WORLD JOURNAL FOR SAND THERAPY PRACTICE
PROMOTING THE ETHICAL PRACTICE OF SAND THERAPY

Relational-Cultural Theory in Sand Therapy for Survivors of Child Sexual Abuse with Complex Post-Traumatic Stress Disorder

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Abstract

Survivors of child sexual abuse (CSA) commonly experience negative mental health consequences, including symptoms associated with complex post-traumatic stress disorder (CPTSD). Child survivors may benefit from expressive therapies such as sand therapy and other therapies that allow for a focus on relational functioning, which becomes hampered when relational violations occur (Bank, 2006). Relational-cultural theory (RCT) emerged in response to a need for clinicians to focus on relational aspects of and societal impacts on clients' lives. When applied in sand therapy, RCT affords therapists a unique opportunity to explore their clients' individual, interpersonal, cultural, and systemic experiences. This article introduces the applicability of RCT in sand therapy with child survivors of CSA who experience CPTSD.

Keywords: relational-cultural theory, sand tray, sand therapy, child sexual abuse survivors, complex posttraumatic stress

Internationally, the estimated prevalence of child sexual abuse (CSA) is 12.7% to 18% for girls and 7.8% for boys (Stoltenborgh et al., 2015). Reported prevalence of CSA varies widely due to differences in definitions of CSA and what constitutes sexual abuse. Nonetheless, CSA remains a public health concern that leaves survivors susceptible to negative consequences throughout their lifetime. Common aftermath of CSA includes negative impacts to survivors' physical wellbeing, mental health, and interpersonal functioning over their lifespan. Survivors may experience adverse physical outcomes such as chronic medical issues and sexual transmitted infections (Prakash et al.,

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2025) as well as social outcomes such as negatively affected employment and income (Wolf, 2023). Later in life, negative impacts additionally include increased likelihood of sexual revictimization (Finkelhor et al., 2015) leading to other common mental health challenges (Prakash et al., 2025). In their umbrella review of 19 meta-analyses, Hailes et al. (2019) found CSA associated with increased risks of long-term psychosocial concerns such as substance misuse and psychiatric outcomes such as schizophrenia and post-traumatic stress disorder (PTSD). Research findings indicate that many child survivors of CSA meet criteria for PTSD, including hyperarousal (e.g., hypervigilance, irritability), avoidance (e.g., avoiding situations related to the traumatic event) and reexperiencing (e.g., disrupted sleep or nightmares, flashbacks, intrusive thoughts; Hébert & Amédée, 2020).

Child survivors also commonly experience symptoms associated with complex post-traumatic stress disorder (CPTSD; Hebert et al., 2024). Although the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V-TR; APA, 2013) does not include CPTSD as an official diagnosis, the World Health Organization (WHO) added CPTSD to the International Statistical Classification of Diseases and Related Health Problems (ICD-11; WHO, 2022). In addition to PTSD symptoms, children and youth who experience CPTSD present with disturbances in self-organization (DSO) such as affect dysregulation (e.g., hyper- and hypo-arousal states), issues with identity development (e.g., challenges with self-worth and sense of self), and relational disturbance (e.g., isolation, inability to trust).

With strong empirical evidence for reducing clinical symptoms of posttraumatic stress and other presenting concerns (e.g., depression, anxiety, externalizing behavior problems), trauma-focused cognitive behavioral therapy (TF-CBT) is linked to improved adaptive functioning in youth with CPTSD (Murray et al., 2015) with some adaptations to model (e.g., extended sessions; Cohen et al., 2017). However, for CSA survivors with CPTSD, combining TF-CBT with other evidence-based approaches relying on relationally focused interventions potentially leads to improved outcomes (Caouette et al., 2021). In fact, Karatzias et al. (2022) found that survivors with CPTSD who experience relational challenges in adulthood (i.e., attachment styles) may benefit from interventions targeting attachment security and fearfulness in their beliefs about relationships (e.g., attachment working models).

Given the potential neurobiological ramifications of CSA combined with the symptomatology linked to CPTSD, interventions that go beyond verbal accounts of the experience, such as sand therapy, can prove helpful. The benefits of those interventions compound if the therapist offers them from an approach that addresses DSOs from a relational lens through focusing on their relational and emotive functioning, one's ability to navigate sense of self or an ability to use one's voice, and the impact of relational-sociocultural contexts on their lives.

