical, sexual, and psychological abuse are more likely to run away from their homes than peers in stable family environments (e.g., Thrane, Hoyt, Whitbeck, & Yoder, 2006). In one study, researchers found that

physical and psychological abuse predicted running away, which then predicted higher likelihood of delinquent behavior and victimization (Kim, Tajima, Herran-kohl, & Huang, 2009). Furthermore, those youth who live on the street part- or full-time have high rates of completed suicide; results of a longitudinal study revealed that 50% of deaths in street youth were due to suicides (Roy et al., 2004). Running away is less frequent among younger children than adolescents, and decreases as adolescents get older. Sunseri (2003) found that risk of running away peaked at age 16 and then decreased.

Revictimization

Rates of revictimization among complex trauma survivors are high, as many as two to six times more than their nontraumatized peers (Finkelhor et al., 2007). Theories proposed to account for such high rates of retraumatization include learning maladaptive ways of relating to others (Messman-Moore & Long, 2003), attempting to gain mastery over the initial trauma (Chu, 2011), "freezing" or missing cues before or during a dangerous situation (Cloitre, 1998), substance use at the time of victimization (Kilpatrick et al., 1997), and interacting with abusive individuals because of a negative view of self (Chu, 2011). For those who utilize dissociation as a way to cope, decreased environmental awareness may also make individuals particularly vulnerable (Cloitre, Scarvalone, & Difede, 1997). Additionally, Noll and Grych (2011) propose the *read-react-respond* model, in which trauma survivors must be able to accurately *read* the cues of the situation, *react* physiologically to the threat, and engage in *responses* intended to stop the threat or remove them from the threat.

Dissociation

Dissociation is a primitive, survival-focused, coping mechanism wherein the mind "shuts down" in response to overwhelming trauma. Symptoms may include "blackouts," amnesia for traumatic events, imaginary playmates, feeling the presence of internal "others," feeling as though oneself is unreal (i.e., depersonalization), or feeling as though the external world is strange or unreal (i.e., derealization; International Society for the Study of Dissociation [ISSD], 2004). Dissociation has been associated with high rates of *betrayal trauma*, or abuse by parental figures relied on for physical and emotional needs to be met (O'Rinn, Lishak, Muller, & Classen, 2013). Furthermore, exposure to multiple traumas has been associated with increased dissociative amnesia (Kenardy et al., 2007).

Play-Based Interventions for Fostering Safety and Stability

Appropriate pacing of trauma treatment is of paramount importance, particularly as many clients will struggle with setting appropriate boundaries regarding traumatic memories, either by oversharing or avoidance (Steele, van der Hart, &

Nijenhuis, 2001). Depressive symptoms, self-harming behaviors, and suicidal thoughts must be managed before the processing of trauma memories can be introduced into treatment (Brand, 2001). Therefore, safety- and stabilization-focused activities are first-line and ongoing interventions throughout treatment. Following recommendations in the field to combine play therapy with other treatment approaches (see Drewes, 2011 for review), the following sections present integrative interventions aimed at improving self-care, increasing awareness of symptoms, decreasing destructive behaviors, and increasing self-empathy, all within the context of a healthy therapeutic relationship. Many of these interventions are informed by child-centered and cognitive–behavioral theories and may include relationship building, psychoeducation, skills building, and experiential activities. For additional activities, see Green and Myrick (submitted).

Establishing Safety in the Relationship

Following complex trauma, youth need a treatment environment where they can reestablish feelings of trust, security, and reconnection. Consistent with child-centered theory (e.g., Landreth, 2002, 2012), unconditional acceptance and gentle limit setting by the play therapist is a powerful way to assist children and adolescents in developing a sense of safety. For some children, the therapeutic relationship may be their first experience in a healthy, mutually respectful relationship (Gil, 2011), and issues such as *empathy* and *power* may be crucial aspects of early, safety-focused treatment (Vicario, Tucker, Smith Adcock, & Hudgins-Mitchell, 2013).

Allowing oneself to be genuine is a fundamental way for play therapists to model and teach *empathy*. Therapists can allow clients to see the way they are impacted by the experiences shared in sessions. One client, Lindsey, began to cry after her play therapist told her, "I feel sad that you think I am a jerk," in response to Lindsey calling her names. In processing this response, Lindsey, a 9-year-old female who had experienced severe physical abuse, shared that she was afraid that her play therapist would not want to see her for therapy anymore. She added that the play therapy sessions were her favorite activity and worried that she would "screw up" another good thing, like she believed she had at home. Thus, for Lindsey, a primary goal of the first phase of treatment was for her to develop a relationship with her therapist in which she felt safe and trusted that she would not be rejected.

