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# SANDTRAY THERAPY FOR INPATIENT SEXUAL ADDICTION TREATMENT: AN APPLICATION OF CONSTRUCTIVIST CHANGE PRINCIPLES

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*A model of sandtray therapy, specifically designed as an adjunct intervention for a trauma-based inpatient treatment program for sexual addiction, is described using clinical illustrations. Constructivist theoretical assumptions provide the rationale for both the model and the principles of change. The process of meaning-making and reconstructing one's inner world and sense of self are foundational in trauma resolution and may be facilitated through the use of sandtray intervention.*

Sand is a reminder of history. Geology reminds us that a

> grain was produced by forces that made the rock it was eroded from, by the Earth's surface environment that eroded it from its parent and carried it to a resting place, and by the internal deformation of the Earth's crust that buried it (Siever, 1998, p. 1).

People have had much the same experience. Many forces have come to bear on every person, some from the family of origin, some from other socio-environmental factors, and some from crisis and trauma. The "internal deformation" of a grain of sand speaks metaphorically of the intrapsychic pain that many of our clients bring to us. Sand is a product of its history, and so are we (Homeyer & Sweeney, 1998, p. 21).

Sandtray therapy has been used as a viable psychotherapeutic intervention since the early twentieth century (Boik & Goodwin, 2000). In this article, a brief history of the development of sandtray as a therapeutic technique and general procedures associated

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with it are presented. A specific model of sandtray therapy, designed as an adjunct intervention for a trauma-based residential treatment program for sexual addiction, is described using clinical illustrations. The case review excerpts include a description of various directives developed for use with this particular model and their rationale as an intervention. Specific examples are given that illustrate various constructivist principles of change. In particular, sandtray therapy provides a protected space where the tacit can become explicit, clients' inner worlds can become organized and reconstructed, and views of self can be positively reconstructed.

## Sandtray as a Therapeutic Technique

As a preemptive statement to their description of sandtray therapy, Homeyer and Sweeney (1998) contended that, although there is a plethora of techniques used in the mental health profession, people who are hurting are not healed through technique. Instead, "people experience emotional healing when they encounter someone and when they encounter self. It is an inner process, a relational process, and a heart process" (p. 18). Meta-analytic reviews of psychotherapy efficacy have substantiated this position (Teyber & McClure, 2000).

De Domenico (1995a) contended that the use of sandtray therapy, in the presence of a receptive other such as a therapist, is an opportunity to realize and act out the need to bridge the gap between the "inner world of existence" and the "outer world of existence" (p. 5). Moreover, sandtray therapy facilitates the expression of underlying complex psychological and emotional issues that otherwise may be impeded by unique client factors such as "limitations in the areas of logical thinking, short-term memory, expressive language" (De Domenico, 1995a, p. 3), prior negative sensory experiences, poorly integrated insight, and perceptions of the world as an unsafe place (Homeyer & Sweeney, 1998).

The earliest use of sandtray therapy as a therapeutic technique is attributed to British pediatrician Margaret Lowenfeld, who, inspired by H. G. Well's book *Floor Games* (Wells, 1911), developed the "World Technique" in the 1920s (Boik & Goodwin, 2000). Lowenfeld's method, which involved creating scenes or "worlds" in the sand, was refined in the 1950s by Dora Kalff, who incorporated Jungian theoretical principles, referring to

her method as Sandplay (Boik & Goodwin). In addition to Lowenfeld's World Technique and Kalff's Sandplay, there are other theoretical and technical approaches to the therapeutic use of the sand tray, including Gestsalt (Oaklander, 1988), cognitive behavioral (Homeyer & Sweeney, 1998) Adlerian (Sweeney, Minnix, & Homeyer, 2003), Jungian (Allan, 1988), and constructivist (Dale & Lyddon, 2000; Dale & Wagner, 2003).

The model of sandtray therapy described in this article is based on the Sandtray-Worldplay method developed by Gisela Schubach De Domenico. Her method expanded Lowenfeld's (1950) technique, which is experience-focused (De Domenico, 1995a) and acknowledges the process of the unconscious (De Domenico, 1995c). De Domenico's technique is phenomenological and hermeneutical in that it focuses on the wholeness of the experience and searches for intrinsic meaning in the experience. Furthermore, she describes sandtray as an "integrative-image-thinking activity" that reveals the meaning of one's "intrapsychic experiential reality" (De Domenico, 1995c, p. 1). A theoretical assumption of De Domenico's approach is that sandtray therapy contains a "plurality of myth," including the manifestation of the self, experiences of chaos and transformation, and the building of community (De Domenico, 1989).

Sandtray therapy is a multidimensional medium used as a psychotherapeutic technique, in which the therapist provides a sand tray and a multitude of miniature objects with which to create scenes in the confines of the space of the tray. The interior of the sandtray is painted blue, to simulate sky and water. The miniatures selected to represent the client's world are displayed on open shelves. Common categories include animals (both wild and domestic); family groups of various ethnic figures; stage of life figures; occupational and hobby objects; buildings; vegetation reflecting the lifecycle; vehicles; scary, mythical, and playful figures; fences and signs; spiritual objects; and household items. There is no right or wrong way to construct the scenes; therefore, the client is free to choose the process and outcome of his or her sandtray experience. Ammann (1991) said the sandtray is like "a soul garden," a kind of container for the display of the client's psychic life. She described the tray as a "free and empty space" where the client can transform his or her world. Amman went on to say that the space is where the conscious and unconscious interact.

Sandtray therapy has been used with adults as well as with children and has been incorporated as a psychotherapeutic technique for a variety of psychological issues (Bradway, 1985; Carey, 1999; Clegg, 1984; Dale & Lyddon, 2000; De Domenico, 1995a, 1995b, 1995c; Gil, 1994; Hunter, 1998; Kamp & Kessler, 1970; Lowenfeld, 1950; Weinrib, 1983). The Sandtray-Worldplay technique is noninterpretive (De Domenico, 1995a, 1995c), due to the idiosyncratic nature of each client's thinking process. In this technique, the therapist invites the client to build a world in the sand. The client is then invited to tell about the tray's creation. During this process, the focus is kept on the "world" metaphor. Instead of direct interpretation, the therapist attempts to understand the client's world from the client's perspective and facilitates the process by amplifying emerging themes, discussing the identity or symbolism of objects, and attempting to enlarge or clarify the client's personal meaning (Boik & Goodwin, 2000). The therapist is seen as an ally and serves as a "witness," taking note of the object choice and placement and the construction of the world.

