FAMILY SANDPLAY THERAPY

BY

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FAMILY PLAY THERAPY HAS BEEN IN EXISTENCE FOR MANY YEARS BUT HAS BEEN SUBSUMED UNDER THE RUBIC OF EITHER FAMILY THERAPY OR PLAY THERAPY. PUPPETRY, ART THERAPY, SANDPLAY, FAMILY THERAPY, AND PLAY THERAPY HAVE ALL BEEN PRACTICED SINCE AT LEAST THE 1920'S WHICH IS DISCUSSED IN MY BOOK (CO-EDITED WITH CHARLES SCHAEFER, PH.D.) **FAMILY PLAY THERAPY**, 1994. THIS BOOK COVERS A BROAD SPECTRUM OF FAMILY THEORETICAL BASES SUCH AS OBJECT RELATIONS, PSYCHODYNAMIC, BEHAVIORAL AND INTEGRATIVE. SPECIALIZED TECHNIQUES SUCH AS FAMILY ART, FAMILY SANDPLAY, PSYCHODRAMA, AND PUPPETRY ARE INCLUDED IN THE BOOK.

SANDPLAY, ONE OF THE TECHNIQUES DISCUSSED THEREIN, CAN BE USED IN MANY WAYS AND HAS BEEN EXPANDING EXPONENTIALLY IN RECENT YEARS. IT BEGAN WITH MARGARET LOWENFELD'S WORK IN ENGLAND IN THE '20'S AND LATER WAS INCORPORATED INTO DORA KALEF'S JUNGIAN WORK IN SWITZERLAND. THE LIMITATIONS OF THE JUNGIAN METHOD, HOWEVER, PRECLUDE ANY EXPERIMENTATION OF OTHER FORMS OF THIS VALUABLE TECHNIQUE.

THE RATIONALE FOR COMBINING FAMILY THERAPY, PLAY THERAPY AND SANDPLAY INTO A SINGLE MODALITY, THAT OF FAMILY SANDPLAY THERAPY, IS AS FOLLOWS:

1 THIS TECHNIQUE IS DESIGNED TO INCLUDE EVEN THE YOUNGEST MEMBER OF A FAMILY IN THE PROCESS. IN FAR TOO MANY INSTANCES IN THE PAST, AND CONTINUING STILL TODAY, TRADITIONAL FAMILY THERAPY HAS EXCLUDED CHILDREN UNDER 10 OR 12 YEARS OF AGE WITH THE RATIONALE THAT THEY WOULD BE "DISRUPTIVE", "WOULDN'T UNDERSTAND" AND WOULD BE EXPOSED TO PARENTAL CONFLICTS. THIS ATTITUDE SUGGESTS THAT THE CHILDREN SPEND FAMILY LIFE WITH BLINDERS AND EAR MUFFS ON INSTEAD OF BEING FULLY ATTUNED TO ALL THE STRENGTHS AND WEAKNESSES IN THEIR FAMILIES.

IN FAMILY SANDPLAY THERAPY, ONE SEES THAT RESISTANCE IS LOWERED SINCE ALL THE ADULTS (INCLUDING THE THERAPIST) DEMONSTRATE THEIR WILLINGNESS TO MEET THE CHILD ON HIS/HER LEVEL, THROUGH THE MEDIUM OF PLAY. THIS IS EXPLICITLY ILLUSTRATED BY THE MERE FACT OF HAVING THE SESSION IN THE SANDPLAY ROOM RATHER THAN IN A MORE FORMAL OFFICE SETTING. THIS IS DISCUSSED BY ORGUN IN **FAMILY PLAY THERAPY** (PP. 49-55) IT SEEMS AS IF EVERYONE IS MORE RELAXED IN THIS ATMOSPHERE—PARENTS, CHILDREN, AND THERAPIST.