Power is another important aspect of treatment. There exists a significant power differential in the therapeutic relationship, and therapists and clients can establish differences between "power-over" and "power with" (Vicario et al., 2013), particularly through the use of child-centered therapy where the child is the leader. Dan was a 6-year-old male with a history of neglect and abuse. Through the first several months of treatment, he directed the therapist's play extensively; his favorite game was "cops and robbers" in which he was always the police officer who caught the therapist (i.e., thief). During one session, the therapist commented on his power position in the play, saying, "Dan, you always give me another chance, even though I keep making mistakes." In the next session, Dan invited the therapist to be a fellow police officer to help him catch another criminal (i.e., a stuffed animal). A few sessions later, Dan told the therapist to be the police officer, and he was the

criminal. This theme began to lend itself to other play scenarios as Dan developed an increased security and comfort with sharing power.

Improving Self-Care

Improving Sleep

With adolescents and older children, changes in sleep hygiene can be tracked using a *sleep journal*. As in other cognitive–behavioral interventions aimed at tracking thoughts, feelings, and behaviors, clients document activities before going to sleep, difficulty falling asleep, staying asleep, or waking up in the morning, and any remembered dreams. For youth who enjoy creativity, sleep journals can be decorated with collages of relaxing images. This journal is brought into sessions and ways to improve *sleep hygiene* are discussed. Some changes are easier than others to make, so starting with a fun activity, such as changing around the bedroom to increase comfort, often provides an opportunity for success. Other changes, such as a regular bedtime and wake time, decreased use of electronics at night, and using the bed only for sleep, may be harder and require gradual changes. Keeping track of sleeping issues on a daily basis also assists with remembering details of each night and also identifying patterns. For example, Beth realized she had difficulty falling asleep without the TV on at night. However, she also realized that when the TV was on, she woke up frequently and tended to have dreams related to the shows she watched. She and the therapist decided to try a nightlight and white noise machine to provide a less stimulating means of comfort.

Even when sleep hygiene is improved, however, some children and adolescents may continue to struggle with sleep because of nightmares. Imagery Rehearsal Therapy (IRT; Krakow & Zadra, 2006) and Exposure, Relaxation, and Rescripting Therapy (ERRT; Davis, 2009) are two cognitive–behavioral treatment (CBT) interventions specifically adapted to treat nightmares in youth. IRT involves psycho-education, mental modifications of nightmares to make them more pleasant, and daily rehearsal of the modified dream, while ERRT involves changes in sleep habits, challenging of cognitive distortions, relaxation techniques and exposure exercises. Both have had preliminary success (Fernandez et al., 2013; Simard & Nielson, 2009), although neither have been successful at eliminating nightmares completely.

Dream Your Bad Dream (Boyd-Webb, 2001) and *Draw the Dream On* (Green, 2009) are two simple, play-based activities to incorporate IRT or ERRT into complex trauma treatment. They encourage externalization of the internal dream experience and empower children to gain control over their nightmares. In the first activity (Boyd-Webb, 2001), clients draw a picture of their dreams and then destroy the picture as a way to demonstrate that the dream will never bother them again. Some children will rip up their pictures, yet others will color over them. Finally, some children choose to draw a hero in the picture, or an alternate ending where the scary aspect of the dream is neutralized. Real-life or imaginary superheroes may make an appearance in a dream. A police officer scared a robber away in one 7-year-old's dream. Another version of this CBT activity involves creating a *dream remote control* that can help children "change the channel" on their bad dreams and experience increased control over thoughts.

In the second activity (Green, 2009), children maintain a dream journal, and use magazine pictures or original artwork to represent nightmares. The therapist asks the child to "draw the dream on" so that the dream can be finished in a way the child finds to be less scary. *The Party Hat on Monsters* (Crenshaw, 2001) activity is similar; the child decreases the intensity of the dream by making one aspect silly or funny. For example, Pat had a recurrent dream in which his mother was swinging a wooden bat toward him. Using the party hat activity, he replaced the bat with a stalk of broccoli, which made him laugh. He took this picture home with him and put it on his nightstand; he never reported difficulty with the dream again.