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Sand Therapy

Sand therapy is described as a form of therapy that includes "the unfolding and processing of intra and inter-personal issues through the use of specific sandtray materials as a nonverbal medium of communication led by the client or therapist and facilitated by a trained therapist (Homeyer & Sweeney, 2023, p. 6)." In the 1920s, Margaret Lowenfeld created sand tray therapy, called the World Technique at the time, to help children express and communicate their inner worlds, and she later used this form of therapy with adults. Sand therapy research continues to indicate this modality exists as an effective and suitable treatment option for children and youth survivors of CSA (Homeyer & Lyles, 2022).

At present, there remains a dearth of research on sand therapy with child survivors of CSA and CPTSD, specifically. However, the available research on sand therapy with CSA survivors reveals that CSA survivors convey telling differences in their participation with sandtray interventions when compared to other abuse types and control groups. For example, Harper (1991) found survivors of CSA (n = 40) presented as well organized yet lacking fantasy play and approval seeking when compared to the other groups. The researcher felt a *personal* unease in observing their sandtray creations across four one-hour sessions and attributed this to a possible underlying and pervasive emotional disturbance as compared to the other groups. Cunningham et al. (2000), on the other hand, studied a sample of children (n = 15) and noted that CSA participants, when compared to a group with health condition and a no known trauma group, chose items randomly and created chaotic trays. Though interchangeably using "sandplay" and "sand tray" within their article, Tornero and Capella (2017) found improved organization in their sand tray environments and overall positive outcomes within their sample of CSA survivors (n = *7*) across three intervention points, with each point including a sand tray session. Their findings revealed violence-related play behavior including characters acting aggressively, requiring safety, and resolving conflict in elaborate ways. The researchers noted that their findings coincided with the literature on play behavior of CSA survivors, such as digging or hiding objects in the sand, which often represents secrecy or a need to escape (Homeyer & Landreth, 1998).

Child survivors and therapists stand to benefit from robust empirical support for sand therapy as research in this area continues. At present, therapists, trained in using expressive therapeutic modalities such as sand therapy and working with clients to examine and to symbolically express their inner worlds, take heart knowing sand therapy fits well for use across theoretical techniques, theoretical orientations, and cultural groups (Homeyer & Sweeney, 2023; Ramsey, 2014). The following section provides an overview of relational-cultural theory (RCT) and its applicability in sand therapy.

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Relational-Cultural Theory

Originally focused on better understanding psychological needs of women, Jean Baker Miller's (1976), *Toward a New Psychology of Women*, challenged conventional psychotherapy practices that primarily drew from individualism and traditional psychodynamic approaches. Miller and colleagues believed that their clients' experiences were not best understood through a separate-self model with autonomy as the goal; rather, they noted that healthy interdependence and connection contributed to the clinical and developmental needs of their clients and were not hallmarks of weakness. Although the earlier days of RCT centered on the experiences of women, the theory evolved to become regarded as applicable to people of all genders with a focus on the dynamic nature through which people are shaped through their relationships and cultural contexts (Jordan, 2018).

Psychodynamic, feminist, and social justice principles underpin the relational-cultural framework (Jordan, 2018). Like therapeutic work within psychodynamic approaches and attachment theories, RCT counselors seek to learn about early relationships and to identify relational patterns and understandings. However, counselors using traditional psychoanalysis, psychodynamic approaches (e.g., object-relations), and other relational and psychotherapies view interpretation of the unconscious as the central therapeutic goal. In RCT, counselors instead aim to facilitate movement out of isolation and into growth-fostering relationship. Additionally, within psychodynamic and other approaches, their emphasis on separating and not depending on others diverges from the emphasis within RCT that honors humans' true nature — the inherent need to connect with others (Banks, 2015).

RCT Concepts

Primary concepts of RCT include *connection*, *disconnection*, *mutuality*, *authenticity*, *relational images*, *power*, and *relational resilience*. Each concept provides a relational-cultural view of people and an explanation of their contribution to individuals' functioning.

