Play Therapy with Traumatized Children

Daniel S. Sweeney, Ph.D.
NW Center for Play Therapy Studies
George Fox University
Physiological, psychological, sociological, spiritual or relational harm caused by external stimuli, usually resulting in internal & external impairment
Sources of Trauma

- Physical Abuse
- Death
- War
- Injury/Illness
- Social Discrimination (e.g., racism)
- Vicarious Trauma (proxy)

- Sexual Abuse
- Natural Disasters
- Divorce
- Neglect
**Trauma = Soul Murder**

*Soul murder*, "the dramatic term for circumstances that eventuate in crime — the deliberate attempt to eradicate or compromise the separate identity of another person . . . sexual abuse, emotional deprivation, physical and mental torture can eventuate in *soul murder* . . . Children are the usual victims. For the child’s almost complete physical and emotional dependence on adults easily makes for possible tyranny and therefore child abuse”

(Shengold, 1989, p. 2).
Factors Affecting the Impact of Trauma

- Severity of the traumatic event
- Developmental level of the client
  - Children are more vulnerable to damage
- Client’s genetic predisposition/resiliency
- The phenomenological experience (perception)
  - Each client’s experience is unique
- Premorbid functioning (trauma history?)
- Quality of family functioning
  - Including caregiver response/reaction
- Attachment history
  - Early adequate nurturance can lessen trauma impact
- Onset of intervention
  - Early intervention prevents strengthening of defenses and coping strategies
Psychic Trauma . . .

- is obviously beyond normal experience
- generates substantial (& often incomprehensible) emotions
- disrupts normal psychological assumptions
- disrupts perception of the past & present
- disrupts expectations about the future
- disrupts preexisting schemas
- disrupts meaning (existential dimension)
# Traumagenic States

*(Beverly James)*

<table>
<thead>
<tr>
<th>Self-Blame</th>
<th>Eroticization</th>
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</thead>
<tbody>
<tr>
<td>Powerlessness</td>
<td>Destructiveness</td>
</tr>
<tr>
<td>Stigmatization</td>
<td>Fragmentation of bodily experience</td>
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<tr>
<td>Loss &amp; Betrayal</td>
<td>Attachment or Dissociative DO</td>
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</tbody>
</table>
### Symptoms

<table>
<thead>
<tr>
<th>Condition</th>
<th>Trait</th>
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</thead>
<tbody>
<tr>
<td>Inability/unwillingness to give &amp; receive affection</td>
<td>Fire setting</td>
</tr>
<tr>
<td>Lack of impulse control</td>
<td>Lack of conscience, guilt, remorse</td>
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<td>Poor eye contact</td>
<td>Blame-shifting</td>
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<tr>
<td>Distorted boundaries with strangers</td>
<td>Excessively clingy &amp; needy</td>
</tr>
<tr>
<td>Excessive anger and aggression</td>
<td>Manipulative</td>
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<tr>
<td>Stealing &amp; lying behavior</td>
<td>Unwillingness to answer simple questions</td>
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<tr>
<td>Self-destructive</td>
<td>Persistent questioning</td>
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<tr>
<td>Destructive towards others, property, animals</td>
<td>Histrionic emotional outbursts</td>
</tr>
<tr>
<td>Stealing /hoarding/binging food</td>
<td>Provocative to/of others</td>
</tr>
<tr>
<td>Poor peer relationships</td>
<td>Toileting problems</td>
</tr>
<tr>
<td>Learning disabilities/disorders</td>
<td>“Psychotic” defense behaviors</td>
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Differential Diagnosis

- Posttraumatic Stress Disorder
- Other Anxiety Disorder
- Adjustment Disorder
- Mood Disorder
- Pervasive Developmental Disorder
- Mental retardation
- Social Phobia
- ADHD
- Oppositional Defiant Disorder
- Conduct Disorder
- Bipolar Disorder
- Reactive Attachment Disorder
- Organic conditions
- Developmental Trauma Disorder
- DESNOS
Issues in Trauma
(van der Kolk, 1996)

- Intrusive reexperiencing
- Autonomic hyperarousal
- Numbing of responsiveness
- Intense emotional reactions
- Learning difficulties
- Memory disturbances & dissociation
- Aggression against self & others
- Psychosomatic reactions
Responses to Trauma
(van der Kolk, 1996)

- Abnormal & heightened response to trauma-specific stimuli
- Abnormal arousal in response to stimuli which is not trauma-related, signifying a loss of stimulus discrimination
Psychobiological Effects of Trauma

- Increased levels of catecholamines (epinephrine & norepinephrine), which results in increased SNS activity
- Decreased corticosteroids & serotonin, which results in the inability to moderate the catecholamine-triggered fight or flight response
- Increased levels of endogenous opioids, resulting in pain analgesia, emotional blunting, & memory impairment
Chronic exposure to stress/trauma affects both acute and chronic adaptation of these chemicals — it permanently alters how an organism deals with its environment on a daily basis.