De Domenico (1995a) explained that the role of the therapist is to become a co-explorer of the client's world versus an expert of the client's world. The therapist helps the client to carefully experience and observe his or her unique sandtray creation and translate the experience into verbal language. Because the "image language" in the sandtray involves thoughts, sensations, feelings, memories, and experiences, the client's total personality can be expressed in conventional language (De Domenico, 1995c).

## Carne's Trauma-Based Model of Treatment for Sexual Addiction

The model of sandtray therapy described in this article was developed as an adjunct therapy for a residential treatment program for sexual addiction at a behavioral health center in the Southeastern United States. Carnes (2001) developed the program—a trauma-based, task-centered approach to treatment—based on the outcome of his research regarding the nature of sexual addiction and the process of recovery (Carnes, 1989). He incorporated knowledge from the field of addictionology, which purports that dynamics common to alcohol and drug addiction extend

**TABLE 1** Common Characteristics of Sexual Addicts

| |
|---|
| 1. A pattern of out-of-control behavior |
| 2. Severe consequences due to sexual behavior |
| 3. Inability to stop despite adverse consequences |
| 4. Persistent pursuit of self-destructive or high-risk behavior |
| 5. Ongoing desire or effort to limit sexual behavior |
| 6. Sexual obsession and fantasy as a primary coping strategy |
| 7. Increasing amounts of sexual experience because the current level of activity is no longer sufficient |
| 8. Severe mood changes around sexual activity |
| 9. Inordinate amounts of time spent in obtaining sex, being sexual, or recovering from sexual experience |
| 10. Neglect of important social, occupational, or recreational activities because of sexual behavior. |

Note. From Carnes (1992, pp. 11–12).

to obsessive sexual behavior. Among common characteristics of sexual addicts, the most distinguishing dynamic is a pattern of destructive, out-of-control behavior (see Table 1). In addition, Carnes incorporated knowledge from the field of family therapy, which provides insight into compulsive behavior as a function of the "shame-based family system" (Carnes, 1989, p. 7). The products of a shame-based system include damaged self-esteem, alienation, avoidance of intimacy, feelings of powerlessness, and problems with dependency.

According to Carnes (1989), it is highly likely that sexual addicts have a history of trauma. In fact, his research revealed that approximately 81% of sexual addicts had been sexually abused, 73% were physically abused, and 97% were emotionally abused. Empirical research has amply demonstrated that exposure to trauma, such as abuse, often results in affect dysregulation, poor impulse control, negative effects on identity, and a compulsion to repeat the trauma (Van der Kolk, McFarlane, & Weisaeth, 1996), all of which are associated with the sexual addict. According to Van der Kolk et al. (1996), the overall aim of trauma therapy is trauma resolution, in which clients regain emotional and behavioral control and understand how the trauma has affected both their inner world and their behaviors. Clients are helped to place the trauma in a larger perspective while exploring its personal meaning. Carnes' model attempts to treat sexual addiction, in part, by addressing the underlying component of trauma. In

addition, his model is designed to systematically address core issues associated with addiction.

Carnes' research suggests that positive outcomes are achieved and maintained best when the recovery process is broken down into defined tasks from which competencies are developed for managing problems (Carnes, 2001). The program consists of 30 specific recovery tasks, which are implemented with specific outcome criteria designed to result in predictable life competencies. Clients learn to dispel old myths about sexuality, integrate old and new healthy sexual behaviors, develop nondestructive relationships, and reconstruct their sense of self. The process of reconstructing a sense of self is foundational in trauma resolution and may be aptly facilitated with the use of sandtray intervention based on constructivist conceptual notions.

## The Conceptual Context: Constructivist Theory

Constructivism is associated with a postmodern view of the world, which postulates that there are a number of viable theories that can explain a given body of facts. Therefore, an epistemological position asserted by constructivists is that humans actively create uniquely personal and social realities (Mahoney, 2004). This phenomenological perspective suggests that humans structure their realities around patterns that are often tacit, yet viably adaptive and personally meaningful. Mahoney and Moes (1997), for example, contended that common themes of self-organization, as evidenced in one's developmental history, include tacit, deep structural ordering processes such as one's sense of personal valence, reality, power, and identity. According to constructivist thought, even the most extreme client behavior often has a logic derived from the client's unique developmental history.

Mahoney (2004) wrote that humans actively seek, create, and attempt to maintain order and meaning in their lives. In addition, Mahoney and Moes (1997) described the self as embedded in social systems and pervaded by social systems "so that developments in one necessarily influence the other" (p. 180). The self is socially constructed through personal stories or narratives, which are fluid and evolving (Bruner, 2004). Moreover, these personal narratives provide a sense of self-coherence (Bruner, 2004; Greenberg, & Angus, 2004). Similarly, Bruner proposed that

humans constantly construct and reconstruct the self to accommodate their present situations. Constructivists view challenges to order as opportunities for development and growth. Moreover, emotional experience, exploration, and expression are viewed as motivators for change and development (Greenberg & Pavio, 1997), unlike other psychological traditions that view emotion as something to be controlled, reduced, or eliminated. Mahoney contended that strong emotional states, when they exceed one's ability to cope, can enable one to access core beliefs so that an alternative view of reality—referred to as *second order change* (Lyddon, 1990)—can take place. Overall, constructivists ascribe to the meta notion that emotions are "fundamentally adaptive" (Greenberg & Pavio, p. 15). Another meta notion that has evolved from constructivism is that resistance to change is viewed positively as a "healthy tendency to protect against changing too much, too quickly" (Greenberg & Pavio, p. 33). Neimeyer (2005) cogently described this tension between the forces of stability and change in clients' lives and the importance of therapist sensitivity to this dialectic:

> One the one hand, the client can hold on to any number of cherished views of self, other, or world in a self-protective fashion, something that can impose obstacles to therapeutic movement. One the other hand, if we respectively observe those obstacles and allow our clients to *speak from* them instead of trying to *override* them, then they can become avenues toward therapeutic gains. (pp. 90–91)

A constructivist approach to psychotherapy emphasizes the human relationship. Specifically, Mahoney (2004) described compassionate human relationship and presence as a central emphasis. He described the client/therapist relationship as a "transformational crucible" in which clients can risk exploring new ways of relating to themselves (p. 17). Mahoney described psychotherapy as a collaborative process that is processed-focused, stating, "Psychotherapy is not something that is done *to* them [clients], but *by* them" (p. 19).

