Sandtray and Solution-Focused Therapy

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Both solution-focused (SF) and sandtray therapies have been shown to have effective healing properties. SF, a primarily verbal therapy, uses carefully worded and timed questions and comments that solicit the clients' already existing strengths and resiliencies to solve the current and future problems. Sandtray therapy relies primarily on nonverbal communication through the use of carefully selected miniatures within the confines of a sand tray to facilitate clients' healing and strengthen internal resources. Because these therapies at first appear to be so different, it is not surprising that their combined application is rarely mentioned in the literature. Yet, similarities between the two therapies do exist and may be combined to provide an empowering and brief experiential therapeutic journey. A brief background and theoretical orientation to SF therapy is provided, accompanied by illustrations of the merger of these two approaches. Also discussed are similarities between SF and sandtray therapies and the advantages of combining them in work with children and adolescents.

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Regardless of age, ethnicity, or gender, sand is a medium that crosses all boundaries. It is difficult to resist moving one's hands through the sand, touching and feeling its fine grain, moving it from one side to another, making paths, and building mountains. With sand and carefully selected miniatures, one can move through the past, present, and future; describe unspeakable events; confront one's demons and overcome challenge; become a new person while retaining the best of the old; and create the potential self and its many possibilities.

Indeed, the use of sand and its miniatures is an established therapeutic approach with children, adolescents, and adults (Homeyer & Sweeney, 2005). A primarily nonverbal method of intervention, the "work" is done through the sand material and the carefully selected toys the client uses to construct and sometimes to play out his or her world. Because sandboxes are familiar to most children, sand play is not likely to be threatening and more likely to be a safe way to express what may seem to be unacceptable feelings and impulses (Oaklander, 1988). Sandtray therapy has other benefits as well. For clients who are less prone to verbal communication or who may not be language proficient, the sand and the miniatures become the language through which the child can communicate (see Vinturella & James, 1987), producing tangible results (Hunter, 2006). For those who are stuck in old ways of problem-solving, sandtray therapy opens up new perspectives from a "three-dimensional field" (Bainum, Schneider, & Stone, 2006, p. 36). Unlike other

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types of expressive techniques, such as drawing or writing, skill is not required for creating scenes, so that self-consciousness and fear of judgment are not so problematic (Bradway, 1979). For some, the sand itself is so relaxing that deep and painful issues are less frightening to discuss in the therapy session (Homeyer & Sweeney, 1998).

Beginning with Margaret Lowenfeld in the early 1900s, the use of sandtray began as a therapeutic approach, which she called the "World Technique." Clients used miniatures as a vehicle for communicating and expressing their emotions and resolving conflicts in their internal and external experiences (Turner, 2005). In 1956, Dora Maria Kalff, a Jungian therapist, studied with Lowenfeld, applying Jungian concepts to the World Technique, subsequently developing Sandplay. Both Kalff and Lowenfeld believed the goal of sand work was to uncover the nonverbal, but Kalff believed that the creation of a series of sandtrays led to healing at deeper, unconscious levels. Lowenfeld was much more active with the client during the creation of the sandtray, talking with the client, asking questions, and making interpretations; whereas, Kalff believed such dialogue was intrusive and focused more on the completed tray with the role of the therapist being one of an observer (Homeyer & Sweeney, 2005).

Since that time, several theoretical approaches to play therapy have been applied to the therapeutic and healing property of sandtray work, including Adlerian (Bainum et al., 2006), Jungian (Peery, 2003), Gestalt (Oaklander, 2003), family (Carey, 2006), and group play (Hunter, 2006) therapies. Clinicians using these different theoretical approaches employ, to different degrees and in different formats, sand and its miniatures as a method of assessing, communicating, and facilitating the healing process; however, most of the literature on therapeutic sandtray addresses Kalff's Jungian approach (Bainum et al., 2006).