Endogenous opioids, which inhibit pain & reduce panic, are secreted after prolonged exposure to severe stress. The dissociation and stress-related analgesia experienced by trauma victims may be related to this.

Medications that stimulate ANS arousal may precipitate visual images and affect states associated with prior traumatic experiences.
While people with PTSD tend to deal with their environment by emotional constriction, their bodies continue to react to certain physical and emotional stimuli as if there were a continuing threat of annihilation.

Traumatized people go immediately from stimulus to response without being able to make the intervening psychological assessment of the cause of their arousal, which causes them to overreact and intimidate others.
The limbic system is thought to be the part of the CNS that maintains and guides the emotions & behavior necessary for self-preservation and survival of the species. Trauma appears to cause limbic system abnormalities in the amygdala and hippocampus.

- The amygdala readies the body for action
- Trauma victims essentially get “hi-jacked” by the amygdala
- This happens before the “thinking” part of the brain (i.e., cerebral cortex) can weigh the threat
Amygdala
- Evaluates the emotional meaning of incoming stimuli
- Guides emotional behavior through projections to other areas of brain

Hippocampus
- Categorizes & stores incoming stimuli into memory
- Records in memory the spatial & temporal dimensions of experience
- Early trauma affects maturation of the hippocampus, which makes such children vulnerable to misinterpret sensory input in the direction of danger and threat
The Child’s Brain

- The first three years of life are the prime times for billions of neural connections to be made in the child’s brain.
- The brain of a 3-year-old is 2-½ times as active as that of an adult brain.
- The experiences a child receives between birth & age 3 directly affect the way neural pathways develop in the child’s brain.
- By age 4, a child’s brain is 90% adult size.

(Healy, 1998; Perry, 2002)
Neurobiological effects of trauma

- Clients (including child witnesses) exposed to *marital violence* experience psychobiological responses, including changes in heart rate, blood pressure & salivary cortisol
- Child clients with PTSD often exhibit significantly smaller corpus callosum and frontal lobe volumes, when compared to controls
- Cerebellar volume is decreased with maltreated children & adolescents
  - In fact, the longer the trauma exposure, the smaller the volume
Hyperarousal & Dissociation

Hyperarousal

- Alarm reaction is mediated by the locus coeruleus
- Increased HPA activity
- Despite being away from the threat and original trauma, these parts of the client’s brain are activated again & again – the memories of fear are seared into the client’s neurobiology
Dissociation

- Found particularly in very young children & females
- Client is faced with a traumatic experience & dissociates
- Vagus nerve, the parasympathetic part of the autonomic nervous system, becomes activated, leading to a slowing of the heart rate & a fall in blood pressure
- Possible that as part of the dissociation process, endogenous opiates are activated by stress & alter the perception of the negative stimuli
Brain Plasticity

- Plasticity refers to the way that the brain creates, strengthens, & discards synapses & neuronal pathways in response to the environment.
- This means that the brain is capable of changing in response to experiences, especially repetitive and patterned experiences.
- It is this plasticity of the brain which holds out hope for interventions to ameliorate damage.
Neurobiological effects of trauma

Key points

- For clients who have experienced trauma, abuse or neglect, their brains develop very adaptively to their negative environment – but maladaptively to other environments.

- For children, the developing brain organizes & internalizes information in a use-dependent manner – the more they live in a disorganized state (physiologically & psychologically), the less they are capable of dealing with stress & the more likely their development is disrupted by exposure to trauma.
"Clients who are aroused [from fear] can't take in cognitive information . . . they're too busy watching [the teacher or therapist] for threatening gestures, and not listening to what she's saying” (Bruce Perry, M.D., Ph.D.)

This behavior makes sense, given the constant threats in the client's world. His brain has become exquisitely tuned to emotional and physical cues from other people.