Constructivists believe that clients are active agents, always in the process of choosing. Therefore, working collaboratively with the therapist, they are the primary agents of change via engaged practice. As a client and therapist address consequences associated with the client's past choices, the constructivist therapist

capitalizes on the client's current strengths, providing affirmation and "protection of hope" (Mahoney, 2004, p. 23). Constructive therapists are sensitively attuned to the patients' pace of change, comforting and challenging them according to their closed and open cycles of experiencing. For example, Mahoney stated, "Psychological development is often reflected in shifts of attention, changes in perceptions and personal meanings, changes in interpersonal relationships, improved capacities to rebound from setbacks (to 'regain balance'), and changes in self-relationships" (p. 37). According to Mahoney, changes in self-relationship are explained as increased self-awareness and comfort with emotional experience, greater openness to experience, greater self-acceptance, increased capacities to self-comfort and to receive and give affection, a greater sense of personal empowerment, and a sense of more hopeful or grateful engagement with life.

## The Treatment Context

### *Overview*

The sandtray therapy intervention at the behavioral health center described above is implemented primarily in group therapy format, which is offered one hour per week. New clients enter the group, and those who have completed the program leave the group on a weekly basis. Therefore, the group is designed as an open group. The length of the sexual addiction treatment program is 6 weeks, including a 23- to 72-hour assessment phase and a 42-day treatment phase. Group membership varies each week from as few as three to as many as nine clients. Clients range in age from 18 years and above and work in a variety of employment and professional settings. The majority of clients are upper-middle-class Caucasians. Currently, there are scholarships available to assist with the financial cost of the program as well as marketing efforts to inform minority ethnic groups about the treatment services.

An important constructivist concept is that the self is embodied in social systems (Mahoney, 2004; Neimeyer & Stewart, 2000). Therefore, the social interaction and support within the group process can be very effective in facilitating recovery from sexual addiction. A potential negative aspect of sandtray construction by

an *individual* group member within a group setting is the risk of conducting individual therapy within the group therapy process (Yalom, 1995). With judicious attention to group member inclusion, however, all can participate in a meaningful way by bearing witness to the construction of an individual's sandtray scene. For example, all group members can learn about the process of the integration of experience and the process of meaning-making, which results in greater knowledge of self. The group members can hear the nonadaptive beliefs of other addicts and explore more viable alternatives. Furthermore, the relationships of sexual addicts often involve exploitation and objectification of others as well as nonmutuality (Carnes, 1992). Silent participation, therefore, provides opportunities for increasing patience and tolerance in attitudes and behaviors toward others, as well as practicing being fully present with one another. Fellow group members also can benefit from discussions that follow the sandtray construction. Even though sandtray began as a primarily nonverbal means of therapeutic intervention, this particular intervention was designed to use the powerful modality of narrative processing. From the dialogues between client and therapist and other group members emerge new ideas and new meanings that are cocreated.

An accepting and encouraging atmosphere is established at the beginning of each session as a means to sensitively attune to each client. The therapist might ask new group members, "What do I need to know about you?" Based on the constructivist assumption that each person has a uniquely and personally constructed reality, it is important for the therapist to convey to each participant that there is no right or wrong way to construct the scenes and that only he or she can interpret the meaning. This type of reassurance is important because it is not uncommon for sexual addicts to initially harbor skepticism about the therapist's intentions due to a low degree of trust. Clients are *invited* to participate in the sandtray experiences and, when necessary, encouraged to stay with or move toward emotional experiences, although often painful, for the purpose of changing and developing on a deeper level. In the following section, a series of clinical excerpts is presented with the goal of illustrating the constructivist mechanisms of change and the facilitation of sexual addiction recovery based on Carnes' model. As a result, each illustration is prefaced by the relevant constructivist principle

and name of the intervention employed. Written consent was given by all of the clients whose clinical information was used for illustrative purposes. Client identity has been modified to protect client confidentiality and privacy; however, basic clinical aspects of each case have not been altered.

## Clinical Illustrations

### *Self-Organization and the "Three Circles" Directive*

Clients are active agents, always in the process of choosing and actively seeking, creating, and attempting to maintain order and meaning in their lives (Mahoney, 2004). Becoming aware of developmental antecedents, clients can organize and reconstruct their inner worlds, which often result in engendered hope. Kent is a 35-year-old medical student who was in his last successful week of the recovery program. He was invited to create his "three circles" in the sandtray. "Three Circles" is a directive based on Carnes' model, which was developed to help clients create a personal definition of sobriety. Unlike the substance-dependent individual, sexual addicts do not necessarily practice total abstinence, because their sexuality is a natural biological process. Instead, they decide which demoralizing sexual behaviors they are powerless over and abstain from those. Those demoralizing behaviors make up the inner circle. The outer circle is composed of healthy sexual behaviors that enhance clients' lives and their recovery. Carnes (1989) contended that our shame is rooted in perfectionism. Fallible humans will inevitably fall short of their goals. For the sexual addict, this could mean slipping into a cycle of self-condemnation followed by shame, and eventually acting out. The middle circle is composed of boundary behaviors, which if not addressed, will lead to the acting out behaviors in the inner circle. The sexual addict is encouraged to look for common elements among the behaviors in each of the three circles.

Kent spontaneously depicted segments of three concentric circles, illustrated in Figure 1. Dotted lines have been electronically superimposed onto the sandtray scene photograph to delineate for the reader the location of Kent's inner circle (#1), middle circle (#2), and outer circle (#3). Kent first constructed with ease and deliberation the outer circle (#3). Next he constructed his

**FIGURE 1** Kent's sandtray scene: The Three Circles directive.

inner circle (#1) with clarity and purpose. The middle circle (#2) was much more challenging for him, as he had difficulty choosing images and deciding on their placement. As Kent described his circles, the therapist was mindful of the metaphors he employed, because from a constructivist perspective, metaphors are not just forms of speech, they are often forms of thought (Leary, 1990; Lyddon, Clay, & Sparks, 2001).