Recently, postmodern clinicians have drawn upon the healing aspects of miniatures and the sandtray, including narrative (Freeman, Epston, & Lobovits, 1997) and solution-focused (SF) therapies (Nims, 2007), the sandtray becoming another component of the therapy process. Little has been written, however, about the application of SF philosophy and therapeutic techniques to sandtray with children and adolescents; therefore, it is the author's aim to address this void and demonstrate the practical application and integration of SF theory and techniques to sandtray and its miniatures. The reader is encouraged to examine the writings of well-known and experienced practitioners and researchers, including those of Homeyer and Sweeney (1998, 2005), Hunter (2006), and Turner (2005) regarding the specifics of sandtray, including selection of miniatures, tray and sand options, and interpretation, as these will not be addressed here.

SF THERAPY AND ITS APPLICATION TO SANDTRAY WORK

Basing their work on the communication approaches of Gregory Bateson and Milton Erikson, Steve de Shazer and Insoo Kim Berg developed, researched, and wrote extensively on SF therapy. Unlike other therapies that are based on already established philosophies and techniques, Berg and de Shazer based their work on inductive procedures of attending to what worked with clients and what clients had

to say about what was useful in therapy (De Jong & Berg, 2008). Researchers (Corcoran, 2006; Franklin, Biever, Moore, Clemons, & Scarmardo, 2001) have demonstrated that SF therapy is an effective approach not only with adults, but also with children and adolescents, so that it is increasingly being adopted in schools as an alternative to the more pathology-oriented focus on problems (Gingerich & Wabeke, 2001). Berg and Steiner (2003) and Selekman (2005) discuss the use of SF therapy with younger children using developmentally appropriate language and reliance on playful and concrete approaches, such as art, games, and stories.

The philosophy of SF therapy rests on the resilient nature of the individual and the already present strengths that can be employed to solve current and future problems. Taking the focus of therapy off the problem, the therapist works to assist the client in identifying personal strengths, much like searching for hidden treasure. Not ignoring the past, the therapist validates personal pain and difficulties and brings to clients' awareness their abilities and coping skills to endure, conquer, and overcome past difficulties. Clients are often surprised by the very different focus on strengths in the present and how these can be employed in the future rather than delving into lengthy stories of past problems and traumas (De Jong & Berg, 2008).

The SF therapist attends to and focuses on clients' key words, carefully exploring exceptions and successful attempts in dealing with problems, thus assuming clients have the resources necessary to solve their problems, want to change, and can visualize hopeful futures. Not dwelling on problem descriptions, SF therapists are continually impressed with clients' successes and curious about how clients have been able to manage and cope so well in challenging circumstances (De Jong & Berg, 2002; Gingerich & Wabeke, 2001).

SF and sandtray therapies share several underlying principles that might generate potential for their convergence into theoretical applications that stress resiliencies, strengths, and possibilities without the limitations that primarily verbal approaches often demand. Both sandtray and SF therapies seek to help clients by "empowering them to be masters of their own lives. . .capitalizing on their competency areas, respecting their defenses, and giving them room to tell their painful stories, when, or if, they are ready to do so" (Homeyer & Sweeney, 1998; Selekman, 1997, p. 4). Both focus on the interpersonal processes involved in healing the self, not techniques. Homeyer and Sweeney (1998) state that it is not the technique that heals, rather, people are healed through their interactions with self and others. Healing involves inner, relational, and heart processes. SF therapists believe that "communication is considered the process by which system members define self in relation to other and simultaneously create the ongoing nature of their relationship" (Beyebach, Morejón, Palenzuela, & Rodríguez-Arias, 1996, p. 301).

The SF therapist is similar to several of the known sandtray therapists. For example, the SF therapist working with sandtray employs the observer role of the Kalff therapist but also Lowenfeld's active role during creation of the sandtray. The SF therapist combines the stance of observer with interviewer, collaborator, and explorer (Homeyer & Sweeney, 1998, 2005; Hunter, 2006; Siegelman, 1990). Both Adlerian sandtray and SF therapists are goal-directed and believe that movements toward change are necessary (Bainum et al., 2006; De Jong & Berg, 2008).

FOCUSING ON STRENGTHS

Three different approaches used to find and amplify strengths and develop goals that are both unique and common to SF therapy are compliments, relationship questions, and exception-finding questions. Each, used throughout the therapy process, can easily be illustrated using the sandtray and its miniatures.