At the same time, he may be failing to develop problem solving and language skills.

Perry has found that in a group of neglected children, the cortex, or thinking part of the brain, is 20 percent smaller on average than in a control group.
Therapy in light of Neurobiological Response

 ✓ In people with PTSD, specific deactivation of the dorsolateral prefrontal cortex (which is responsible for executive function) interferes with the ability to formulate a measured response to the threat. At the same time, high levels of arousal interfere with the adequate functioning of the brain region necessary to put one’s feelings into words: Broca’s area.

 ✓ Traumatized people suffer *speechless terror*. 
“Trauma by definition involves speechless terror: patients often are simply unable to put what they feel into words and are left with intense emotions simply without being able to articulate what is going on.”

(van der Kolk, in Yehuda, 2002)
“Fundamentally, words can’t integrate the disorganized sensations and action patterns that form the core imprint of the trauma”

“To do effective therapy, we need to do things that change the way people regulate these core functions, which probably can’t be done by words and language alone”

(van der Kolk, 2003)
“In a 1996 neuroimaging study using PET scans, we learned that when people relive their traumatic experiences, there is decreased activation of Broca’s area in the brain (related to language) and increased activation of the limbic system in the right hemisphere of the brain. This suggests that when people with PTSD are reliving their trauma, they have great difficulty putting their experiences into words.”
"The stress response is a primitive ingrained part of the human CNS . . . the cortex, where we “think,” is obviously involved, but the key parts of the CNS involved in PTSD are the brain stem and the midbrain. These brain areas mediate the physiological, hyper-reactivity, hypervigilance, anxiety, emotional lability, behavioral impulsivity, and sleep problems of PTSD. No matter how much you talk to someone, the words will not easily get translated into changes in the midbrain or the brain stem” (Perry & Pate, 1994).
Treatment of Trauma

- If therapy focuses directly on the emotionally charged content of the trauma, a client’s basic physiological state may shift.
- This shift may lead to the client essentially being what Perry (2006) calls “brainstem-driven”.
- The resultant anxiety – not to mention the possible diminished functioning of the Broca’s area – leads clients to act in a primitive manner.
- This renders the language of therapy less accessible, or perhaps useless.
Neurobiology of trauma and trauma treatment?

Simply stated, traumatic & neglectful experiences ... cause abnormal organization & function of important neural systems in the brain, compromising the functional capacities mediated by these systems ... Matching the correct therapeutic activities to the specific developmental stage and physiological needs of a maltreated or traumatized (client) is the key to success.  

(Perry, 2006)
Therapy in light of Neurobiological Response

“It is the ‘relationship’ which enables access to parts of the brain involved in social affiliation, attachment, arousal, affect, anxiety regulation and physiological hyper-reactivity. Therefore, the elements of therapy which induce positive changes will be the relationship and the ability of the (client) to re-experience traumatic events in the context of a safe and supportive relationship.”

(Perry & Pate)
Treatment of Trauma should be multi-dimensional

- Education about trauma
- Social support
- Parent training
- Psychoeducational interventions
- Psychotherapy (individual, family, & group)
- Pharmacotherapy
- Holistic adjuncts (physical activity, nutrition, spirituality, humor)
Trauma Interventions

- Respite care
- Filial therapy
- Play therapy
- Behavior management
- Pharmacotherapy
- Sandtray therapy
- Art therapy
- Massage therapy
- Cognitive therapy
- Drama therapy
- Psychoeducational training
- Group therapy
- Other expressive therapies
- Animal-assisted therapy
- Music therapy
- Sensory integration (OTR)
- EMDR
Sensory Nature of Trauma

- All trauma is sensory in nature – or at least has a large sensory component.
- The diagnostic criteria for PTSD is sensory in nature
  - Persistent re-experiencing of traumatic event
  - Avoidance of cues associated with trauma
  - Persistent physiological hyper-reactivity or arousal
- Perhaps – trauma treatment should be sensory in nature (play & sandtray therapy?)
**Traumatized Children’s Play**

- In play, children can slowly assimilate traumatic experiences by reliving them with appropriate release of affect.
- Children deal with stress and traumas by playing out similar situations and gradually achieving mastery over them.
- In play, the children is in control of the events and there is less anxiety because it is just pretend.
Characteristics of Posttraumatic Play

- Carrying power to nontraumatized children
- Possibility of therapeutically retracing posttraumatic play to an earlier trauma
- Can be dangerous, since prolonged posttraumatic play may create more terror than was consciously there when the play started
Play of Traumatized Children