Connection

In RCT, connection refers to contact within growth-fostering relationships which comprise mutual empathy, mutual empowerment, and "five good things" (i.e., zest or energy; clarity of self, others, and the relationship; productivity; sense of worth; and desire for further connection; Miller & Stiver, 1997). Connection is optimal as people are hardwired for connection (Banks, 2015). However, disconnection is healthy, common, and expected across relationships.

Disconnection

Disconnection emerges when an interaction leads to misinterpretation and misunderstanding at best and at worst a threat of danger. People navigate disconnection healthily when navigated with respect. Yet, disconnection can lead to isolation when it occurs chronically and acutely (Jordan, 2018).

Mutuality

Mutuality, the bedrock of RCT, characterizes the ability to impact another and to remain open to being impacted by others. Mutuality, from a RCT perspective, exists among therapists and clients. However, mutuality is not reciprocity. In therapy, the therapist maintains their therapeutic role and ethical responsibility and avoids relying on the client to hold space for the therapist the same way the therapist does for the client. Instead, the therapist allows the client to know that they matter to the therapist, and the therapist stays open to becoming impacted and vulnerable (Jordan, 2018).

Authenticity

Authenticity exists when one possesses the ability to present one's true perspective, emotions, and experience with others in the relationship. Feeling safe in sharing and trusting others to witness and hold one's self-expression allows for genuineness. Yet, authenticity is not the sharing of oneself without regard to the possible impact on others (Jordan, 2018).

Relational Images

Relational images develop early in life and serve as templates for how people expect to function within relationships and how they expect to be treated. When these images impede healthy engagement, therapists can seek out discrepant relational images to counter the negative images and to serve as reminders of times where the negative relational images were not present (Miller & Stiver, 1997).

Power

People experience power as a relational-societal dynamic in which one experiences either power over or power with. *Power over* dynamics depict a group or person exercising control over another group or person. *Power with*, on the other hand, indicates collaboration and mutual empowerment wherein all parties uplift the other (Jordan, 2018).

Relational Resilience

The founders of RCT define relational resilience as the willingness to attempt engagement with others and to move toward mutual empathy even in the face of adversity (Jordan, 1992). In the relational-cultural view, healthy relational dynamics involve people feeling supported in their vulnerability and feeling safe to state their needs. Working through trauma in supported way leads to an "abiding respect for the power of human connection accompanied by an increasing awareness of our absolute need for the love and support of others …" (Jordan, 1992, p. 7).

Taken together, the abovementioned RCT principles allow therapists to conceptualize their clients from a place of context and mutuality and to focus on providing safety in the therapeutic relationship that serves as fertile ground for modeling connection, empowerment, and forming new and discrepant relational images. The benefits of such a therapeutic relationship becomes even more salient for survivors of trauma.

RCT for Trauma

From feminist and social justice perspectives, RCT examines power dynamics, social location, and the cultural and systemic embeddedness of all people. People exist within and become impacted by relationships and systems. Again, RCT departs from individualistic goals found within feminist therapy and other theoretical orientations. Instead, RCT emphasizes healthy interdependence (not co-dependence) and posits that growth occurs through and toward connection (Miller & Stiver, 1997). Survivors of relational trauma, however, commonly struggle with healthy connection and relational functioning.

When a person experiences a violation perpetrated by another person, especially one that they know well, the betrayal can leave the violated person believing that people in general are unsafe and their relational functioning is impacted (Banks, 2006). Parts of the brain become shaped in a manner that leads to impaired social functioning. Research in neuroscience offers promising and hopeful findings regarding the role of neuroplasticity, which allows for reshaping of the brain through new and corrective experiences (Banks, 2015). These corrective experiences can include positive and healthy relationships, including the therapeutic relationship. The RCT therapeutic relationship is the vessel for change along with the focus on moving one from isolation to connection, unsafe to safe to authentically self-express, and disempowered to empowered. In this way, RCT contributes to co-regulatory goals of sand therapy and to the overarching goals of addressing DSOs associated with CPTSD.