Compliments

Compliments in SF therapy can serve to open doors that might seem closed, particularly to those mandated to come to counseling, but also to the discouraged who seem unable to uncover personal strengths and resources. Therapists can enlist three different types of compliments throughout the session—direct, indirect, and self-compliments. The direct compliment is a statement that recognizes what the client is doing that is successful. It is not a compliment without substance; rather, it is based on factual data, which may or may not have been recognized by the client. For example, the therapist might state to Anna, a middle school girl having difficulty completing her homework, "I am amazed at how much work you have done since I saw you last week." The indirect compliment enlists relational aspects into the solution by helping clients to indirectly compliment themselves through the recognition of what others might notice or say. An example of an indirect compliment could be "I wonder what your mom might say about the hard work you have been doing in school." The self-compliment allows the client to speak at the expert on his or her strengths and success and is often considered the most credible. For example, the therapist might ask, "How did you manage to get your homework done?" (Berg & De Jong, 2005).

Compliments in sandtray therapy may augment the client's feelings of empowerment and facilitate the sandtray process. For example, one client demonstrated his ability to run away from his father who was inebriated, illustrating his actions through sandtray fences, buildings, and figures. The author using a direct compliment pointed out his good problem-solving skills and his ability to think quickly. Using the indirect compliment, the client was asked what others in the sandtray might say about his actions to which he responded that he had done just as his mother had instructed, and he thought she was proud of him.

Relationship Questions

SF is an interactional theory, in that the way clients view themselves is based on how others view them, so that although change is discussed in future terms, it is also discussed in interactional terms through relationship questions. These questions assist clients' understanding of their behaviors and how changes in those behaviors affect others, which in turn affects the clients.

Three types of relationship questions are commonly used in SF therapy. The most direct relationship question is in regard to how the client perceives others' viewpoints and behaviors about the client's changes. For example, the therapist

might ask Anna, the young girl having difficulty completing her homework, "Who will be the first to notice when you are getting your homework completed?" A second type of relationship question places the emphasis on the client's significant support member, for example, "What will your mother say when you get your homework done?" A third type of relationship question beckons the client to prove him or herself to the significant person with a challenge, "What will it take to prove to your mother that you do not need to be bugged anymore about doing your homework?" or "What has to happen, so that your teacher does not think you have to come here anymore?" These last two questions are often effective with those who are mandated to come to counseling or who are reluctant to admit responsibility in the problem or its solutions (De Jong & Berg, 2008).

Sandtray provides a vivid action picture of what happens in relationships when change occurs. For example, the therapist might work with the client to create a genogram, a graphic display of at least three generations that provides clues to individual and family patterns and functioning (for symbols and information on genogram construction, see McGoldrick, Gerson, & Petry, 2008). The therapist may begin by stating "I would like to get an idea of who everyone is in your family, and since it is difficult for me to remember names, I find it easier if I try to make a family map." Gil, the first to demonstrate the use of genograms in sandtray therapy with families, suggests that the therapist use a large sheet of easel paper on which to draw the genogram for the family members, and then have clients select from the miniatures those that represent themselves and place them in the drawn boxes or circles representing the respective family members. The genogram need not be limited to just family members but may also include the family pets and friends. The client(s) is then asked to talk about his or her selection (Gil, McGoldrick, Gerson, & Petry, 2008). With some children and adolescents, it is possible to set up the genogram directly in the sand rather than on paper, so that the sand itself can be a component with which to work. The therapist might go to each miniature asking what would be noticed, which of the miniatures would notice, and what the reaction would be if changed occurred. Further, the figures might talk to one another, asking questions about the strengths the client exhibited in reaching her goal or provide ideas about ways the goal might be reached. Each of the three relationship perspectives can be illustrated effectively and concretely through the miniatures as they talk to one another, giving the sense that all are in the room. Shifts can be further demonstrated as the young client purposefully places the miniatures to represent relationship changes or support.