Reenactment vs. Retraumatizing

**Reenactment Play**
- Leads to mastery
- Child feels free to express emotion
- Child feels in control
- Satisfactory conclusion

**Retraumatizing Play**
- Fails to provide resolution
- Creates rather than relieves anxiety
- Magnifies feelings of helplessness
- Should be interrupted
Expressive Therapies with Traumatized Children
(Schaefer, 1994)

- **symbolization** – children can use the media (e.g., a predatory animal puppet, sandtray miniature, etc.) to represent an abuser

- **"as if" quality** – children can use the pretend quality of expressive therapy (e.g., drama) play to act out events as if they are not real life

- **projection** – children can project intense emotions onto the media (clay, puppets, etc.), which/who can then safely act out these feelings

- **displacement** – children can displace negative feelings onto the media (sand, dolls, etc.) rather than expressing them toward family members
What Traumatized Children Learn thru Expressive Therapies

- Learn that the world can be safe, consistent & predictable
- Learn that feelings (both positive & negative) are acceptable
- Develop the capacity to trust and attach with other persons.
- Learn to be creative & resourceful in confronting problems
- Develop a greater capacity to cope
- Experience behaviors and feelings of control/mastery
- Develop an internal source of evaluation
- Learn to be more self-directed, responsible & autonomous
- Develop an enhanced sense of self & become more self-accepting

(adapted from Landreth, 2002)
What is Play Therapy?

... a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child (or person of any age) to fully express and explore self (feelings, thoughts, experiences, and behaviors) through the child’s natural medium of communication, play. (Landreth, 2002)
Why Play Therapy?

1. Adult therapy presupposes the ability to engage verbally, cognitively, and process abstract concepts.
2. Children are developmentally different than adults, and do not communicate the same way adults do.
3. Play is the child’s natural medium of communication.
Why Play Therapy?

1. This is true for the verbally precocious child as well.
2. Empathy (entering the client’s world) with children involves entering their world of communication – play.
3. Play therapy provides a place for the child to experience control.
Why Play Therapy?

1. The play therapy process serves to create a therapeutic distance for children, thus providing a safe place for abreaction to occur.

2. Play therapy is uniquely kinesthetic.

3. The play therapy process provides boundaries and limits, which promotes safety for the child.
Why Play Therapy?

1. Play therapy provides a needed and effective communication medium for the child with poor verbal skills.
2. Conversely, play therapy cuts through verbalization used as a defense.
3. The challenge of transference may be effectively addressed through play therapy.
Why Play Therapy?

1. Deeper intrapsychic issues may be accessed more thoroughly and more rapidly through play therapy.
Play Therapy Rules – Don’t

- Don’t criticize any behavior.
- Don’t praise the child.
- Don’t ask leading questions.
- Don’t allow interruptions of the session.
- Don’t offer information or teach.
- Don’t preach.
- Don’t initiate new activities.
- Don’t be passive or quiet. (Landreth, 2002)
Praise vs. Encouragement

**PRAISE** is primarily given to children when they do a task well and usually involves an evaluative response. Because of this, children can learn to not trust in their own ability to evaluate and learn to depend on other's evaluations of them. Children can easily misinterpret their value as persons, their "goodness" or "badness", according to the amount of praise statements received or not received. The child can come to believe: "Only when I receive praise am I a valuable person, and if I don't receive praise that must mean I am not valuable."
ENCOURAGEMENT implies faith in the child as he is, not in his potentiality. The emphasis is on the child's actions, not on the child's worth. Encouraging statements build on the positiveness of the action and the effort — and can always be given; when a child attempts a task, fails at a task, or accomplishes a task. A child needs encouragement as a plant needs water.
Play Therapy Rules – *Do*

- Do set the stage.
- Do let the child lead.
- Do track behavior.
- Do reflect the child's feelings.
- Do set limits.
- Do salute the child's power and effort.
- Do join in the play as a follower.
- Do be verbally active. *(Landreth, 2002)*
Therapists/Adults should communicate to children . . .