3 THE CHILD IS TAKEN OUT OF THE MUCH-HATED IDENTIFIED PATIENT ROLE WHEN ONE FOCUSES ON THE FAMILY INTERACTIONS RATHER THAN FOCUSING ON THE CHILD'S PROBLEMS PER SE. MOST CHILDREN ARE THE SPOKESPERSONS FOR FAMILY DYNAMICS AND KNOW INTUITIVELY THAT THEIR PROBLEMS ARE REALLY REFLECTIONS OF SOME DISTURBING THINGS IN THEIR ENVIRONMENT.

4 PARENTS CAN BE HELPED IMMEASURABLY TO STAY CONNECTED TO THEIR OWN "INNER CHILD" AND TO RELATE TO THEIR CHILDREN FROM THAT PLACE RATHER THAN FROM A STRICTLY AUTHORITARIAN POSITION. THIS IS NOT MEANT TO IMPLY THAT NECESSARY DISCIPLINE AND STRUCTURE ARE OMITTED OR OVERLOOKED. THE THERAPIST, IN THIS SETTING, CAN ASSIST THE FAMILY TO FIND NEW METHODS OF FAMILY COOPERATION SO THAT SEVERE DISCIPLINARY MEASURES ARE NO LONGER NEEDED. HOWEVER, WITH SOME OVERLY RIGID, CONSTRICTED FAMILIES THIS CAN TAKE MUCH LONGER THAN WITH MORE FLUID FAMILY SYSTEMS.

5 PARENTS CAN SEE FOR THEMSELVES WHAT SANDPLAY THERAPY IS ALL ABOUT AND LEARN TO VALUE THIS MODALITY AS A DIFFERENT WAY TO RESOLVE PROBLEMS. THIS NON-VERBAL, METAPHORICAL NATURE OF THE INTERACTIONS CAN OFTEN BE EASIER FOR THE ADULTS AND THE CHILDREN TO UNDERSTAND THAN WHEN VERBALIZATION IS THE MAJOR FORM OF COMMUNICATION.

6 TRANSFERENCE AND COUNTER- TRANSFERENCE ISSUES ARE SOMETIMES LESSENED BECAUSE OF THE ACTUAL PARENTS, OR OTHER CARETAKERS, BEING PRESENT. THIS CAN, OF COURSE, BE QUITE COMPLEX DEPENDING ON THE RELATIVE HEALTH (OR PATHOLOGY) THAT EXISTS IN THE PARENTAL/CARETAKING SYSTEM.

7 THE THERAPIST ALSO BENEFITS WHEN PLAY IS INCLUDED AS PART OF THERAPY, ALTHOUGH IT DOES REQUIRE STRONG MOTIVATION THAT CAN TAX ONE'S CREATIVITY TO THE UTMOST. THIS DOES NOT INFER THAT ONE IS SIMPLY "PLAYING", BUT THAT CAREFULLY THOUGHT OUT STRATEGIES, BASED ON SOLID THEORETICAL UNDERSTANDINGS, CAN ENHANCE AND BROADEN ONE'S REPERTOIRE IMMEASURABLY.

8 TIME-LIMITED THERAPY IS A DEFINITE POSSIBILITY WITH STRUCTURED FAMILY SANDPLAY THERAPY GOALS. FOR EXAMPLE, HELEN LANDGARTEN IN HER REFERENCED BOOK (PP. 221-233) HAS OUTLINED HER WAY OF RAPIDLY EVALUATING FAMILY DYNAMICS THROUGH FAMILY ART PSYCHOTHERAPY. MANY THERAPISTS CAN USE THESE TECHNIQUES

EVEN WITHOUT FORMAL ART THERAPY TRAINING. HOWEVER, SOME STUDY RELATED TO ART THERAPY IS DEFINITELY AN ASSET.

