USING SANDTRAY THERAPY IN SCHOOL COUNSELLING TO SUPPORT STUDENTS COPING WITH DEVELOPMENTAL TRAUMA

by

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Abstract

In Canadian schools today, there are many children coping with the effects of developmental trauma. Due to the issues and behaviours these children often exhibit, school counsellors are left to support these children with limited time, resources, and tools. In many cases, school counsellors are the only source of professional mental health support available to these children. It is possible that sandtray therapy may be a developmentally appropriate method that school counsellors can use to deliver therapy to these children in a way that feels less intimidating than talk therapy. It provides the student with a sense of control and safety to explore underlying issues without having to explicitly verbalize them, allowing the student to potentially maintain regulation during the therapy process and upon returning to class. The findings of this capstone will encourage school counsellors to incorporate sandtray therapy into the scope of their practice to support students who are coping with developmental trauma. By providing school counsellors with a professional development workshop detailing the effects of developmental trauma on students, the sandtray therapy process and its benefits, and ideas on how to incorporate sandtray therapy into the school counselling practice, school counsellors will have the information they need to pursue the next steps in using sandtray therapy in the school counselling setting.

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Chapter 1: Introduction

Introduction

This paper provides an understanding of how developmental trauma effects school-aged children and examines how sandtray therapy can be used by counsellors to support these students in the school setting. It also includes a workshop for counsellors to learn more about the importance of providing students coping with developmental trauma appropriate interventions, as well as strategies for using sandtray therapy in the school counselling setting.

Statement of the Problem

The high rate of children potentially coping with developmental trauma in Canadian schools poses an issue for school counsellors to find appropriate and effective therapies while balancing the demands and restrictions of the job.

Developmental Trauma, also referred to as complex trauma, is a term used to describe chronic abuse, neglect or other harsh adversity experienced in the home during childhood, and the caregiver is either the cause of the stress or does not help reduce the stress (*What Is Developmental Trauma ACEs*, 2025). According to the *Raising Canada* report (2024) 60% of Canadians reported some form of physical or mental abuse before the age of 15. The report goes on to state that children who are victims of severe abuse and/or neglect are more likely to experience emotional dysregulation, impaired cognitive deficits, and social difficulties compared to those who do not experience these types of maltreatment.

It is hard to know exactly how many children in our schools today are currently experiencing developmental trauma, but according to Raising Canada (2024), in 2022 close to

300,000 children were reported and investigated because of suspected maltreatment, and 61,104 children in Canada are involved with child welfare and living in out-of-home care due to maltreatment. These statistics indicate that, inevitably, there are children in our public schools who are coping with developmental trauma. As counsellors these children end up in our offices sometimes because school staff are aware of the circumstances these children are facing, and sometimes because the student's behaviours are drawing the attention of school staff and the potential need for school counselling.

The recommended course of action for children coping with trauma is to refer them to outside counselling services where they can receive more long-term treatment. Although these referrals often do take place, parents are often unable to or unwilling to take their child to receive support (Reardon et al., 2017). Common barriers to accessing support include cost of services, lack of insurance coverage, wait times to receive services, indirect cost such as loss of wages due to missing work, the cost of traveling to appointments, and parental lack of understanding regarding seriousness of the issue or the treatment involved (Reardon et al., 2017). Because of these barriers, children are most likely to get support and intervention for mental health concerns within the school setting (Brener & Demissie, 2018).

Walker (2015) assessed the literature regarding the school counsellor's role and responsibilities across Canada and found some common themes. Counsellors in Canada are responsible for providing counselling services, addressing mental health issues, intervening during crises, and providing support to students regarding course choices and career goals. In addition, these guidelines also highlight the fact that school counsellors should consult and coordinate with teachers, parents, health professionals, and community agencies. On top of these common responsibilities, most counsellors have other responsibilities that vary from province to

province, district to district, and school to school. Counsellors can also be responsible for delivering social and emotional curriculum and case managing students with ministry designations.

Sandtray therapy is a therapeutic technique used by many counsellors and therapists, where clients create scenes using miniature figurines and symbols in a tray filled with sand. It allows individuals to express thoughts, emotions, and experiences with very few or no words, making it especially useful for children, trauma survivors, and those struggling with verbal expression (De Little, 2019; Homeyer & Sweeney, 2023). The therapist observes and facilitates the process, helping clients explore their subconscious, process emotions, and gain insight into their challenges. Because of the non-verbal nature of sandtray therapy and the fact that it can support children in a developmentally appropriate way, sandtray therapy has the potential to be an excellent way for counsellors to support students coping with developmental trauma in the school setting (De Little, 2019; Homeyer & Sweeney, 2023).