- I’m here
- I hear you
- I understand
- I care
Therapeutic Responses

- Are brief and interactive
- Allow child to lead
- Are personalized
  - Avoid: “David really likes hitting that Bobo.”
  - Use: “You really like hitting that Bobo.”
- Touch feeling (match child’s affective level)
Other characteristics of therapeutic responses

- Avoid asking questions
- Help child to go on – do not interrupt natural flow of child’s play
- Are nonevaluative
- Do not praise!
- Build self-esteem
**Evaluation and Praise**

**Child:** (Child finds a comb and combs the hair of two dolls.)

**Therapist:** You’re making them so pretty. (Since children want to please, child may continue the activity to get more praise.)

**Suggested:** You know just how to comb her hair. (Reflects child’s ability rather than making a judgment as to how the results turn out.)
**Evaluation and Praise**

**Child:** I made an airplane. (She then flies the airplane around the room.)

**Therapist:** Oh, you made an airplane! That’s a nice looking airplane. (Therapist excitement exceeds child’s level of feeling. Value judgment.)

**Suggested:** And you can make it fly around. (Avoids simple word reflection and gives child credit.)
Facilitative Responses

- Was the response freeing to the child?
- Did the response facilitate decision making or responsibility?
- Was spontaneity or creativity facilitated?
- Did the child feel understood?

(G. Landreth)
Tracking

- follows, or tracks, with eyes & words
- occurs from the therapist’s chair
- labels child’s feelings
- identifies child’s behavior; goal of misbehavior
- accepts feelings, regardless of actions
- responds to child’s meaning
Facilitative Responses

- tracking behavior
  - “now you’re pouring sand...”
- reflecting feelings
  - “you’re really mad at the alligator...”
- reflecting content
  - “those two are fighting...”
- esteem building / encouragement / focusing on strengths
  - “you decided... you’ve got a plan...”
Facilitative Responses

- conveying understanding
  - "You’re cooking."

- freeing the child
  - "In here, you can spell it anyway you’d like to."

- setting limits
  - ACT limit setting model
Facilitative Responses

- facilitating decision making & responsibility
  - “In here, you can decide.”
- facilitating spontaneity & creativity
  - “It can be whatever you’d like it to be.”
- enlarging the meaning
  - “It can be scary to be all alone.”
Therapeutic Limits

Purpose & Function

- Limits define the boundaries of the relationship.
- Limits protect the child, the therapist, and the play therapy room/materials.
- Limits promote security and safety for the child — both physically and emotionally.

consistency ➔ predictability ➔ security

- Limits demonstrate the therapist's intent to provide safety for the child.
Therapeutic Limits
Purpose & Function

- Limits anchor the session to reality.
- Limits promote therapist’s acceptance (maintaining a positive attitude toward the child).
- Limits allow the child to express negative feelings without causing harm and the subsequent fear of retaliation.
- Limits direct catharsis into symbolic channels.
Therapeutic Limits

Purpose & Function

- Limits promote the child's development of:
  - Decision-making skills
  - Self-control
  - Self-responsibility
- Limits protect the child from guilt.
- Limits provide for the maintenance of legal, ethical, and professional standards.
Harmful behavior
- The child should not harm self
- The therapist is not to be harmed
- Other children are not to be harmed

Behavior disruptive to therapy routine
- Leaving the playroom before end of session
- Refusing to leave the playroom at end of session
Therapeutic Limits
What to Limit

➢ Play therapy materials
  ▪ Toys belong in the playroom
  ▪ Toys are not to be deliberately broken
Therapeutic Limits
When to Limit

- When needed

- Immediately prior to action requiring a limit
Therapeutic Limits
How to Limit – ACT

- A - Acknowledge the child's feelings, wishes, and wants
- C - Communicate the limit
- T - Target acceptable alternatives

(Landreth, 2002)
**Therapeutic Limits**
How to Limit – ACT

A - **Acknowledge** the child's feelings, wishes, and wants

C - **Communicate** the limit

T - **Target** acceptable alternatives

*I know you’d like to shoot me, but I’m not for shooting, the bop bag is for shooting.*
The “ultimate” limit
- only if ACT doesn’t work
- add the consequence

“I know you’re mad and you want to shoot me, but I’m not for shooting, the bop bag is for shooting. **If you choose to shoot me again, then you choose not to play with the dart gun anymore today.**”
Summary – Therapeutic Responses

- Avoid questions
- Be succinct
- Track behavior
- Reflect feelings (Match the child’s affective level)
- Facilitate decision-making
- Encourage – don’t praise
- Set limits when needed
Stages of Therapeutic Process

(Norton, 1997)
Assessing progress & determining readiness for termination

(Landreth, 2002)