Exploring for Exceptions

Problems rarely occur all of the time or at the same severity. Invariably, exceptions occur. Exploring for exceptions, the therapist first listens and watches for times when the problem may not have occurred, when the client used inner and external resources to assist in solving the problem, or when the problem should have occurred but didn't (De Jong & Berg, 2008). The therapist explores in detail what happened during those times the problem should have occurred but didn't, who was present, what the effect was on the client, and how the exception affected

others. Exceptions also include asking the client what he or she would like to be different, how it will make a difference if these changes occur, what it would be like, and if, perhaps, the client is already experiencing some of these changes (Walter & Peller, 1996).

For example, Anna might be asked to create in the sand a time when she did her homework or even part of it. By asking this question through sandtray, Anna is forced to think about the details, who was present, and where she was when this exception occurred. The therapist would then ask questions regarding what was most helpful in completing her work, who provided or could provide assistance, what it feels like to be successful, who notices, and other details that allow her to rehearse the successful sequence of events and begin to note how this might be repeated. Anna's sandtray also informs the therapist of the client's strengths but also the obstacles or challenges that may require attention.

STAGES

SF therapy contains five stages: (a) "describing the problem,"(b) "exploring for exceptions," (c) "developing well-formed goals," (d) "end of session feedback," and (e) "evaluating client progress"(De Jong & Berg, 2008, pp. 17–18). Primarily, SF therapists rely on verbal language to process and progress through each stage; yet, sandtray therapy offers a more nonverbal alternative, both client and therapist using the sandtray to communicate to one another.

Stage I: Describing the Problem

Just as many sandtray therapists do, it is appropriate in the beginning of therapy to ask the client to "create a world," "build your world," "build a scene," or "select a few miniatures that really speak to you. Place them in the sand. Then add as many you like to create a world in the sand" (Homeyer & Sweeney, 1998, p. 60). As the client initially constructs the world in the sandtray, therapist communication should be carefully considered. This may be likened to the client's verbal discussion of pain, problems, and resolution of past and present life events, because the miniatures and sand are the means through which communication takes place (Homeyer & Sweeney, 1998). As the client constructs the sandtray, the therapist listens and attends more through body language and less through words. Just as a sandtray therapist would use person-centered techniques, the SF therapist employs the similar techniques of paraphrasing and reflection on content and feelings (De Jong & Berg, 2008; Vinturella & James, 1987). As the relationship between the client and therapist builds, questions are minimal, and the therapist remains open to the client's story.

Who and What Are Important to Clients

Questions are used by the therapist to explore who and what are important to the client, indications of past successes, and to identify key words the client uses in

identifying the problem. Questions should not be used to get the client to say something the therapist already knows or has in mind but rather for a better understanding of the client and how he or she experiences the world. The therapist would then use the client's key words and sometimes ask about their meaning (De Jong & Berg, 2008). Just as in sandtray therapy, the therapist does not assume meaning of specific miniatures or that items stand for something, since the meaning of the item is specific to each child (Vinturella & James, 1987). Instead, the therapist asks questions about miniatures and how they are related to one another and to the world the client created. Questions would naturally address the current and past problems, feelings, and associations, but SF therapists do not dwell on the discouraging aspects of a problem or the negative feelings associated with it, as this tends to amplify the problem and focuses attention on the painful aspects of clients' lives rather than on the clients' strengths and power to cope and find solutions (Gingerich & Wabeke, 2001).

Another approach to helping clients to discuss what is important to them is through the construction of a genogram. The genogram may be constructed in the beginning sessions to obtain an understanding of the family and friends and their relationships to one another and the client. For example, in one situation an adolescent selected miniatures to represent family members, including those who had died, which he buried in the sand using skeletons and gravestones. Then, next to these gravesites he placed bottles depicting alcohol use and wrecked automobiles, in addition to police and ambulance vehicles, providing a graphic display for both the adolescent recently accused of substance abuse and the therapist of just how much death and alcohol use had impacted him and his family.

Once an understanding of who and what are important to the client has been established, the client might be asked to set up the "hoped-for future" when things are different (Gil et al., 2008, p. 257). This approach follows the SF philosophy of focusing on positive futures while allowing the young client to visualize through sandtray therapy what could actually be different and how change might affect and be affected by family members.