Seeking Medical and Dental Care

Children who have experienced complex trauma may experience significant anxiety when dental and medical care is required. As in abusive situations (particularly sexual abuse), children are left alone with a person who is more powerful, experience or anticipate pain, and are told that potentially painful experiences are driven by caring (Willumsen, 2001). Play therapists must sometimes assume the role of advocate for their clients (e.g., Kolos, 2009). With complexly traumatized youth, this may mean assisting caregivers in finding sensitive, experienced practitioners who are willing to pace their examinations, allow parents to be present, or allow comforting stuffed animals or music in the room. Play therapists can also encourage caregivers and children to plan to arrive early to appointments, and to schedule appointments during a slower time of day. Prior to medical and dental procedures, play therapists can address related anxiety through experiential role plays in which the child and therapist take turns being the patient and practitioner, or through role plays where the child acts as the parent who must help a stuffed animal understand why going to the doctor/dentist is important. Therapists can assist in the latter by helping the child identify coping thoughts such as, "I know it is scary, but I will be so proud of myself when it is over," and "The doctor is not my abuser." For older children and adolescents, bibliotherapy or related videos are also useful in answering questions and providing psychoeducation.

Improving Daily Self-Care

Psychoeducation about daily self-care is also important for many complexly traumatized youth. The *My Body Needs* . . . activity, described elsewhere by the authors (see Green & Myrick, submitted; Myrick, 2010), allows youth to identify ways they currently care for their bodies and can be expanded upon as clients develop more healthy ways to care for themselves. Some youth struggle to remember all of the ways they need to care for themselves; creating tangible reminders may be useful during sessions and increase feelings of mastery. For example, Joe, an 8-year-old boy, argued regularly with his foster mother at bath time. He insisted that he had taken a bath the night before and did not need one. He and the therapist discussed reasons that his body needed regular cleanliness. Then, they printed out calendar sheets and colored every other block in with the color blue; on blue days, he was to take a bath. At his next

appointment, he shared that he had taken baths on every blue night; Joe's foster mother reported there was "one less battle" at home. With the therapist's direction, she reinforced Joe for taking good care of his body.

Increasing Awareness of Symptoms

Developing *awareness of the function of self-destructive thoughts and behaviors* is another important aspect of treatment. Functions may include ambivalence about self-care due to feelings of worthlessness, reenactment of trauma dynamics which feel normal, and means of communication. Some adolescents may be able to answer questions such as, "What was happening right before you self-harmed?," "How did you feel after you self-harmed?," or "When you self-harmed (or threatened to do so), what did you think/hope would happen?" (adapted from Brand, 2001). Play therapists can assist clients to "rewind the clock" or make timelines for moments when they felt threatened or acted on self-destructive thoughts. These cognitive- and feelings-based questions and activities lend themselves to skills-building regarding affective regulation, impulse control, expressing needs using words, and relaxation. *Container* exercises are commonly used cognitive skills that involve youth managing overwhelming feelings by visualizing a container in which the feelings can be stored; it can be added to an already existing "laughing place"[1] imagery exercise:

> Now, as you walk around your laughing place, taking in all of the sights, sounds, smells, tastes, and sensations, notice an empty container. Notice the shape, size, and whether or not you can see in it or not. Notice that your container can be closed. Now, open the container and begin placing difficult thoughts and feelings in the bottom, one at a time. When you have finished, close that container, knowing that you, and only you, can decide when those thoughts and feelings may come out.

Once completed, play therapists can encourage adolescents to draw, or even build, their container. One teenage boy, Juan, described his container as a safe, with both a lock and a difficult combination. Another client, Sarah, described her container as a glass jar with a cork lid; she explained that she liked being able to see what she put in the container so that she could decide when it could come out in session. Container exercises can also be applied with *grounding*, an experiential technique which allows the client to remain in a present state, as opposed to a dissociated one. Teaching youth how to ground themselves when they begin to dissociate can be helpful in keeping them safe. Simple ways to encourage grounding include asking the client to describe a picture in the room, five things he sees or hears, or the texture of the chair in which he is sitting. Tactile grounding exercises include asking the client to feel his feet on the ground, squeeze a pillow, or grasp the arms of the chair. Some youth enjoy having their own grounding objects, such as smooth rocks or textured toys.

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[1] For traumatized youth, the authors use "laughing place" or similar terms to describe the oasis encountered during an imagery exercise. For many survivors, the words "safe" or "happy" may be triggering or difficult to embrace.