When the therapist asked Kent, "Did anything surprise you about your circles?" he answered, "Yes. I wasn't aware of how much a problem the empty well still is for me." Reflecting on a recent family therapy session with his father, Kent described him as an "empty well," unable to give his son what he needed emotionally. Talking about the meaning in the metaphor with group members, Kent was able to understand its developmental antecedents and how it related to the figure of a bear that he chose to represent his anger.

An alternative to helping clients understand the meaning in their metaphors is to encourage alternatives in the metaphor (Lyddon, Clay, & Sparks, 2001). For example, the therapist could ask, "What are ways your father is not like an empty well?" In most cases, awareness of developmental antecedents is quite apparent in the sandtray scenes of clients who have successfully completed most of the treatment program. This awareness is an example of progress toward wholeness and sobriety and serves as an effective model for newcomers to the treatment program. Kent indicated that he would have not been able to construct the scene at the beginning of his treatment, implying that he had moved from chaos to a greater sense of order in his inner world. Through the use of the Three Circles directive, Kent clarified for himself and other group members the importance of reconstructing one's inner world as a major milestone marker on the journey to recovery.

### *Reconstructing the Self and the "Subpersonality Integration" Directive*

Humans constantly construct and reconstruct the self to accommodate their present situations. These personal narratives are fluid and evolving, and provide a sense of self-coherence. Anthony, a 56-year-old executive and business owner who was not progressing in his recovery, was invited to participate in the "Subpersonality Integration" directive (see Figure 2) developed

**FIGURE 2** Anthony's sandtray scene: The Subpersonality Integration directive.

by De Domenico (Boik & Goodwin, 2000, p. 191). This intervention provides an opportunity for clients to (a) recognize and explore diametrically opposed, denied, or rejected parts of themselves, and (b) understand and integrate those attributes. Internal conflicts often are brought to light, and clients can then learn to have those denied or rejected parts of themselves function more adaptively.

For this procedure, Anthony was invited to choose three objects that he found appealing or attractive in some way and to place them in a row in the sand. He was then invited to choose three objects that were aversive to him or that he found unattractive or offensive in any way and to place them in a row facing the first three objects. He was then asked to talk about why he did or did not like the chosen objects.

The focus was then turned from the objects to Anthony. The therapist invited him to associate each object with himself by asking questions such as, "If part of you is like that object, what part of you would it be?" or "What aspect of you is similar to that (naming the object)?" or "How is that like a part of you?" (Boik & Goodwin, 2000, p. 172). Such an exploration is designed to facilitate greater awareness, balance, and resolution of complex parts of the self.

Order of object choice appears to have significance in sandtray therapy (Homeyer & Sweeney, 1998). Often the object placed first in the sand has a salient relevance to the client. Anthony's first object was a skeleton. When asked if he had any history of trauma in his life, he stated that he had never experienced "any trauma at all." However, Anthony's clinical psychosocial history indicated that his father and beloved brother had recently died. Across from the skeleton, Anthony placed a palm tree, which he stated represented escape, peace, and relaxation. Anthony described a playful and fun-loving side of himself, which he symbolized with a green plastic frog. Across from the frog, Anthony placed a Samurai warrior, which, according to him, represented control.

When confronted by the group about his apparent disregard of the death of his family members and his often-maladaptive attempts to control many aspects of his life, Anthony indicated that he had experienced no emotional impact from the losses. Moreover, he appeared to intellectualize his need to control,

stating that many employees and family members depended on him. He consistently turned his attention to the frog when confronted by the group about issues of loss and grief, insecurity, inadequacy, and overwhelming sense of responsibility to others. Anthony seemed to be symbolically resisting discussion of difficult issues.

Denial, intellectualization, and minimization often are considered signs of resistance in therapy. However, the constructivist assumption that resistance is seen as an attempt to self-protect is to be understood and used therapeutically by the therapist (Mahoney, 2004). For example, in the case of Anthony, the therapist verbalized an observation based on the awareness and acceptance of Anthony's resistance:

> You have a tremendous responsibility for the welfare of a lot of people. It must be quite burdensome for you, especially since you no longer have your brother as a confidant. It must be so burdensome that you need to escape and rest.

Anthony acknowledged that the therapist had connected with a pivotal construct that, until now, had been out of his awareness. Carnes (2001) stressed the need to confront denial and eventually, through systematic tasks, to integrate opposing "shadow" parts of the self. Remaining sensitive to the pace of a client's change process and both comforting and challenging the client according to his or her closed and open cycles of experiencing (Mahoney, 2004) increases the likelihood that the client will be able to move forward in recovery. In Anthony's case, by giving voice to Anthony's self-protection, the therapist created a dialogical space, which, according to Hermans (2004), instigates the "retelling of the story in such a way that new relationships are established between existing story parts or new elements are introduced" (p. 175). Hermans, for example, explained that the goal of psychotherapy is to facilitate the reorganization of the "position repertoire in such a way that a flexible movement between positions is realized and subjective well-being is increased" (p. 179). Anthony gained insight into his need to self-protect. He was then able to create a new perspective of himself and realize the need to learn to function more adaptively.

### *Making the Tacit Explicit and the "Replaying the Trauma in the Tray" Directive*

An overarching goal of constructivist intervention is to make the tacit explicit in order to increase awareness and knowledge of self and to revise one's way of being in the world (Guidano, 1991; Mahoney, 2004). Jesse, a young professional in his late 20s, was brutally raped at the age of 15 by an older male cousin. He kept the attack and subsequent, similar incest experiences secret for several years. He was invited by the therapist to use the sandtray to recreate a traumatic incident as it occurred and afterward to tell the story of the trauma. After depicting himself being raped, Jesse starred silently and pensively at the scene. After a long pause, he stated, "I have carried this around in my head for years, and I have often wondered if it were real. Now I see it and I *know* it's real."