STAGE II: DEVELOPING WELL-FORMED GOALS

Goal-setting is one of the main pillars of effective SF therapy (Iveson, 2002). SF therapists believe goals should be: (a) formed using solution language, not the absence of a problem; (b) specific, concrete, measurable, and behavioral; (c) doable and realistic; (d) described within a social and interactional context; and (e) valuable to the client (Berg & Steiner, 2003). A variety of approaches assist in goal setting, but well-formed goals are actually set by the client from his or her frame of reference using imagined alternative futures and affirmations of what is already occurring or what clients have already done. This can be accomplished through several different types of questions, including the miracle question, exception questions, and scaling questions (Berg & Steiner, 2003; De Jong & Berg, 2008).

Miracle Question

Once the client has discussed the problem situation, the miracle question is asked, inviting the client to project what life will be like without the problem. The answer to the miracle question becomes the goal and focus of treatment (Rita, 1998). This question helps clients develop new perspectives on problems and widens the area of possible solutions (Walter & Pellar, 1996). The following illustrates the miracle question and how it might be used with sandtray. "Suppose that you go home this afternoon, you get a snack, and maybe do some homework and watch TV. Then, you go to bed with your favorite pillow and fall gently to sleep. While you are sleeping, a miracle happens, so that the problem that is troubling you is gone. However, since you were sleeping you didn't know the miracle happened, but when you wake up in the morning the problem is gone. Create in the sand what your world will look like if this happened" (adapted and modified from De Jong & Berg, 2008). Of course, the sandtray miniatures, such as wizards, fairy godmothers, angels, and other mystical figures can be used to actually ask the miracle question. With younger clients, it is appropriate to substitute more familiar language for "miracle," such as a fairy godmother who waves her magic wand (Berg & Steiner, 2003). Being able to manipulate one's world in the sand in ways that goals are already achieved provides the client with sense of control, a chance to rehearse the behaviors needed to make change occur, and the opportunity to notice the interpersonal impact that the change might have. The therapist is provided the opportunity to ask the client in a more concrete approach who or what may assist and support him or her in reaching goals.

Occasionally, clients will answer the miracle question with something that is unrealistic, such as divorced parents reconciling or a deceased grandparent being present. When this happens, it is better not to argue that it is unrealistic but rather to ask, "What will you be doing that you aren't doing now?" Often, the answer to this question can be expanded (Berg & Steiner, 2003). For example, a client might state, "I would be going to the park with my dad." From this the therapist could ask the client to construct times when the client has been to the park that may not have been with his or her dad or to construct times when the client has felt as he did when he went to the park with his dad. The focus is then on what the child is doing or feeling and how this behavior might be already occurring or could be repeated rather than focusing on the unrealistic components. This takes place around the miracle world the child has created in the sand with questions focusing on strengths, exceptions to problems, and possibilities for the future (De Jong & Berg, 2008).

Scaling Questions

Scaling questions are often used to develop goals, as well as to assess motivation, success, feelings of efficacy, and other cognitive, behavioral, and feeling states (Berg, 1994). Scaling questions can be used to assess the current condition and then plan what needs to happen for the situation to get better. For example, the therapist might use a scale of 1 to 5 for younger children or 1 to 10 with older children asking, "On a scale from 1 to 10, with 1 you are doing horrible and 10 you are doing great, the best ever, what number would you say you are right now?"

Not all children are ready to verbalize, and some are not capable of understanding the concept of scaling questions. Using the sandtray, the therapist might use different sizes of sticks (cars, blocks, and other miniatures) to represent each of the numbers, with the smallest stick representing the more negative feelings. The child may then point to the stick size that signifies where he or she is. With older children, it is sometimes useful to have them select from the different mythological, animal, or people figures what might represent each of the numbers on the scale. For example, the author observed one adolescent choose different types of superheroes, city workers, and horror movie figures for each of the scaled numbers. One day, he chose a worker with a shovel to represent a 5, which was the number he gave himself. This seemed to be an effective visual to communicate the feelings and thoughts he had about taking care of his siblings, protecting them from an abusive parent, and keeping his family intact.