Decreasing Self-Destructive Behaviors

Play-based interventions can be merged easily with treatments empirically validated for decreasing self-destructive behaviors in youth, such as dialectical behavioral therapy (DBT; Callahan, 2008), cognitive therapy for suicidality (e.g., Berk, Brown, Wenzel, & Henriques, 2008), and rational emotive behavioral therapy (REBT; Vernon, 2009). For those who harm themselves for the purpose of *tension reduction* or a means of temporary distraction or relief (Briere & Spinazzola, 2005), a *distraction box* (Green & Myrick, submitted; Myrick, 2010) to hold coping thoughts and activities in a place easily accessible to clients can be useful. Similarly, creating a list of pleasant activities allows clients to have their needs met in a safe way. Typical guidelines should include activities that are (a) enjoyable, (b) active rather than passive, (c) inexpensive, (d) harmless, (e) accessible to do often, and (f) involve other people (Curry et al., 2005). For those who have a difficult time identifying ideas, looking through magazines, searching together on the Internet, or gaining ideas from favorite books, TV shows, or movies can assist youth in this activity.

Break the Chain (Vernon, 2009) is designed to illustrate choices and decisions youth make in difficult situations. *Break the Chain* allows children and adolescents to identify decisions, reasoning behind choices and worries, and probable outcomes. Play therapists prepare for this activity by cutting strips of red and green construction paper. The client identifies a situation that resulted in a self-destructive behavior, which is written on the first strip of red paper. This strip is then stapled or taped together to make a link of the chain. Each subsequent choice is written on a red strip and linked to the chain. Typically, one complete chain will consist of one situation, choices, and then the final outcome with which the client is unhappy. The client identifies where he or she can "break the chain" and begins writing different, adaptive choices on the green strips. These rings are attached where the chain was broken as a way for the situation to go differently. Sonja was an 8-year-old female who was regularly in trouble for running away during recess. Upon discussion, it became apparent that running away helped her feel cared for by others. An illustration of a chain for this situation is presented in Figure 1; the bolded statement on the right is a coping thought that could "break the chain."

Recognizing and protecting oneself from revictimization is particularly important as youth begin exploring peer and intimate relationships. *People meters* encourage youth to evaluate their relationships using healthy criteria. Clients create a list of traits they want in a friend and assign a color to each. For youth who have not had many loving, supportive relationships, this may be a difficult task and may lead to discussions about what they are worthy of from others. Once the list has been made, clients and their therapists identify "warning signs." Henry, mentioned previously, listed characteristics such as bossy, teasing, and overly interested in sexuality (e.g., watching a lot of pornography) or aggression. These signs were designated the color of red. Next, clients identify current people in their lives and, using paper doll cutouts, color in the body with the amount of each trait they believe the individuals possess. For example, Sarah, previously mentioned, created a cutout for her best friend. She colored the body mostly green (kind), yellow (helpful), and blue (good listener). She also colored one hand on the cutout in red. Sarah told her therapist that the red represented the fact that sometimes her friend

Playing at recess - Throwing a ball into the street

Teacher told me to stop throwing ball.

"She is mean. She let's other kids play with the ball."

Felt Sad; "No one likes me."

"I should just run away."

Ran away

Teacher was worried. " I guess she does like me."

Playing at recess - Throwing a ball into the street

Teacher told me to stop throwing ball.

"She is mean. She let's other kids play with the ball."

"Maybe she thinks I will get hurt."

"If she is worried about me, she must like me."

