The Sand Tray Technique in the Treatment of Patients With Dissociative Disorders: Recommendations for Occupational Therapists

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The sand tray technique is also helpful in the exploration and uncovering of dissociated trauma. The main treatment goal in working with patients with dissociative disorders is to uncover, understand, and work through those memories that were dissociated. Memories are gradually reassociated and integrated into a more unified and organized sense of self. The sand tray technique is an excellent medium for the attainment of this goal, because it allows patients to gradually uncover and process traumatic memories in a manner that no longer overwhelms them. The patient’s affect can later be effectively worked through with the primary psychotherapist’s help.

Use of the Sand Tray Technique by Occupational Therapists

Although I previously emphasized the content-oriented use of the sand tray (Sachs, in press), I believe this task is suitable for a process analysis, which focuses not on what the patients do, but on how they go about doing it. In this way, the sand tray procedure is similar to many occupational therapy techniques and can be easily incorporated into a routine occupational therapy assessment.

Currently, most mental health professionals are not using the sand tray technique. Because this technique appears to be sensitive to the presence of a history of abuse or the eliciting of dissociative behaviors, however, its routine inclusion at some point in the overall assessment of a psychiatric patient seems justified. The sand tray procedure is more easily used in an occupational therapy assessment than in a psychological or psychiatric examination because of occupational therapy’s traditional focus on activities. The occupational therapy assessment may reveal a history of abuse that has not surfaced in routine psychological or psychiatric assessments. This likelihood becomes even more probable when the patient appears to be polysymptomatic and the diagnostic picture seems unclear.

The routine use of the sand tray technique in assessments could complement its use by the primary psychotherapist. For example, in my version of this procedure, the patient is left alone to work with the tray and other materials. The primary psychotherapist, therefore, has little or no knowledge about the process of the patient’s sand tray construction. An occupational therapist can provide this information by observing the patient’s work and taking notes about how it is accomplished. Thus, the occupational therapist would monitor the act of creation, and the primary psychotherapist would assess the completed sand tray.

The following information would greatly enhance the primary psychotherapist’s interpretation of
the patient’s sand tray construction: (a) the method of approach to the sand tray task (i.e., does the patient work as though he or she has an idea of what the final product will look like or does he or she work in spontaneous bursts of activity that become organized over time?),(b) the affect displayed in response to certain objects, (c) indications that the patient tends to animate objects (e.g., does the patient kiss or stroke objects?), and (d) the factors that seem to influence the selection of an object and where it is placed in the sand. For example, does the patient approach other tasks in the same way as he or she approaches the sand tray? Do life-sized objects in the patient’s environment (e.g., chairs, bathtubs, lighted matches) elicit the same type of affective response as similar kinds of miniature objects available for use in the sand tray? Do changes in the patient’s sand tray performance parallel changes in his or her behavior in other situations? All of the above questions are asking whether the new adaptive coping skills are generalized. The occupational therapist can apply these suggestions for using this medium in the treatment of patients with dissociative disorders as well as those with other psychiatric disorders.

Conclusion

Patients with dissociative disorders who were victims of early childhood abuse are often psychodynamically complex. The multidisciplinary team’s treatment approach affords these patients both verbal and nonverbal opportunities to uncover and successfully process dissociated trauma. Occupational therapy, art therapy, and specific milieu groups offer rich therapeutic environments in which issues of past and present-day living skills can be addressed. I recommend that occupational therapists use the sand tray technique for treating patients with multiple personality and dissociative disorders for the following reasons:

1. This technique provides an opportunity for the spontaneous detection of a potential abuse history or of the presence of dissociation when no direct indication of either of these possibilities is suggested by routine psychological or psychiatric assessments.
2. Observations of how the patient makes a sand tray complements the primary psychotherapist’s interpretations of the finished sand tray construction.
3. This technique gives the occupational therapist a useful way of organizing, integrating, and understanding developmental changes in the patient’s behavior over time.

References