Research Question

With the many responsibilities placed on the role of the school counsellor, little time is left for supporting students, and yet, there are vulnerable students whose potentially only line of mental health support is the school counsellor. The question remains, how can school counsellors incorporate sandtray therapy into the scope of their practice to support students who are coping with developmental trauma?

Positionality Statement

> "The greatest hope for traumatized, abused, and neglected children is to receive a good education in schools where they are seen and known, where they can learn to regulate

> themselves, and where they can develop a sense of agency. At their best, schools can function as islands of safety in a chaotic world."(Van der Kolk, 2015 p353)

This quote from Bessel Van der Kolk's (2015) book *The Body Keeps the Score* sums up one of my deepest beliefs about the power and potential of the education system. In British Columbia, Canada, schools have the privilege of holding this province's children for 6 hours a day, 180 days of the year for 13 years of their lives. That amount of time poses the opportunity for a significant impact in a child's life and simultaneously holds significant responsibility regarding that impact. I have seen how schools can be a place of respite for a child whose home life is chaotic and unstable, and I have also seen how they can be a place that adds to the trauma-load a child carries through their life.

In my 15 years as an elementary school teacher in British Columbia, it became increasingly apparent that my job as a teacher was not only to teach the curriculum but also to create a trauma informed space for children to learn the skills to be successful in life. Counsellors in schools also have an important role in defining the school culture around mental health support and trauma informed practice. They are key advocates for the children in their buildings and their districts. They find ways for teachers, administrators, families, and communities to join together to support the most vulnerable children to find success and joy in learning and in life. As well, school counsellors provide students with counselling support to manage their feelings, develop resiliency, and face challenges.

In my experience school counsellors are given little time to provide the students on their caseload with the breadth and depth of counselling experiences needed to be effective. With the large number of non-counselling responsibilities and expectations placed on counsellors, many

feel that they are not providing their students with what they need. To complicate things, students coping with developmental trauma can be some of the most disruptive in the system and the schools and districts are not able to provide the amount of therapy and support these students need. Unfortunately, there are also so many barriers preventing these students from accessing the support they need, and sometimes the school counsellor is the only resource these students have.

In this paper, I am hoping to provide counsellors with an option that is time efficient and developmentally appropriate to support students who are coping with developmental trauma. I believe that there is an ongoing need to advocate for more support and resources for these students, and that school districts and the provincial government are failing our students in providing the funding for these supports and resources. I want to find solutions that can help ease this issue today, while we continue to fight for support.

Theoretical Framework

This paper uses the Polyvagal Theory to examine the neurobiological response of the brain and body to stress. Historically, the scientific understanding of the stress response was binary: either activated or regulated. When triggered, individuals were thought to enter a fight-or-flight state (Porges, 2017). However, in 1994, Stephen Porges (2017) challenged this perspective by introducing the Polyvagal Theory, which offered a more nuanced understanding of the stress response and introduced a three tiered model of the nervous system (Van der Kolk, 2015). It focuses on the mammalian biological need for safety and how this need drives the human response to both internal and external neuroceptions of safety.

By using the Polyvagal Theory to focus on the neuroscience of the effects of trauma, a better understanding can be gained about the reasoning behind a person's behaviours in relation to their experiences. Polyvagal theory reveals that mammals are wired to seek safety and

connection. When a person is exposed to trauma the neurobiology of the brain is affected. Because neuroscience is being used to understand the problem, it therefore makes sense that neuroscience be used when developing therapeutic responses (Porges, 2017).

Polyvagal Theory explains the importance of therapeutic attunement when supporting children who are coping with developmental trauma. When a client and a therapist create a therapeutic alliance, changes occur in the brain allowing new neuropathways to develop particularly in the areas of safety and connection (De Little, 2019; Porges, 2017). Mammals learn from their experiences and as such begin to develop expectations based on those experiences. The new neuropathways created through the development of the relationship between the client and the therapist can change the brain's learned expectations (Badenoch & O'Mahony, 2021; Porges, 2017). A client, who once anticipated danger and detachment from caring adults, has now had new experiences within the therapeutic setting and their brains are potentially able to develop expectations of safety and make healthy relational connections (Badenoch & O'Mahony, 2021; Porges, 2017).

The sand tray setting, used in sandtray therapy, can allow for the therapeutic relationship and other new experiences to happen all without the use of words. Polyvagal Theory presents the idea that those who have experienced trauma are less able to access their traumatic memories through verbal communication (Porges, 2017; B. Van der Kolk, 2015). Having a way of accessing traumatic events without verbal communication becomes possible when therapists incorporate expressive therapies such as sandtray therapy into their practice. Sandtray therapy also provides the client with a sense of safety due to the control the client has over the narrative healed within the confines of the tray (De Little, 2019; Grayson, 2022; Homeyer & Lyles, 2022).