9 ONE CAN LEARN A GREAT DEAL FROM OBSERVING THE NON-VERBAL ASPECTS OF FAMILY SANDPLAY THERAPY WHICH IS CLEARLY RELATED TO MORE TRADITIONAL FAMILY THERAPY OBSERVATIONS. DISTANCE AND CLOSENESS CAN IMMEDIATELY BE SEEN AS WELL AS WHICH SUB-SYSTEMS ARE IN EXISTENCE. POWER ISSUES ARE OFTEN REVEALED NON-VERBALLY AS ARE SCRAPEGOATING AND PARENTIFICATION. THESE ISSUES WILL, OF COURSE, BE REVEALED IN VERBAL THERAPY, BUT OFTEN WILL TAKE MUCH LONGER TO BE OBSERVED. BY ILLUSTRATING NON-VERBAL MESSAGES TO THE FAMILIES AS THE THERAPIST OBSERVES THEM, THIS QUICKLY EFFECTS A REALIGNMENT OF ROLES.

FAMILY SANDPLAY THERAPY INCORPORATES SEVERAL OF THE CREATIVE ARTS MODALITIES SUCH AS ART, DRAMA AND SANDPLAY, ALL OF WHICH CAN BE INCORPORATED INTO A FAMILY SYSTEMS FRAMEWORK.

I PERSONALLY USE A CHILD-CENTERED APPROACH WHICH INVOLVES AN OVERALL FAMILY ASSESSMENT, FOLLOWED BY AN ASSESSMENT OF THE IDENTIFIED PATIENT. THEN I OFFER MY RECOMMENDATIONS TO THE FAMILY AS TO WHAT SEEMS TO BE THE MOST DESIRABLE TREATMENT MODALITY. AT TIMES, THE DECISION IS TO IMPLEMENT FULL-FAMILY THERAPY RIGHT FROM THE START. AT OTHER TIMES, THE DECISION IS TO BUILD A WORKING RELATIONSHIP WITH THE IDENTIFIED PATIENT WITH MOVEMENT TOWARDS INCLUDING OTHER FAMILY MEMBERS AT APPROPRIATE, WELL-DESIGNATED TIMES. EACH CASE IS UNIQUE AND EACH RECOMMENDATION IS FULLY ASSESSED BEFORE A THERAPEUTIC DECISION IS MADE.

AS PART OF MY CONTINUING WORK WITH A FAMILY SANDPLAY THERAPY MODALITY, I ONCE TREATED A FAMILY WHOSE 15 YEAR OLD DAUGHTER WAS IN A HOSPITAL BECAUSE OF ALCOHOL OVERDOSE. (THIS CASE IS FULLY DESCRIBED IN MY NEW BOOK, **SANDPLAY THERAPY WITH CHILDREN AND FAMILIES**, ARONSON, 1999. I WAS ASKED TO SEE THE FAMILY BEFORE THEIR DAUGHTER WAS RELEASED FROM THE HOSPITAL. THE DAUGHTER HAD BEEN TAKEN FROM THE EMERGENCY ROOM OF A LOCAL HOSPITAL DIRECTLY TO AN INPATIENT UNIT THAT SPECIALIZED IN TEENAGE DRUG AND ALCOHOL ABUSE. THE SITUATION WAS DIAGNOSED BY THE ATTENDING PHYSICIAN AS A SUICIDE ATTEMPT. PSYCHOLOGICAL TESTING WAS ADMINISTERED WHILE SHE WAS HOSPITALIZED AND SHE WAS DIAGNOSED WITH CONDUCT DISORDER (312.8) AND OPPOSITIONAL DISORDER (313.81). (DSM-IV, 1994, PP. 85-94) THE PARENTS ALSO LEARNED THAT SHE HAD BEN INDUCING VOMITING FOR SEVERAL MONTHS.