To elucidate this approach, the author offers the following case example based on a composite client, not on one particular client. To date, this author knows of one other conceptual work (see Moon and Comstock, 2024) that proposes a RCT approach for addressing CSA survivors

in sandtray therapy. The authors shed insight into the benefits of using a relational-cultural approach in sandtray therapy, which allowed the counselor and client to understand the five good things in the client's healing process as well as the client's strategies of disconnection. The case below offers practical application for using RCT in sand therapy, specifically with an adolescent survivor who experiences CPTSD.

Case Example: RCT in Sand Therapy with Brenda

Brenda, a 13-year-old girl, outcried to a history of CSA by her grandparent's partner. Teresa, an RCT counselor, receives Brenda's self-report and her caregivers' (i.e., her biological parents) reports of symptoms associated with CPTSD, specifically vacillating between outbursts and dissociative presentation, poor self-concept, and social anxiety. Teresa is a licensed professional counselor and registered play therapist who routinely uses expressive arts and sand therapy in her practice, where she primarily serves survivors of sexual trauma. She believes sand therapy is fitting for Brenda's presenting concerns and would like to offer this treatment option in their initial sessions together.

Trauma-Informed Relational-Cultural Framework

Herman (1992) introduced three stages of recovery for treatment of CPTSD (i.e., safety, remembrance and mourning, and reconnection with life). Later, the International Society for Traumatic Stress Studies (ISTSS) proposed a three-phase approach for counseling those who experience CPTSD: (a) stabilization and strengthening of skills, (b) review and reappraisal of trauma memories, and (c) reintegration into the larger community (Cloitre et al., 2012; Herman, 2015). However, current ISTSS guidelines (2019) do not outright suggest phase-based treatment and instead advocate for a more flexible, individualized approach.

Thus, from a RCT perspective and a relational neuroscientific and trauma-informed lens, the current article proposes RCT treatment goals (adapted from Kress et al., 2017) with the understanding that these are not stepwise phases, but rather overlapping and recursive zones of a child survivors' experiences. For these areas combined with DSO targets, therapists aim to: (a) build sense of safety through focusing on their relational and emotive regulatory functioning within their connections and disconnections; (b) exploring previous or current relational images to move toward one's ability to navigate sense of self or an ability to use one's voice; and (c) model authenticity and convey mutuality, empathy, and power with dynamics in the counseling relationship to mitigate the impact of disturbances in relational-sociocultural contexts on their lives.

Sand Therapy using RCT

Using Homeyer and Sweeney's (2023) transtheoretical six-step model for providing sand therapy, Teresa applies the RCT framework to: (1) prepare the room and herself, (2) select the prompts and introducing the sandtray to the client, (3) facilitate clients' creation in the sandtray, (4) post-creation process with the client, (5) clean up the sandtray and miniatures, and (6) document the sand therapy session.

Preparing the room, Teresa checks that the sandtray is a clean slate in appearance and void of debris or hidden miniatures and/or objects, and then ensures miniatures are accessible and in their proper place. She takes several minutes to prepare herself for her session with Brenda through setting her intention to remain attuned with Brenda's work. As an RCT counselor, Teresa also sets intentions to foster mutuality with Brenda, to show up authentically, and to empower Brenda to fully express her experience as much as she is able.

To complete the second step in the Homeyer and Sweeney (2023) model, Teresa introduces Brenda to the sandtray and the figures. Operating from a RCT approach, Teresa uses invitational language to offer sandtray as an option, to establish informed consent, and to empower Brenda to determine her readiness or comfortability. She explains the purpose and intent of sand therapy sessions. Brenda hesitates and crosses her arms. Teresa acknowledges that Brenda might perceive this form of therapy as strange or childish but demystifies the process by sharing that therapists have used sand therapy across age groups for nearly 100 years, and sand therapy provides a soothing and tactile experience. Teresa offers Brenda to consider raking the sand with her finger or with sand tools, which Brenda begins to do and suppresses a smile.

The prompts focus on safety, authenticity, mutual empathy, empowerment, and an examination of relational connections (e.g., the five good things) as they pertain to surviving CSA and addressing CPTSD symptoms. To begin the initial sand therapy session Teresa provides her with the following prompt: *"Create a scene in the sand showing time or experience when you felt safe in the presence of another person."* Teresa chooses to direct the focus on a "positive relational moment" (Banks, 2015, p. 157), or a time one can recall feeling safe and interpersonally cared for, to orient Brenda into sand therapy and to create safety that would allow an ease into more difficult topics of concern. Brenda engages pensively and utters that she rarely experiences true safety with others. After some thought, she selects figures (people) to represent her cousin, maternal aunt, and best friend.