Significance of the Study

In university level programs that teach school counselling today, there is little emphasis put on understanding developmentally appropriate ways to support younger children in a counselling setting. Many people who graduate from school counselling programs will work in elementary schools. The fact that children are still learning and are often unable to express their feelings through traditional talk therapy methods is downplayed in these programs. New counsellors are coming into schools with little or no training in play or expressive therapy and are finding it difficult to support children who have limited ability to verbally express difficult things. When a child's normal developmental abilities of oral expression are combined with the effects of developmental trauma, traditional therapy can be almost impossible to implement. When combined with the time and other constraints that school counsellors are expected manage, they are left wondering how they are going to support their most vulnerable students.

I believe that sandtray therapy can provide a therapeutic approach that can be adapted to fit the limitations of the school counselling setting and still provide a student with an effective, developmentally appropriate, and non-invasive form of therapy. I will be providing counsellors with suggestions, strategies, and tips on how to adapt traditional sandtray therapy methods to work for students receiving school counselling, while overcoming the limitations, in the school counselling setting.

Definition of Terms

Play therapy

Play therapy is a therapeutic process where a therapist provides selected play materials and facilitates the development of a safe relationship for the client to express and explore feelings, thoughts, experiences, and behaviours through play (Landreth, 2024).

Sand tray therapy, sandtray therapy, Sandtray Therapy

Sand tray therapy is a therapeutic process using sand, a tray, miniature figurines, and sometimes water to facilitate the therapeutic process. It can be used with clients of any age as a form of play therapy used to process interpersonal and intrapersonal issues, and explore feelings, thoughts, experiences, and behaviours. It is also called sand therapy (Homeyer & Sweeney, 2023).

Sandplay therapy

Sandplay therapy refers to a specific Jungian based method of delivering sand therapy developed by Dora Kalff. It is also referred to as the Kalffian– Jungian Sandplay method (Homeyer & Sweeney, 2023). Due to its very specific method of delivery, I will not be discussing Sandplay Therapy in this paper, however, it is still important to recognize the distinction.

Trauma

Trauma is the term used to describe the emotional repercussions of having lived through a distressing event. The same event can be traumatic for one person and not traumatic for another, and this makes categorizing an event as traumatic difficult. Therefore, it is easier to define trauma in relation to how the event is perceived by each individual and not the event itself.

Developmental Trauma

Developmental trauma is a term used to describe abuse, neglect, or other harsh adversity that a child is exposed to within the childhood home. When a child is exposed to overwhelming stress and the caregiver is unable to alleviate that stress or is the cause of the stress, the child experiences developmental trauma and is at risk for a variety of lifelong of complex emotional,

cognitive and physical illnesses (*What Is Developmental Trauma ACEs*, 2025). Complex trauma and complex post-traumatic stress disorder (C-PTSD) are other terms used to describe the symptoms of developmental trauma.

Outline of the Remainder of the Paper

The remainder of this capstone consists of two chapters. Chapter two presents a literature review focusing on developmental trauma by exploring its prevalence in Canadian society, its neurobiology through a polyvagal theory lens, and its impact on children both in the classroom and into adulthood. Chapter two also looks into sandtray therapy as a potential counselling support tool that school counsellors can utilize in the school setting. It also examines the limitations, challenges, and barriers that school counsellors face regarding incorporating play therapy into school counselling, in order to address the challenges that could arise when incorporating sandtray therapy.

Chapter three then goes on to offer recommendations on how to incorporate sandtray therapy in to school counselling by providing a professional development workshop. This workshop can be delivered to school counsellors to explain the effects of developmental trauma on students, the sandtray therapy process and its benefits, and ideas on how to incorporate sandtray therapy into the school counselling practice. It also provides information on how to address the potential challenges of incorporating sandtray therapy into the school counselling setting, as well as information on how to pursue the next steps necessary in order to implement sandtray therapy into the school counselling setting.

Chapter 2: Literature Review

Introduction

Children today are coming into schools with a variety of issues, disorders, and diagnoses. Developmental trauma is a complex set of symptoms that some students are carrying with them as they come to school every day. Developmental trauma in children refers to repeated exposure to abuse, neglect, or other adversities experienced during childhood, either caused or unaddressed by a caregiver. It profoundly impacts a child's neurobiology and behavior often resulting in profound emotional, cognitive, and social challenges (*What Is Developmental Trauma ACEs*, 2025). With 60% of Canadians reporting maltreatment prior to the age 15 (Raising Canada, 2024), students coping with developmental trauma is an ongoing issue in schools today.