Once the current situation is assessed using a scale, the second question could be, "What would it take for you to be a 7?" Using the previous example, the therapist might ask, "What would it take for you to be Spiderman (the figure the child had selected to represent the 7)?" For clients who are reluctant to make changes or who seem hopeless about change occurring, one might ask, "What would it take to move from a 5 to a 5-and-a-half?" This would represent such a slight change that little effort would seem to be necessary, yet clients are often willing to suggest something, which is often just enough to initiate forward movement.

Another approach to this exercise might be to ask the child to make three different scenes in the sandtray representing three different events that occurred since the last session. The client might then scale each of these events and discuss what the elements were that made these events successful, or what times during these events that just a little success occurred. Questions might then be asked to determine what could happen to help these successful events materialize in the future. The answers to these questions would then become future goals.

A timeline might also be useful in setting goals. For example, with middle schoolers, the author asked clients to depict their lives on a timeline. A marker was provided to indicate the present. Clients often used miniature babies and children to represent themselves, as well as siblings and friends. Gravestones representing the death of loved ones and street signs for markers of positive and negative events in life were used frequently. Clients were then asked the miracle question in terms of the more distant future: "Suppose tonight that you go to bed and while you are sleeping a miracle happens. In the morning you wake up and find that it is 20 years into the future, and all of the things you want to happen have happened. What will you notice is different about your life?" Once the client responds, the follow-up questions might revolve around what the client has been doing over these 20 years to make this miracle occur. Many have used a bride and groom to represent themselves in the more distant future, as well as books and school houses to represent their understanding of the need to do well in school. The present has often been represented by figures representing friends, objects such as a bicycle and skateboard to represent those things they were doing, as well as liquor cans and bottles to represent their present and past behaviors or that of their parents.

END OF SESSION FEEDBACK: COMPLIMENT, BRIDGE, AND SUGGESTION

As the session draws to a close, the therapist takes a "break" to reflect on the therapy session during which time he or she develops a compliment, bridge, and suggestion based on the session. The therapist might leave the room, if the client is able to be left alone, but oftentimes it is appropriate to take 5 to 10 minutes of a "thinking break" (De Jong & Berg, 2008). For the therapist using sandtray therapy, the break time is an excellent point at which to reflect on what the child has constructed, take pictures, and jot down notes. Without leaving the therapy room, the therapist can state, "Let me look at the hard work you have done"; or "I want to be sure to remember what we did today, so I want to take down a few notes and take some pictures, if that is okay with you." The break is also the time the therapist develops feedback for the client through the compliment, bridge, and suggestion.

After several minutes, the therapist compliments the client, directly or indirectly, using or not using the sandtray as an illustration. Compliments serve to affirm to the client that the therapist has been listening and appreciates the efforts the client is taking in working on this problem. Compliments also serve as a way to point out to the client his or her strengths and successes, which may have gone unnoticed by the client because of the effort it has taken to struggle with the problem (Berg & De Jong, 2005; De Jong & Berg, 2008). Illustrating this in the sandtray is even more powerful and can provide tangible acknowledgment of the struggle but also the strengths of the client. For example, one client who portrayed himself a weak and disheveled figure with the miniatures had been able to cope with the impending divorce of his parents and the embarrassment of an alcoholic parent who had made life difficult. Since his strength to cope with this problem was amazing but unnoticed, it would be appropriate to place a superman behind the same figure he had selected, with the figure he selected not being removed, as this would negate the feelings of powerlessness he had. Rather, the therapist might state, "It seems like there are times where life is difficult, but underneath it you seem to have some hidden power to overcome, much like superman does when he goes into the phone booth. The power doesn't come out until there is trouble."

The bridge is the part of the message that links the compliment to the suggestion and provides some rationale and motivation for what the therapist might suggest (Berg & Steiner, 2003). The bridge might begin with "I agree" or "This has been difficult," thus affirming the efforts or challenges posed by the problem. This is done before assigning the suggestion.