As this tacit material became more real and explicit, Jesse was given the opportunity to amplify any area in the tray that might need further resolution. He acknowledged a sense of powerlessness that he had felt during the traumatic event, which he believed continued to render him powerless in many areas of his life. Through a dialogue with group members who validated his experience, he was able to understand the adverse impact the trauma had had on his inner world and his behavior. As a result, Jesse's progress in the program changed dramatically during the next few weeks. For example, he demonstrated a greater openness to the various therapeutic opportunities of the program, began to relate on a deeper and more serious and trusting level with his peers and the staff, and engaged in significantly more prescribed tasks associated with the overall recovery program.

### *Primary Emotions as Adaptive Functions and the "Replaying the Trauma in the Tray" Directive*

Constructivists propose that primary emotions serve adaptive functions and can be organizing opportunities with potential for growth (Greenberg & Pavio, 1997). Therefore, inviting the client to "lean into" his or her emotions is believed to have

potential therapeutic benefit. Tammy is a 41-year-old homemaker who became pregnant at age 16. According to Tammy, her parents forced her to give up her baby son for adoption, and afterward forbade any discussion of the topic.

Tammy was invited to depict a traumatic event in her life (see Figure 3). She created a scene in the sand, which she described as symbolically depicting the adoption of her son. She chose figures to represent herself, her son, her son's adoptive parents, and a fence to symbolize the isolation and loneliness she felt. Tammy completed her tray in a short amount of time, commenting on the sparseness of objects and stating that she felt "stuck." Sparseness of objects placed in the tray often is seen in the sandtray depictions of people who feel depressed (Homeyer & Sweeney, 1998, p. 66). The therapist amplified the emerging theme and facilitated the client's observation by stating, "Tell me more about the stuckness," and "Can you imagine what it would be like to be unstuck?"

Consistent with constructivist notions, Ecker and Hulley (1996) highly regarded the importance of focusing on the functional value or the meaning of the symptom. The functional value of the symptom became apparent to Tammy when she was invited to change the scene in a way that would make things "better" (see Figure 4). Without hesitation, Tammy removed the fence and surrounded the object she had chosen to represent herself with supportive figures as well as a cross, which represented God. She repositioned the figures that represented the adoptive parents and her biological son so that they faced the figure that represented her. Tammy tearfully commented that she had never been able to express her pain over the loss of her son. As a result of this new awareness, she began to experience and express significant feelings of anger. Moreover, she recognized that her feelings of depression and "stuckness" were related to her unexpressed anger. The reconstructed scene helped Tammy experience the pain of the past and present, consider new meanings for her emotions, develop a narrative of the future, and build a positive sense of self. Carnes (1989) similarly suggested that reconstructing a sense of self is important because, for the addict, self-knowledge and self-responsibility are vital for recovery.

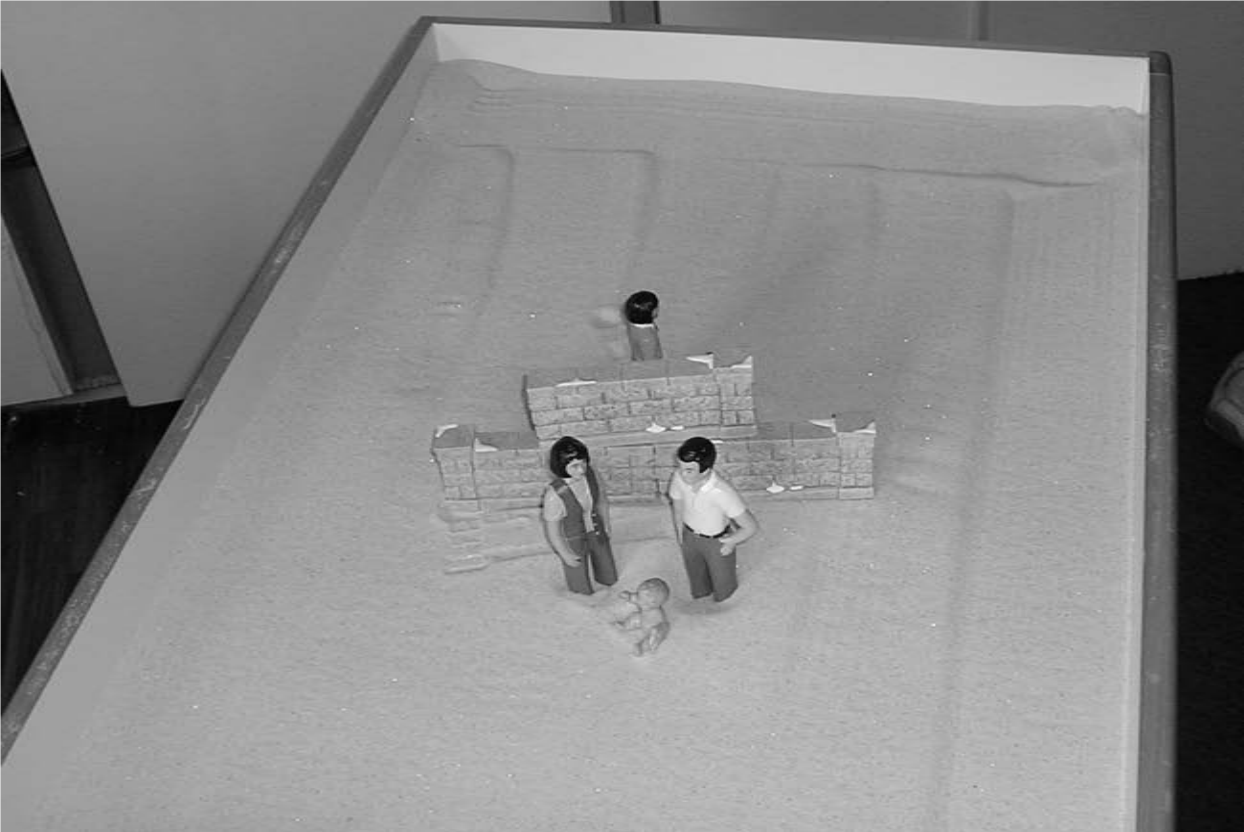

**FIGURE 3** Tammy's sandtray scene: Replaying the Trauma in the Tray directive.

**FIGURE 4** Tammy's sandtray scene: Replaying the Trauma in the Tray directive.

**FIGURE 5** Group sandtray scene: Continuum of Sobriety directive.

### *The Dynamic Self and the "Continuum of Sobriety" Directive*

Humans constantly construct and reconstruct the self to accommodate their present situations (Bruner, 2004). Illustrating this idea of the dynamic self, six group members were invited to participate in "Continuum of Sobriety," a joint sandtray directive designed to help clients see the world of destructive sexuality they have inhabited and, by way of contrast, envision a possible world of healthy sexuality (see Figure 5).