Play with something else
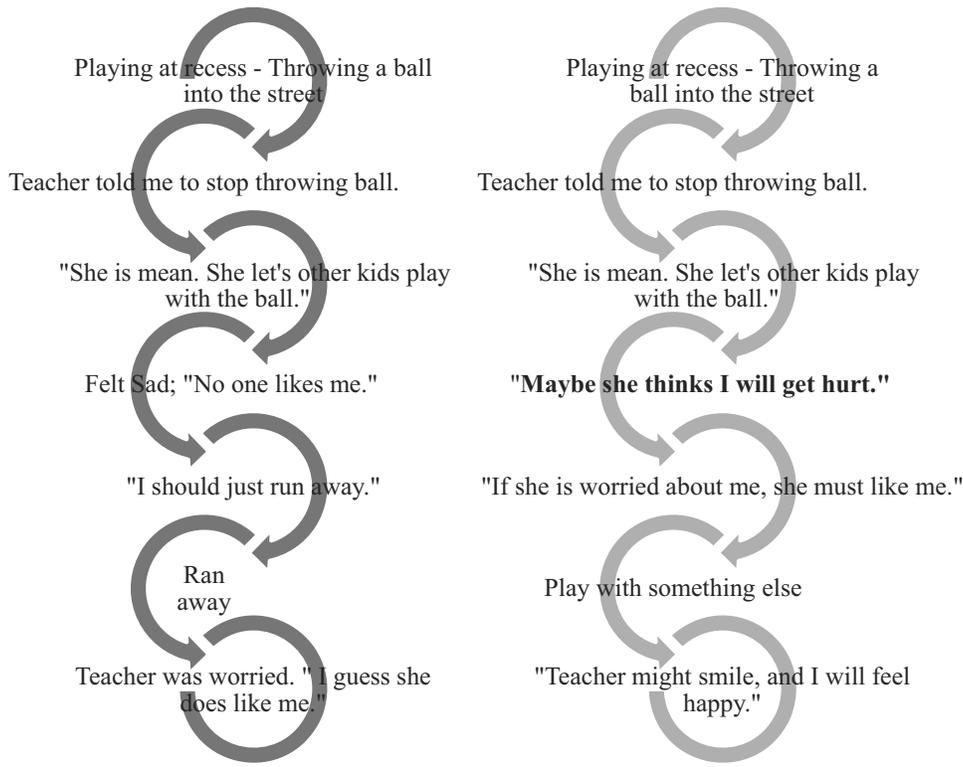
"Teacher might smile, and I will feel happy."

Figure 1. Chain of events: Throwing a ball at recess. The color version of this figure appears in the online version only.

was mean to other friends, which made Sarah uncomfortable. This cognitive–behavioral activity can be used throughout treatment as a guide while youth navigate their new social experiences, and can be particularly useful for adolescents who may begin to explore romantic relationships.

Increasing Self-Empathy

Finally, *acceptance* of all parts of oneself, even those that the client views as weak, worthless, or bad is one way to begin challenging cognitive distortions and developing a foundation for skills building and increased self-esteem. The notion that a client must validate emotional experiences is a core tenet of DBT (Linehan, 1993), and matches the emphasis on unconditional positive regard in child-centered play therapy. Activities described throughout this article can assist clients and therapists in reframing behaviors; understanding behaviors as purposeful can increase acceptance and validation of oneself. For example, John's play therapist commented on how strong John's anger was and how it enabled him to protect himself from bullies. She also commented on how his anger that turned into aggression got him into trouble. John added that he felt out of control when he was angry, regretful that he became aggressive, and embarrassed that it got him in

trouble at school. From there, he and the therapist discussed how John might be able to harness his anger so that it still served a protective function, but in a way where he felt proud of himself instead of out of control and ashamed.

Reasons for Relationships (Vernon, 2009), based on REBT principles, aims to identify reasons why individuals are in relationships. Clients create a word cluster beginning with the word "relationship;" around it, they write or draw as many words or ideas as they can that related to their view of relationships' roles in their lives. Annie, a teenage client in a cruel peer group, wrote "feeling special," "not lonely," "loveable," and "cool." She was unable to identify any other aspects of her life that made her feel these ways, which led to therapeutic work in the area of self-esteem building, as well as recognition and protection from unhealthy relationships. Once she was able to identify other things that helped her feel special, included, loveable, and cool, the unhealthy peer groups with which she was associating became less valuable to her and she began spending her time elsewhere.

CONCLUSION

The needs of youth affected by complex trauma can be great, and treatment should aim to address as many of these needs as possible. In the proposed phase-based approach to treatment (Cohen et al., 2012; Green & Myrick, submitted), all three phases of treatment are important; however, those who treat complex trauma survivors across the life span (e.g., Brand, 2001; Courtois, 1997; Gil, 2011) emphasize the importance of establishing a therapeutic relationship and prioritizing personal safety and stability. Feelings of helplessness, inherent in traumatic experiences, can lead to destructive behaviors, difficulty developing meaningful relationships, and a poor view of self. Thus, a play therapist's role in the psychotherapy is to assist clients in managing these symptoms. For some, experiencing and developing these skills may precede safety or predictability at home (Gil, 2011), highlighting the importance of the relationship with the play therapist even further. Integrating the primary tenet of play therapy—an unconditionally accepting, developmentally appropriate approach—with empirically supported treatments allows play therapists opportunities to address presenting and ongoing concerns while simultaneously promoting meaningful, healthy interpersonal skills.

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