THE FAMILY CONSISTED OF MOM, DAD, THE HOSPITALIZED GIRL, A BOY OF 11, AND ANOTHER BOY OF 9 ½. THE 11 YEAR OLD BOY WAS AN EXTREMELY ANGRY CHILD. HIS ANGER SPILLED OVER INTO VIOLENT OUTBURSTS WHEN HE WOULD ATTACK ANYTHING AND ANYONE THAT GOT IN HIS WAY. HE WAS DESCRIBED AS "UNBEARABLE" BY HIS PARENTS AND HE HAD PROBLEMS WITH FRIENDS AND TEACHERS AS WELL. THE THIRD CHILD, AGED 9 ½, WAS DIAGNOSED WITH ATTENTION DEFICIT HYPERACTIVE DISORDER (IBID., PP 78-85), AND HAD BEEN MEDICATED WITH RITALIN FOR THE PRECEDING TWO YEARS. HE WAS IN A SELF-CONTAINED CLASSROOM IN HIS SCHOOL. BOTH BOYS HAD BEN VERY UPSET OVER THEIR SISTER'S HOSPITALIZATION. IN THIS ARTICLE, I WILL EXCERPT THE FAMILY WORK THAT WAS ACCOMPLISHED WITH ART AND SANDPLAY.

AT THE TIME OF THE FIRST FAMILY SESSION, THE TEEN-AGER WAS STILL IN THE HOSPITAL AND THE PARENTS HAD NO IDEA HOW LONG SHE MIGHT BE THERE. THE BOYS ACCOMPANIED THEIR PARENTS TO THIS SESSION, BUT WERE QUITE RESTLESS. IN ORDER TO LESSEN THE TENSION LEVEL, I SUGGESTED THAT PERHAPS EVERYONE COULD DRAW A PICTURE OF THE FAMILY DOING SOMETHING. THEY WERE QUITE AGREEABLE TO THIS SUGGESTION, EXCEPT FOR THE YOUNGEST, WHO CLUNG TO HIS MOTHER AND REFUSED TO DRAW. AT THE LAST MOMENT HE ADDED THE FAMILY CAT TO MOM'S DRAWING. AFTER EVERYONE HAD COMPLETED THEIR PICTURE, I SAID THAT THEY COULD SHARE THE PICTURES WITH ONE ANOTHER.

THE OLDER BOY BECAME ENRAGED AT THIS SUGGESTION AND FURIOUSLY ERASED PART OF HIS DRAWING (FIG. 1) EARLIER IN THE SESSION HE HAD ASKED IF WE COULD ALL GO INTO THE SANDPLAY ROOM, AND I TOLD THEM THAT WE COULD DO THAT AFTER THE PICTURES HAD BEEN SHARED. HIS PICTURE IS DIFFICULT TO DECIPHER BECAUSE OF THE ERASURES, BUT ONE CAN SENSE THE FRENZY AND ANXIETY THAT PERVADES IT.

FIGURE 2 WAS MADE BY MOM. IT IS INTERESTING TO SEE HOW SHE HAS PLACED THE FIGURES. EACH ONE IS SEPARATED FROM THE OTHER, AND EACH CHILD IS INVOLVED IN HIS/HER OWN INTERESTS. MOM IS AT THE BOTTOM OF THE PAGE, AS IF SHE WERE CARRYING THE WHOLE LOAD WHILE GOING OFF TO WORK. AS MENTIONED, THE YOUNGER SON ADDED THE CAT AT THE LAST MINUTE.

DAD'S PICTURE (FIG. 3) IS SOMEWHAT UNUSUAL. EVERYONE HAS AN IDENTICAL GRIN ON THEIR FACE. NONE OF THE FIGURES HAS HANDS, FEET, OR CLOTHES, AND ALL ARE SUSPENDED ABOVE GROUND. I COMMENTED ABOUT HOW THE FAMILY MEMBERS ALL HAD TO KEEP SMILES ON THEIR FACES, NO MATTER HOW SERIOUS THINGS IN THE FAMILY WERE. I WAS ALLUDING TO THE FACT THAT ONE OF THEIR MEMBERS WAS IN THE HOSPITAL. MY UNSPOKEN INTERPRETATION OF THIS PICTURE WAS THAT NO ONE IN THE FAMILY WAS GROUNDED (BECAUSE OF THE PLACEMENT OF THE FIGURES ABOVE THE GROUND LINE); ALL WERE