In this directive, half of the group was directed to collaboratively depict sexual addiction using one half of the sandtray, discussing their construction as they proceeded. The remaining group members were then directed to depict healthy sexuality in the other half of the tray, discussing their collaborative effort as they proceeded. Both groups were asked to describe their depictions as if they were talking to someone who was uniformed about either sexual addiction or healthy sexuality.

The construction of sexual addiction was purposeful, effortless, and consenting, whereas the construction of healthy sexuality was tentative, laborious, and conflicting. Clients constructing healthy sexuality had trouble choosing objects, talking with each other, and describing their scene. As a result of the experiential nature of this exercise, clients gained insight into their meager knowledge of healthy sexuality.

Upon completion of the narrative and education about healthy sexuality, all clients were invited to indicate where they perceived themselves on a continuum from sexual addiction to healthy sexuality. Many said they were surprised to see themselves further in their recovery than they had thought. Carnes' tasks for recovery were designed to dispel old myths or assumptions of sexuality that are destructive. In doing so, patients can learn how to care for themselves and, as a result, move toward healthy sexuality. The clients were able to understand in a meaningful way that the self is dynamic and changing. They expressed increased insight into their ability to rework their assumptions about sexuality.

### *Personal Meaning-Making and the "Replaying the Trauma in the Tray" Directive*

Constructivists contend that humans actively seek to create meaning in their lives and that significant change in therapy involves

changes in personal meanings (Mahoney, 2004). Linda, a 41-year-old realtor, was brutally raped by a stranger at the age of 16. She was a victim of rape repeatedly over the next several years. With great detail, she depicted in the sandtray the life-threatening rape at age sixteen (see Figure 6).

Among the many objects in her tray, Linda chose a soldier with a gun to represent the rapist, a young girl half-buried in the sand to represent herself, and a coffin to represent her anticipation of dying during the attack. She chose a winter tree bereft of signs of life, a fence that separated her from potential rescuers, and ominous figures that she placed on the rim of the tray.

Linda nonverbally referenced her peers at specific moments during the construction of her scene, later disclosing that this was the first time she had ever told this story to anyone and that she was looking to them for affirmation and support. After replaying the trauma, she was able to express sadness, although minimally. However, by exploring this emotion more fully, she accessed ingrained, core beliefs of guilt, shame, and unworthiness and was eventually able to change those core beliefs.

Carnes (1989) explained, "Controlling the addiction is a first-order change solution which brings only more drinking for alcoholics and self-management for sexual addicts.... Change occurs at the second-order level when the addict stops the efforts to control and admits to being powerless" (p. 184). Linda's rape was a traumatic event that had remained unintegrated in her life.

Carnes (1989) also contended that patterns of destructive, out-of-control behavior and the compulsion to repeat past trauma are addressed by resolving the trauma, which is accomplished in part by exploring its personal meaning. When invited to change the scene in order to make it different, Linda exuberantly placed the rapist inside the coffin. She removed the barriers from the rescuers, moved the figure representing herself to a place of safety, removed the looming "evil" figure on the left edge of the tray, and replaced the winter tree with a "tree of life" (see Figure 7).

Linda realized that she was not to blame for the rape and transitioned from the perceived role of victim to that of survivor. As a result, she realized that she was capable of overcoming the traumatic event and making positive changes in her life.

**FIGURE 6** Linda's sandtray scene: Replaying the Trauma in the Tray directive.

**FIGURE 7** Linday's sandtray scene: Replaying the Trauma in the Tray directive.

Figley (1985) described the pivotal, healing transition from victim to survivor as "making peace with the memories of the catastrophe and its wake" (p. 399). Externalizing the problem helped Linda place the trauma in a larger perspective while exploring its personal meaning. She demonstrated a larger range of affect during the remainder of her stay in the intervention program. Prior to leaving the program, she also indicated that she felt less guilty, shameful, and worthless and more hopeful about her future.

### *Resistance As Self-Protection and the "Redesigning Life Situations" Directive*

Constructivists adhere to the notion that resistance to change is natural and self-protective. Constructivist therapists work with resistance rather than against it, comforting and challenging clients based on their unique cycles of experiencing.

Janet is a 35-year-old divorced mother of one who was relatively apathetic about her approach to treatment. She was encouraged to participate in "Redesigning Life Situations," based on a directive by De Domenico (Boik & Goodwin, 2000). In this directive, the client is invited to recreate in the sandtray the situation that he or she perceives as producing problems for him or her. The directive was designed to help immobilized clients open up new pathways for problem definition and resolution.

Janet was asked to think of a current problem with which she was having difficulty. She was then directed to put the problem in the sand tray (see Figure 8). Janet was despondent as she depicted the isolation she felt from family and friends, especially due to the loss of her son, who was now living with his father.

Janet was asked to take the therapist and group members on a tour of the tray, describing the problem. She was then asked to select the image in the sand that represented the part of her that was central in creating the problem. Through encouragement and affirmation of her strengths by group members, Janet persevered and identified the stop sign posted outside the fence surrounding her home as the representation of her part in creating and maintaining the problem. She said that she had "closed herself off" due to feelings of helplessness and despair and

**FIGURE 8** Janet's sandtray scene: Redesigning Life Situations directive.

had become sad, despondent, and unable to care for her son or work effectively.

As she viewed the scene in the tray, Janet made a connection between the hypocrisy demonstrated by her family of origin in regard to religion. According to Janet, her parents were rigid and pious in their religious beliefs and expectations of her, but immoral and deceiving in their behavior toward her.

When asked to create another tray with the problem "solved," she made clear, deliberate, and productive choices (see Figure 9). For example, She removed the stop sign and placed the image of herself outside the fence, which had kept her isolated. She surrounded herself with a support group of friends. She placed a pair of angels near the image of herself, representing her desire to define her personal spirituality apart from the pious religiosity of her family of origin. Furthermore, she was able to identify and differentiate the issues she had the power to change and those she did not have the power to change.