Suggestions often depend on how clients perceive themselves in relation to the problem and if exceptions can be uncovered. If clients do not think there is a problem, cannot find exceptions to when the problem is not occurring, or feel they have little control over the problem, it is best to compliment the client for their efforts to cope with the problem, particularly since the problem is so stubborn, and then express openness to visiting with them again. If the client admits to a problem but denies responsibility for any part of the problem, an observational suggestion would be recommended. The therapist might state, "Between now and the next time we meet, I would like you to observe, so that you can describe to me next time, what happens in your life that you want to continue to have happen" (see de

Shazer, 1985, p. 137). By means of the sandtray, this question might be posed using the sandtray the child has created at some point in the session. The sandtray might help the child recall such changes, with the sandtray acting as a photograph of earlier events.

When clients perceive that they are a part of the problem, then behavioral suggestions are appropriate and much more likely to be attempted. The task is often based on a small part of the miracle response (Rita, 1998) and revolves around one of three ideas: (1) observing what occurs that the client wishes to continue; (2) doing more of what is working; or (3) doing something different (De Jong & Berg, 2008). For example, the therapist might state to a client having difficulty getting her homework completed, "I am amazed how well you get your homework done sometimes when no one asks you to do it. I agree it is not always easy to do, because playing is so much fun. What I would like you to do is between now and the next time we meet, decide on two days when you will do your homework without anyone asking. Then, when you come back to see me, I want you to tell me about it."

The compliment, bridge, and suggestion can easily be constructed and rehearsed using the sandtray. For example, it might be that the therapist constructs a sandtray illustrating the strengths and resources the client has demonstrated in the midst of troubling situations, thus illustrating the compliment and bridge. To carry out the suggestion, the therapist might set up the scene exactly as the client had and then ask the client to try something different, but be creative, using the miniatures. In this way, the client is role-playing possible scenarios while observing the impact this might have on others.

EVALUATING CLIENT PROGRESS

During subsequent sessions, the SF therapist looks for successes, then amplifies and reinforces them. A common first question asked in subsequent sessions by the SF therapist is, "What's better?" (De Jong & Berg, 2008). It has been the author's experience that clients sometimes become so accustomed to such questioning that they begin thinking about what's better before entering the therapist's door. The therapist doing sandtray therapy could ask the child to make a scene of what is better. For example, in one situation a client placed each of his parents in the sandtray along with a can of beer beside his mother, stating, "it's just one beer rather than the big bottle of wine. She's not drinking so much." Further questions about this revealed the client to be more relaxed, which had a positive effect on behavior and academic success. Scaling questions can then be used to evaluate the client's progress and assess change, as well as to plan for the next step.

Once the client has stated an exception to the problem, the therapist would amplify such successes (De Jong & Berg, 2008). For example, in the previous situation, the client was asked once his sandtray was completed what he was doing different. He discussed how he was able to focus more on his homework and not worry so much. To be sure he took credit for his behaviors, the author asked other questions, including "How are you able to do this?" "What do you do instead of worry?" Relationship questions are also used to reinforce such behaviors. For

example, "Who has noticed that you are doing your homework more?" "What does your father say about that?"

CONCLUSIONS

The use of SF theory and techniques with sandtray therapy offers a positive and empowering approach to working with clients. This first in-depth exploration of the use of SF therapy with sandtray therapy presents a blending of two therapies that allow the client to visualize and process problems, but also solutions to those problems. Although SF therapists (Berg & Steiner, 2003; Selekman, 1997) have explored the use of SF therapy with children, only Nims (2007) has suggested the use of SF in play therapy and only minimally addressed sandtray therapy. This exploration of the combination of SF therapy with sandtray therapy opens new territory in practice and research and provides new ideas about how the therapist might facilitate client growth and healing. More research is needed regarding the efficacy of this approach with specific problems and age groups.

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Correction to Glover and Landreth (2000)

The article, "Filial Therapy With Native Americans on the Flathead Reservation," by Geri J. Glover and Garry L. Landreth, *International Journal of Play Therapy, 9*(2), 57–80, was originally published with the wrong first page. Printed issues contain the first page for the preceding article, "Effectiveness of Filial Therapy for Korean Parents," by Mikyung Jang. The online version has been revised to present the correct first page. See http://dx.doi.org/10.1037/h0089436

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