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Using sandplay therapy to bridge a language barrier in emotionally supporting a young vulnerable child

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ABSTRACT

The purpose of this study was to explore the usefulness of sandplay therapy to overcome a language barrier in the process of emotionally supporting a very young, Human Immunodeficiency Virus (HIV) & Acquired Immune Deficiency Syndrome (AIDS) infected, orphaned Sotho-speaking child. The qualitative case study involved informal assessment and re-assessment, and employed observation, interviews, field notes, and photographs. In our hermeneutic-reflective narrative of the sessions we employed a psychoanalytical developmental model, an object relations, and a Gestalt therapy perspective, and highlighted the value of therapeutic touch. Our thematic analysis and crystallization of data indicated that 18 sessions of sandplay therapy had been effective in supporting her emotionally, and may be useful for vulnerable children with pre-verbal trauma.

Introduction

This paper reflects the story of a young vulnerable child's work through play to transcend preverbal wounding at the level of organizing experience, and a therapist's efforts to support her across a language barrier in this healing journey. The single instrumental qualitative case study relates selective aspects of therapy with an orphaned, HIV&AIDS infected, almost four-year old Sotho-speaking, girl who showed signs of serious emotional disturbance. The material context of the case is the HIV&AIDS pandemic that results in many children being left vulnerable to physical, sexual, or emotional abuse and in need of emotional support. The theoretical context that informed our hermeneutic commentary on the therapy sessions integrates the mythological developmental model customarily used in sandplay therapy, an object relations perspective, and a Gestalt therapy perspective, and illuminates the value of nurturing touch as a way to heal pre- or non-verbal disturbances.

A case narrative of the subject's history and presentation precedes an analysis of the therapy sessions considering the relevant theoretical constructs, with emphasis on how the elements of silence and relationship that characterize sandplay therapy may serve to bridge the language divide where a helper and child do not speak the same language. Informal assessment of the participant before the intervention revealed she had three primary areas of difficulty that may have been caused by early trauma or deprivation: being overwhelmed by negative emotions, as well as appearing to be emotionally immature for her age; displaying limited relationship and social skills; and having verbal and nonverbal communication difficulties.

Our conclusions from post-intervention assessment as well as thematic analysis and crystallization of data obtained by observation, interviews, field notes, and photographs were that the participant had benefited from the therapy by showing marked signs of emotional healing and maturation; improved relationship and social skills; and improved verbal and nonverbal communication. The aim of this paper is to add to the much needed work of emotionally supporting the huge numbers of very young children and/or linguistically different children who have been subjected to traumas related to early environmental deprivation by way of interventions that do not depend on spoken communication.

Material context

In South Africa many children are left vulnerable to physical, sexual, and emotional abuse due to circumstances beyond their control. The child who participated in this study was affected by HIV&AIDS, the death of her primary caregivers, being institutionalized, facing severe emotional challenges, as well as suspected sexual abuse. Vulnerable children might find it difficult to express their emotions verbally due to limited linguistic skills or insufficient insight into and awareness of their inner feelings. However, emotional expression is regarded as important to promote

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wellbeing (United Nations International Children's Emergency Fund [UNICEF], 2005).

In South Africa, there are eleven official languages. More often than not people in helping roles and children in need do not speak the same language. Even more so than in other countries (Tribe & Lane, 2009), there appears to be a shortage of adequately trained bilingual interpreters. Due to varying levels of linguistic skills in children, as well as the diversity of languages, helpers might have to utilize intervention strategies that do not rely on verbal communication (Dale & Wagner, 2003). In this regard, sandplay therapy could be appropriate for use within populations with diverse languages, cultures, races, ages and developmental levels (Campbell, 2004; Carey, 1990). Following is the theoretical backdrop to this research, where sandplay as an expressive arts therapy is also located within the toy-box of non-directive play therapies.

Theoretical context

Sandplay is an expressive arts therapy related to art and to play (Steinhardt, 2007). Friedman and Mitchell (2008, p. 5) placed this technique "...firmly within the domains of expressive arts therapies, play therapy, EMDR [Eye movement desensitization and reprocessing], and the larger arena of contemporary psychotherapy that recognizes the importance of both verbal and non-verbal approaches." Making art is a primordial way of coping with trauma. Giving form to feared objects or difficult experiences brings them under our own symbolic control (Rubin, 2010). Play is the behavioral and psychic equivalent of oxygen. There is "...a relationship, if not a conspiracy, between the drive to play and the development of mind" (Hughes, 2001, p. xvi). Play may be built into the universe itself, from the tiniest spinning atoms to the largest wheeling galaxies (Blakemore, 2012). Capitolo (2002) maintained that chaos theory could serve as a template for the sandplay therapy process, as the chaotic systems unfolding in the psyche are manifested in play. Bio-outcomes of play include an increase in brain size and organization, greater resilience, optimism, mental flexibility, the development of cortical maps, and an increase in successful adaptive strategies (Hughes, 2001).