- Look for firsts
  - e.g., first session where limits have been set/not set, proximity to therapist

- Note the development of themes
  - a theme is the recurrence of events/topics in children’s play within a session or across sessions
Assessing progress & determining readiness for termination

(Sweeney, 1997)

Indicators should be seen both inside & outside of the playroom. We should expect to see increased levels of independence in therapy and at home and school. We should also expect changes that are more global and generalized in the life of the child, including:

2. Increased ability to problem-solve
3. Increased verbalization [although this should not be an agenda for the therapist]
Assessing progress & determining readiness for termination

(Sweeney, 1997)

1. Greater willingness to experiment and explore
2. Increase in self-worth and self-confidence, and corresponding decrease in shame and self-deprecation
3. Decreased anxiety and depression
4. Increased ability to organize and order things, and corresponding decrease in chaotic thinking and behavior
Assessing progress & determining readiness for termination

(Sweeney, 1997)

1. Increased ability to express emotions and tolerate other people’s expression of emotions
2. Decreased aggression
3. Decreased fear of confrontation, and corresponding increased willingness to negotiate
4. Increased willingness to give and receive nurture
Assessing progress & determining readiness for termination

(Sweeney, 1997)

1. Increased tolerance of frustration
2. Increased willingness to seek assistance
3. Increased ability to make decisions
4. Changes in creative expression, including stories, artwork, etc.
When there is a lack of concrete observable change in children’s playroom behavior, the therapist may experience doubt about self as a therapist, begin to lose faith in the process & decide that a more directive approach is needed. What the therapist needs to be aware of is that this is usually a move to meet the therapist’s own needs to feel more adequate & is not really an attempt to meet children’s needs. The responsibility of children in play therapy does not include satisfying the therapist’s schedule for change in behavior.
Sandtray therapy is an expressive and projective mode of psychotherapy involving the unfolding and processing of intra- and interpersonal issues through the use of specific sandtray materials as a nonverbal medium of communication, led by the client(s) and facilitated by a trained therapist.

(Homeyer & Sweeney, 1998)
Tools of the sandtray therapist

- **Sand & water** – basic elements of the earth
- **Tray** – in which to contain the work
- **Collection of miniatures** – serve as a universe of symbols and images

(Homeyer & Sweeney, 2005)
History

➤ H.G. Wells – *Floor Games*

➤ Margaret Lowenfeld – *The World Technique*

➤ Dora Kalff – *Sandplay*

➤ Violet Oaklander – *Gestalt*

➤ Gisela DeDomenico – *Sandtray-Worldplay*
Advantages of Sandtray

➤ No artistic talent needed
➤ Can be completely nonverbal
➤ Appeals to children, adolescents, adults
➤ With families it is a truly inclusive experience
➤ With groups it is engaging
Why Use Sandtray?

➤ Provides a needed and effective communication medium for clients with poor verbal skills / development
➤ Cuts through verbalization used as a defense
➤ Gives expression to non-verbalized emotional issues
➤ Is effective in overcoming client resistance
Why Use Sandtray?

- Has a unique kinesthetic quality
- Deeper intrapsychic issues may be more accessed more thoroughly and rapidly
- Naturally provides boundaries and limits
- Serves to create necessary therapeutic distance for clients
Why Use Sandtray?

➤ Provides unique setting for emergence of therapeutic metaphors

➤ Helps deal with issues of transference

➤ Creates a place for the individual, couple, family, group clients to experience control
When to use the sand tray technique

➤ An introduction to counseling
➤ A change of pace
➤ Individual
➤ Dyads
➤ Group sessions
➤ Family sessions
➤ To address specific presenting issues, or developing issues in group process
Materials needed

➤ Sand tray
➤ Miniatures
➤ Water
➤ Sand
Sand

- Playground sand
- Should be sterilized
- Not too coarse or too fine
- Color
- Alternatives
Sand tray

- Standard size - 30” X 20” X 3”
- Blue inside
- 1 - wet, 1 - dry, or
- 1, with limited use of water
- Round, square, octagonal
- Placement
Typically, for therapy, 300 +
- Larger collection needed for group sandtray
- Don’t have to be in scale
- Representative of your client’s world
  - Regionally/culturally sensitive
Miniature Categories