Carnes (2001) stated that addiction is an alternative to letting oneself feel hurt, betrayal, worry—and, most painful of all, loneliness. Janet learned ways to protect the self as a result of facing the painful realizations regarding her family of origin. During the remainder of the treatment program, her subjective feelings of powerlessness and helplessness diminished and she became significantly more invested in her treatment process.

### *Further Clinical Considerations*

Additional sandtray interventions used for the treatment program described above included directives designed to create (a) trays depicting family-of-origin relationships and multigenerational transmission of patterns; (b) spontaneous, self-directed trays of unique concerns; and (c) joint trays depicting various idiosyncratic group dynamics.

In addition, there are many other applications designed to address core issues associated with sexual addiction recovery. For example, De Domenico (1995c) developed applications for the use of sandtray with couples. Used as a problem-solving technique, couple's sandtray allows for the opportunity to reveal "relevant personal history, visions of ideal self, goals, hidden parts of self, [and] social self and roles" (De Domenico, p. 3). Boik and

**FIGURE 9** Janet's sandtray scene: Redesigning Life Situations directive.

Goodwin (2000) also provided a detailed description of various sandtray therapy interventions with couples. Directives that take into account multicultural issues of sexual addiction treatment are an important consideration as well: for example, (a) the social construction of sexuality among various ethnic groups, religious groups including professional celibates, and homosexual groups; and (b) cross-cultural views of individualism and collectivism as they pertain to sexuality and therapeutic intervention in general.

Adequate training and supervision in the areas of trauma and sandtray therapy should precede the use of these modalities by professional mental health workers. Depicting trauma in the sandtray has the potential for being an intensely powerful experience. The therapist is responsible for ensuring safety by providing a protected space for clients; therefore, therapists should be trained in trauma intervention with a thorough understanding of abreaction, containment, vicarious trauma effects, and compassion fatigue. Figley (2005), for example, cautioned workers in the trauma field to recognize that the "capacity for compassion and empathy seems to be at the core of our ability *to do the work* and at the core of our ability *to be wounded by the work.* [emphasis added]" De Domenico (1995a) stressed the importance of therapists' personal experience with their own sandtray work. She explained that the therapists can teach their clients to honor their own "creative healing potential" only when they are "intimately familiar with their own journeys in the tray" (p. viii).

Pragmatic issues that are widely considered to uniquely contribute to effective sandtray trauma work include the shape and size of the tray and the color and texture of the sand. For example, De Domenico (1995b) suggested that because the sandtray acts as a regulating and protecting factor, it is important that it not be too large. Standard-size trays are 20″ × 30″ × 3″ (Homeyer & Sweeney, 1998). Recommended sizes for trauma work are 22″ × 26″ × 3″ or 20″ × 24″ × 3″ (De Domenico, 1995b). Clients who have experienced trauma often prefer deeper 5″ or 6″ trays because they, at times, feel the need to send parts of themselves "down under" later to "dig out and feel the terror" (De Domenico, 2005). Round trays are helpful in facilitating the mediation of conflict and dualities (De Domenico) and tend to reduce anxiety and agitation, whereas rectangular trays facilitate the confronting

of issues (Boik & Goodwin, 2000). Larger round and rectangular trays are recommended for group, couples, and family trays.

Various sand textures and colors evoke unique feelings and are chosen depending on the client's current emotional state (Boik & Goodwin, 2000; De Domenico, 2005). For example, clients who have been abused tend to prefer finer sand (100 mesh) to courser sand (40 to 50 mesh); however, some feel that course sand is more grounding. Natural colors of sand range from light to dark beige, black, white, purple/pink garnet, green, and coral. Water used for wetting, flooding, sprinkling, or pouring enhances sandtray therapy intervention.

Well-organized sandtray materials and therapy space enhance the atmosphere of safety that is vital in trauma work. Sandtray objects that are categorized and neatly displayed in permanent locations on shelves provide a sense of predictability and order that is a stark contrast to the world of chaos that commonly accompanies sexual addiction (Homeyer & Sweeney, 1998; Carnes, 1992). Specific to the treatment program described in this article, bringing attention to any newly acquired and displayed objects prior to the session seemed to be appreciated by the clients.

## Conclusion

Humans are creative and adaptive and, when faced with problems, have the capacity to explore alternatives and reorganize and restructure their inner worlds and overt behaviors. Consistent with constructivist assumptions, sandtray therapy is a means of facilitating change through a collaborative and compassionate therapeutic relationship. It is designed to help clients uncover and challenge their tacit assumptions, work with self-protective resistance, and pave the way for progressive change. As we have illustrated, sandtray therapy is particularly well suited for sexually addicted clients, who also tend to have a high likelihood of trauma history. The sand tray naturally provides a protected space and, in constructivist terms, a kind of "conversational forum" (Neimeyer, 2005, p. 78) in which client's innermost beliefs and stories can be depicted, examined, and validated. Drawing from over 30 years of experience in the use of sandtray, De Domenico (1995c) summarized this reconstructive process:

> This multifaceted dialogue reaches profoundly deep levels, ranging from the most preverbal experiences of the inside and outside of the human body to the full spectrum of emotional interpersonal and environmental experiences; from the traumatic to the idyllic; from the most elusive to the most rational conclusions concerning the laws of the family and society; and from the most mundane and concrete to the realm of deeply spiritual numinous, archetypal experiences of consciousness. . .. [I]t is of utmost importance that the therapist support and foster this [sandtray "world" building] process by acting as an experienced midwife. The client births his/her individuality. The therapist aids in this birthing process by understanding it and by helping the client name his/her unique and important signposts of the journey, thus gaining insight and control (p. 5).

## References


Allan, J. (1988). *Inscapes of the child's world: Jungian counseling in schools and clinics.* Dallas: Spring Publications.

Ammann, R. (1991). *Healing and transformation in Sandplay: Creative process become visible.* Chicago: Open Court.

Boik, B. L., & Goodwin, E. A. (2000). *Sandplay therapy: A step-by-step manual for psychotherapists of diverse orientations.* New York: W. W. Norton.

Bradway, K. (1985). *Sandplay bridges and the transcendent function.* San Francisco: C. G. Jung Institute.