The sandplay method consists of the client creating a three-dimensional picture with miniature figures in a tray of sand. Visualization and imagery, psychodrama, body work and movement, and cognitive restructuring are some of the therapeutic strategies that interface with and augment the sandplay process (Institute of Therapies for Emotional Transformation). Sandplay provides a "free and protected space" (Kalff, 1981, p. 23) where the client can express and experience the emotions caused by early trauma, abandonment, or deprivation. Silence and relationship are key elements in sandplay therapy (Chiaia, 2001). The language of symbols is spoken by the choice, combination, and placement of the miniatures, thus communicating the client's deepest hurts as well as untapped inner resources (Fitzpatrick, 2012). Bypassing language, sandplay helps a child to cathartically release painful emotions and work through an impasse, playing out a tea party or a war as a way of proprioceptively understanding and merging with the culture. The method involves an internal relational therapeutic stance that includes present-centered sensory attention in direct relation to the client's in-the-moment experience; the approach is essentially phenomenological (Geller, Greenberg, & Watson, 2010).

Pioneer Dora Kalff used Erich Neumann's mythological developmental model to look for the emergence of the self in sandtrays (Bobo, 1997). Neumann's idea that the individual psyche evolves in an archetypal pattern has been echoed by Hall's theory of recapitulation that is foundational to the field of evolutionary playwork, namely that children's play reflects the course of evolution from prehistoric hominids to the present (Hughes, 2001). Neumann postulated that at birth the child is a totality with the mother's self, and that separation gradually takes place, so that by the third year of life, the child's self is established. The first stage, both of humankind's and the individual's evolution of consciousness, is symbolized by the "uroboros," the snake that swallows its own tail and represents the primordial chaotic condition, wholeness, or infinity. The following stages are: "great mother," "separation of the world parents," "birth of the hero," "slaying of the first parents," and finally, "the treasure hard to attain" (Bobo, 1997, p. 76). The stages may be simplified as "chaos," "struggle," and "resolution" (Hunter, 2006, p. 224). If there has been significant trauma in the early life of a child, the chaotic pre-ego stages is where much of sandplay work will focus (Kalff, 1991, 2003).

From an object relations perspective, when the child's natural growth becomes arrested because mother and other caretakers are unable to provide the necessary self-object functions, the child is at risk of developing a "self disorder" (Waterman, 1997, p. 106). The qualitative developmental leap toward becoming a subject is the shift from object relating to object usage. Object usage enables the person to have an "I-Thou" rather than an "I-it" (Blom & Dhansay, 2006, p. 224) relationship with others. From a Gestalt therapy perspective, this process may be described in terms of creating, destroying, and recreating the dynamic relations of figure and ground (Stevens, 2004). The spontaneous and creative search for strong Gestalts may be expressed in the sandtray, a safe space where the organism creatively adjusts to its environment, seizing upon and ingesting what is nourishing.

According to Zur and Nordmarken (2011), sometimes using touch in therapy may be the only way to heal pre-or non-verbal disturbances. Touch helps the therapist to provide real or symbolic contact and nurturance. It facilitates exploration of, and resolution of emotional experiences, provides containment, and restores significant and healthy dimensions in relationships. Congruent, invited, and appropriate touch increases a sense of empathy, sympathy, safety, calm, and comfort (Hill, 1995).

Clinical and research method

The study was conducted within the *interpretivist paradigm*, following a *qualitative approach*. We designed our instrumental single case study to provide a contextually rich, in-depth description (Baxter & Jack, 2008; VanWynsberghe & Khan, 2007; Zucker, 2009). The kind of intervention outcome results likely to come from qualitative, practice-based enquiry depend on the critical-practitioner stance that combines clinical wisdom and interpersonal forms of knowing with critical science. Here a critical understanding of psychology includes quantitative, ideographic, and narrative methods (Larner, 2001).

We selected the primary participant purposefully according to the criteria pertaining to the study, namely the presence of a language barrier, the participant's vulnerability, and a need for therapeutic intervention. Secondary participants were the subject's caregivers. Informal qualitative assessment (at the beginning of intervention) and reassessment (at the end of intervention) determined whether the participant had been supported emotionally during the intervention. The procedure involved a multi-method data-gathering plan.

There were three initial informal assessment sessions with the primary participant, where an interpreter assisted. We used drawings, paintings, and the non-standardized Scenotest (Von Staabs, 1991) that is based on non-directive play principles. The Scenotest is a projective instrument employed to gain insight into matters that the patient might not be able to express, perhaps due to emotional or physical abuse. At the outset, we conducted informal