- People
- Animals
- Vegetation
- Buildings
- Vehicles
- Fences, signs
- Natural items
- Fantasy
- Cartoon - movie
- Spiritual - mystical
- Landscaping
- Household items
Arrangements of Miniatures

➤ shelves or boxes
➤ grouped in categories
➤ non-chaotic
➤ portable?
Conducting a Session

- Room preparation
- Introduction to the client(s)
- Creation of the tray
- Post-creation
- Sandtray clean-up
- Documenting the session
Room preparation

- Ensure that sandtray(s) & miniatures are in place
- Check that sandtray has no buried miniatures from a previous session
- Sand should be generally flat & somewhat smooth
- Arrange furniture for easy access to sandtray
- Therapist should sit in a nonintrusive place
“Look at the shelves until you find something that speaks to you and put it in the tray. Add to it as you wish. Tell me when you’re done.”
What to say: Directive

- Consistent with therapeutic issue
- Purpose for doing the sandtray

“Make a scene in the sand that shows what it’s been like after the divorce. Tell me when you’re done.”
What does the therapist do?

- Observe the process of the making of the scene
- Provide a “free & protected space”
- Honor the process and the product
Provide free & protected space

➤ Temenos
  ▪ Boundary between the sacred & profane
➤ Listens
➤ Observes
➤ Participates empathically & cognitively
➤ As little verbalization as possible
➤ Active sharing the act of creation
Honors process & product

➤ Validates client perspective - reality

➤ Client(s) are always communicating

➤ “Entering” the sandtray with the client(s)

➤ Silent capacity to enter into the creation of the client’s world ... repair isolation
Important to remember...

➤ My learning is never complete
➤ It is the client’s experience of the process that heals, not my understanding of that process.
Observe the process

➤ Easily - difficult
➤ Determined - hesitant
➤ Involved - uninvolved
➤ Internally - externally driven
➤ Purposefully - non-purposeful
➤ Planful - constructs as it happens
The tray is done ... now what?

- **Visually** observe the world
- **Emotionally** observe the world
- **Evaluate** organization of the tray
- **Identify** the **theme** of the content

**Two basic options** ...

- Allowing the creative process to stand alone
- Using sandtray as a springboard for discussion
Next, process

➤ Ask the client to name or title the tray

➤ Invite the client to tell

- you a story about the scene
- what’s going on in the scene
- what happened just before this scene
- what happens after this scene
- is (not “where is”) the client in the scene
- what (not “who”) has the most power in the scene
Session is over

➤ Take a picture of the tray

➤ Return miniatures to the shelves (after client has left)

➤ Note title, story, content of processing, your clinical insights
Stages in sandtray therapy (Allan, 1988)

- Chaos
- Struggle
- Resolution
Assessing progress

Indicators should be seen both inside and outside of the sandtray room. We should expect to see increased levels of independence in therapy and at home/work/school. We should also expect changes that are more global and generalized in the life of the client.
Assessing progress

➤ Does the sandtray reflect less dependence & more autonomy?

➤ Is there an increase in the amount and quality of verbalization in therapy?

➤ Is there evidence that the client is developing greater insight & an internal sense of self-evaluation?
Assessing progress

➤ Are the miniatures placed with a greater degree of deliberation and order?

➤ Can the client more readily identify self, others, themes & metaphors in the sandtray?

➤ Is the client’s affective response to the sandtray more predictable & congruent?
Assessing progress

- Is the therapist’s affective response to the client’s tray reasonable & congruent with the client?

- Is there an absence of or minimal use of buried objects in the sand?

- Are barriers (e.g., fences, walls, etc.) used appropriately [reflection of healthy, as opposed to rigid or diffuse boundaries]?
“Pain Getting Better” Technique
(adapted from Joyce Mills, 1986)

Three sand trays

1. Make a tray of the “pain”

3. Make a tray of the “pain getting better”

5. Make a tray of what would help the first tray change to the second
Other “Directive” Techniques

- Miracle question
- Kinetic family sandtray
- Giving “voice” to the miniatures
- Make a tray of what you’re “good at”
- Pick a miniature to represent ___________ (feeling, person, self, school, job, etc.)
- REBT?


Thank you!

Daniel S. Sweeney, Ph.D., LPC, LMFT, RPT-S
Director, NW Center for Play Therapy Studies
Graduate Department of Counseling
George Fox University
12753 S.W. 68th Avenue
Portland, Oregon 97223
dsweeney@georgefox.edu
www.nwplaytherapy.org