Subsequent sand therapy session prompts included the converse of these prompts as well (i.e., "Create a scene in the sand that represents relationships or people who feel *the least* safe for you to share your experience.") when Teresa believes they established a level safety conducive to exploring the harder realities of Brenda's experience. For this prompt, Brenda explains that she chooses two people figures to represent her grandparent and the grandparent's partner. She also selects a couch half buried in the sand, a big snake, a small snake, a colorful eel,

and fallen over fences. She imitates the grandparent and the partner criticizing one another and the snakes swarming around the fallen fences, with the eel trailing behind. Brenda repeatedly drops the couch in part or in whole into the sand.

As shown in Table 1, each sample prompt addresses the DSOs (see Cloitre et al., 2012; Herman, 2015) from a RCT perspective.

Table 1
RCT Sand Therapy Prompts Aligned with Goals for children with DSOs

CPTSD DSO symptoms	RCT treatment goals for DSO	Sample RCT Sand Therapy Prompts
Affect dysregulation (e.g., hyper- and hypo-arousal states)	Build sense of safety through focusing on the child's relational and emotive regulatory functioning within connections and disconnections	• *"Create a scene in the sand showing time or experience when you felt safe in the presence of another person."* • *"Create a scene in the sand that shows a time when you felt empowered and heard.* • *"Create a world in the sand choosing figures that shows what it would be like if you felt free to be authentic."*
Issues with identity development (e.g., challenges with self-worth and sense of self)	Explore the child's previous or current relational images to move toward one's ability to navigate sense of self or an ability to use one's voice	• *"Create a scene in the sand showing a time you shared your experiences and felt safe 'using your voice.'"* • *"Select figures that represent how you see yourself/the*

		world/others since disclosing the abuse."
Relational disturbance (e.g., isolation, inability to trust)	Model authenticity and convey mutuality, empathy, and power with dynamics in the counseling relationship with the child to mitigate the impact of disturbances in relational-sociocultural contexts	• *"Choose figures to create a world in the sand that represents relationships or people who feels safest for you to share your experience."* • *"Create a world in the sand choosing figures that represent relationships or people who feel safest for you to disagree or share opposing views."*

In the third step, Brenda creates the sandtray. Teresa remains present and attentive to Brenda and her creation. She notes that Brenda's facial expression mainly conveys a flat effect. During the post-creation processing, Teresa observes the sandtray and asks Brenda to share about her creation. In the first session, Brenda shares about a time when her aunt took her cousin, her best friend, and her to the park after getting milkshakes. Brenda discusses becoming afraid after her cousin pushed her too high on the swings but quickly settled after her aunt slowed her swing to comfortable pace and height before returning to a bench to relax. Teresa evaluates the scene in the sand and makes mental note of themes. Teresa asks Brenda if she anything stands out to her in the sandtray. She invites Brenda to observe the sandtray from various angles and Brenda shared that she noticed that everyone was positioned facing each other and she was the only one facing away from the group.

Across the initial and subsequent sessions, Teresa asks RCT processing questions including: "What does (the main subject of the scene) need to feel connected/safe/seen/heard to (other subjects in the scene)?" "What is going on in the body (of the main subject of the scene)?" "How does this compare with your own body's experience or inner world?" "Who seems in control in this world?" "Who lets you be in charge?" "Who can help?" "How would you have wanted them to respond instead?"

Brenda responded to some of the processing questions in the following ways:

*Teresa: "*Who seems in control in this world?"

Brenda: "My parents do. They are always in charge. Like how they made me go to that house. Every weekend. I begged not to go."

Teresa: "You tried really hard to stay away."

Brenda: "Well it's not like they knew. I was grossed out, embarrassed, and did want to tell. But still!" (*Brenda plays with a bridge miniature in the sand*.)

Teresa: "How would you have wanted them to respond instead?"