Bruner, J. (2004). In L. E. Angus & J. McLeod (Eds.), *The handbook of narrative and psychotherapy: Practice, theory, and research* (pp. 3–14). Thousand Oaks, CA: Sage.

Carey, L. J. (1999). *Sandplay therapy with children and families.* Northvale, NJ: Aronson.

Carnes, P. (1989). *Contrary to love: Helping the sexual addict.* Center City, MN: Hazelden.

Carnes, P. (1992). *Don't call it love: Recovery from sexual addiction.* New York: Bantam Books.

Carnes, P. (2001). *Facing the shadow: Starting sexual and relationship recovery.* Carefree, AZ: Gentle Path.

Clegg, H. G. (1984). *The reparative motif in child and adult therapy.* New York: Aronson.

Dale, M. A., & Lyddon, W. J. (2000). Sandplay: A constructivist strategy for assessment and change. *Journal of Constructivist Psychology,, 13*, 135–154.

Dale, M. A., & Wagner, W. G. (2003). Sandplay: An investigation into a child's meaning system via the self confrontation method for children. *Journal of Constructivist Psychology, 16*, 17–36.

De Domenico, G. S. (1989). *Experiential training level 1: Workbook.* Oakland, OH: Vision Quest Into Reality.

De Domenico, G. S. (1995a). *Sand tray world play: A comprehensive guide to the use of the sandtray in psychotherapeutic and transformational settings (Vol. 1).* Oakland, CA: Vision Quest Into Reality.

De Domenico, G. S. (1995b). *Sand tray world play: A comprehensive guide to the use of the sandtray in psychotherapeutic and transformational settings (Vol. 2).* Oakland, CA: Vision Quest Into Reality.

De Domenico, G. S. (1995c). *Sand tray world play: A comprehensive guide to the use of the sandtray in psychotherapeutic and transformational settings (Vol. 3).* Oakland, CA: Vision Quest Into Reality.

De Domenico, G. S. (2005, July). Introduction to Sandtray-Worldplay. Workshop presented at the 2005 Georgia Association for Play Therapy Annual Summer Workshop, Atlanta, GA.

Ecker, B., & Hully, L. (1996). *Depth-oriented brief therapy.* San Francisco: Jossey-Bass.

Figley, C. R. (1985). In C. R. Figley (Ed.), *Trauma and its wake: The study and treatment of post-traumatic stress disorder* (pp. 398–416). New York: Brunner/ Mazel.

Figley, C. R. (2005). Living with resiliency and creating resilience. Keynote presentation at the Annual Conference of the Association for Traumatic Stress Specialists, Dallas

Gil, E. (1994). *Play in family therapy.* New York: Guilford.

Greenberg, L., & Angus, L. E. (2004). In L. E. Angus & McLeod (Eds.), *The handbook of narrative and psychotherapy: Practice, theory, and research* (pp. 331–349). Thousand Oaks, CA: Sage.

Greenberg, L. S., & Pavio, S. C. (1997). In L. S. Greenberg & S. C. Pavio (Eds.), *Working with emotions in psychotherapy* (pp. 13–32). New York: Guilford.

Guidano, V. F. (1991). *The self in process.* New York: Guilford.

Hermans, H. J. M. (2004). In L. E. Angus & J. McLeod (Eds.), *The handbook of narrative and psychotherapy: Practice, theory, and research* (pp. 175–191). Thousand Oaks, CA: Sage.

Homeyer, L. E., & Sweeney, D. S. (1998). *Sandtray: A practical manual.* Royal Oak, MI: Self-Esteem Shop.

Hunter, L. (1998). *Images of resiliency: Troubled children create healing stories in the language of the sandplay.* Palm Beach, FL: Behavioral Communications Institute.

Kamp, L. N. J., & Kessler, B. G. (1970). The world test: Development aspects of a play technique. *The Journal of Child Psychology and Psychiatry, 11,* 81–108.

Leary, D. A. (1990). *Metaphors in the history of psychology.* New York: Cambridge University Press.

Lowenfeld, M. (1950). The nature and use of the Lowenfeld World Technique in work with children and adults. *Journal of Psychology, 30,* 325–331.

Lyddon, W. J. (1990). First- and second-order change: Implications for rationalist and constructivist cognitive therapies. *Journal of Counseling and Development, 69,* 122–127.

Lyddon, W. J., Clay, A. L., & Sparks, C. L. (2001). Metaphor and change in counseling. *Journal of Counseling and Development, 79,* 269–273.

Mahoney, M. J. (2004). *Constructive psychotherapy: A practical guide.* New York: Guilford.

Mahoney, M. J., & Moes, A. J. (1997). In F. Masterpasqua & P. A. Perna (Eds.), *The psychological meaning of chaos: Translating theory into practice* (pp. 177–198). Washington, DC: American Psychological Association.

Neimeyer, R. A. (2005). Construction of change: Personal reflections on the therapeutic process. *Constructivism in the Human Sciences, 10,* 77–98.

Neimeyer, R. A., & Stewart, A. E. (2000). In C. R. Snyder & R. E. Ingram (Eds.), *Handbook of psychological changes* (pp. 337–357). New York: Wiley.

Oaklander, V. (1988). *Windows to our children: A Gestalt therapy approach to children and adolescents.* Gouldsboro, ME: Gestalt Journal Press.

Siever, R. (1988). *Sand.* New York: Freeman.

Sweeney, D. S., Minnix, G. M., & Homeyer, L. E. (2003). Using sandtray therapy in lifestyle analysis. *Journal of Individual Psychology, 59,* 376–387.

Teyber, E., & McClure, F. (2000). In C. R. Snyder & R. E. Ingram (Eds.), *Handbook of psychological change: Psychotherapy processes & practices for the 21st century* (pp. 62–87). New York: Wiley.

Van Der Kolk, B. A., McFarlane, A. C., & Weisaeth, L. (1996). *Traumatic stress: The effects of overwhelming experience on mind, body, and society.* New York.

Weinrib, E. (1983). *Images of the self: The sandplay therapy process.* Boston: Sigo.

Wells, H. G. (1911). *Floor games.* New York: Arno.

Yalom, I. D. (1995). *The theory and practice of group psychotherapy.* New York: Basic Books.

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