Brenda: *(Looks down and away. Tears up and whispers) "*They could have asked me why I hated going instead of thinking I was just being a stubborn or lazy brat. They could have listened to me more. I think I thought my mom would figure it out. Not sure why I thought she would know. Just expected her to know that something was wrong."

*Teresa: "*Your mom didn't know, and you think she might have had the wrong idea about what was going on."

Brenda: "She definitely had the wrong idea. Super wrong."

Teresa: "You wish she would have listened more. Who in your life listens to you?"

Brenda: "My aunt. Always. She listens and understands."

Teresa: "Ah so your aunt gets it. Sounds like she feels safe to you."

Brenda: "Yes! She is. And she's doesn't try to get me to do things I don't want to do. I mean she makes me clean up after myself, do my homework right away when she watches me after school and stuff like that. She just makes it easy for me to be me. Even though I'm kinda messed up after what happened. Did you know that she cried when she found out? I don't know why when I already told her it was just me, not my cousin. It only happened to me."

Teresa: "So she was sad about what you went through. You think she may have been worried about your cousin, too. Like it could have happened to her."

Brenda: "Yeah and this is why I didn't want to say anything. Everyone is sad, everyone is mad. That's my parents doing whatever they want again. They told the police and now I'm here." (*Brenda's face flushes, and she pushed the bridge down hard into the bottom surface of the tray.)*

In processing, Teresa learns that Brenda felt disempowered and let down by her parents. She also learns that Brenda sees herself as "messed up" and not worthy of her aunt's reaction to finding out about the abuse. Teresa sees Brenda struggling to regulate her emotional responses and commits to providing a corrective relational experience through empathy, validation, and moving at a gentle pace.

At the conclusion of each session, Teresa asks Brenda if she would like to title her creation. Sometimes Brenda offers a title and other times she does not. Teresa also obtains consent to take a picture of the sandtray to store in the client file.

After each session ends, Teresa waits until Brenda leaves the session to remove all sandtray figures and to return them to their shelves. She also smooths out the sand out and

double-checks that she retrieved all the figures (i.e., nothing remained buried by mistake). Then, in the last step of Homeyer and Sweeney (2023) process, Teresa documents the details of Brenda's session. From a RCT perspective, Teresa conceptualizes the sessions in terms of prevailing, shifting, desired or undesired RCT relational images, healthy connections/disconnections, presence/absence of *power with* dynamics. Teresa assesses Brenda's progress in the session.

Discussion

The Homeyer and Sweeney (2023) transtheoretical model for implementing sand therapy allows therapists to use sand therapy within their counseling theory of choice. The primary benefit to clients, no matter the theory, remains the commitment to creating safety in sandtray (Perryman et al., 2019). Given the inhibited sense of safety in meaningful relationships, therapists drawing upon RCT will focus treatment on relearning how to build and to recognize healthy relational dynamics in the aftermath of abuse (Haiyasoso & Schuermann, 2018).

The composite case example provided an application of RCT within sand therapy with a teenage survivor. Even in the snapshot of an initial session with a safer prompt, Brenda relayed an isolated way of being with those she revered as members in her support system. Brenda's progress was slow and nonlinear, which is consistent with avoidant coping associated with CPTSD (Hébert et al., 2021). As she dove into the sandtray and allows Teresa and the therapeutic relationship to support her vulnerability, she grew more relationally resilient and aware of her internal processes.

More research is needed for sand therapy with survivors CSA, specifically those who present with CPTSD. Future research can add to the empirical body of literature for sand therapy as well as for the effectiveness of RCT in addressing CPTSD. Through longitudinal studies of survivors' sand therapy sessions and interviews with caregivers and youth, sand therapy can continue to grow and expand in its evidence base.

In the Closing Moments section of their text, Homeyer and Lyles (2022) quote Bonnie Badenoch's (2020) personal communication where she shares that "the tray itself becomes a boundaried sanctuary for what is being allowed into the light while the human witness also provides the safety of presence (p. 210)." Though referencing attachment, this sentiment also captures the essence of the RCT approach to sandtray therapy for child survivors of CSA. When witnessing and remaining present for a child's account of their inner world, therapists create safety in connection.

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