The Polyvagal Theory explains the symptoms of developmental trauma as the autonomic nervous system's response to perceived threats that can lead to an overactive amygdala and an underdeveloped prefrontal cortex. This affects cognitive processing, emotional regulation, and social connections resulting in children exhibiting hyper-arousal or shutdown states, manifesting as anxiety, impulsivity, or dissociation (Porges, 2017).

Children facing developmental trauma can struggle with attachment, emotional regulation, cognitive function, and self-concept. These challenges often extend into adulthood and increase the risks for other mental health disorders (Anda et al., 2006; Cook et al., 2005; Rothschild, 2017; Silberg, 2022). Researchers currently studying developmental trauma in children find that current diagnostic criteria is inadequate for fully addressing these developmental impacts. This is leading to proposals for a new diagnosis: Developmental Trauma Disorder (DTD) (B. Van der Kolk, 2015).

For treatment of developmental trauma to be affective both the child and their environment needs to be considered (Silberg, 2022). There are a number of therapies that are used today to treat trauma. Establishing a felt sense of safety is crucial for healing, allowing the brain to integrate and reprocess traumatic experiences effectively (B. Van der Kolk, 2015). Sandtray therapy is an expressive, nonverbal psychotherapeutic technique that aids clients in exploring emotions and experiences through the use of miniature figures in a sand tray (*Canadian Sandtray Institute*, 2023; De Little, 2019; Homeyer & Sweeney, 2023). Developed by Margaret Lowenfeld, this approach is particularly beneficial for individuals who struggle with verbal communication, including trauma survivors, as it provides a safe space for expression and subconscious processing (Homeyer & Lyles, 2022; Homeyer & Sweeney, 2023).

Sandtray therapy is versatile and can be integrated with various psychotherapy theories, enhancing accessibility for clients with verbal communication barriers (Homeyer & Sweeney, 2023). Sandtray therapy supports clients across their lifespan, from children to adults, and is especially effective in trauma processing. It strengthens therapeutic relationships by promoting emotional safety and client control (De Little, 2019; Homeyer & Sweeney, 2023).

Incorporating play therapy in schools, including sandtray therapy, can further support children by providing a nonverbal avenue for exploring emotions and experiences, however, counsellors face barriers such as time constraints and limited resources, necessitating advocacy and education to integrate these beneficial therapies into school settings effectively (Drewes & Schaefer, 2010; Reardon et al., 2017; Trice-Black et al., 2018). While there is limited research on sandtray therapy in school settings, play therapy, a related approach, has been effectively used in schools to support children's emotional and behavioral development (Drewes & Schaefer, 2010; Kaempf, 2022; Ray et al., 2015). School counselors can incorporate play therapy to align with

the natural way children learn and communicate. Advocacy and education are needed to overcome these barriers and ensure that all students who require such therapeutic interventions can benefit from them.

Review of Research Literature

Developmental Trauma

Introduction

Developmental trauma in children and adolescents is characterized by repeated or prolonged exposure to traumatic events and has profound effects on their neurobiology and behavior (*What Is Developmental Trauma ACEs*, 2025). The Polyvagal Theory, introduced by Stephen Porges (2017), provides a framework for understanding the body's unconscious response to threat and safety through the autonomic nervous system (ANS). By examining developmental trauma through this framework, we can see how trauma can significantly alter children's brain chemistry and structure, affecting their ability to regulate emotions and connect with others. Persistent trauma exposure can lead to an overactive amygdala and underdeveloped prefrontal cortex, making self-regulation and social engagement difficult. This can result in a child becoming stuck in a state of hyper-arousal or shutdown, displaying symptoms such as anxiety, impulsivity, or dissociation (Porges, 2017; B. Van der Kolk, 2015).

Children exposed to developmental trauma may face challenges across various domains, including attachment issues, affect regulation, cognitive function, and self-concept. They might struggle with forming relationships, regulating emotions, and academic achievement (Anda et al., 2006; Cook et al., 2005; Rothschild, 2017; Silberg, 2022). The effects of developmental trauma often persist into adulthood, increasing the risk of mental health disorders such as post-

traumatic stress disorder (PTSD), depression, anxiety, and personality disorders (Lanius et al., 2010; Rothschild, 2017; B. Van der Kolk, 2015).

Currently, diagnostic criteria for trauma-related disorders like PTSD do not fully address the developmental impacts on children. Researchers propose a new diagnosis, Developmental Trauma Disorder (DTD), to better capture the unique needs of children with developmental trauma exposure (DePierro et al., 2022; Ford et al., 2022; Spinazzola et al., 2018, 2021; B. A. van der Kolk, 2005).

Effective treatment for trauma in children involves addressing both the individual and their environment. Techniques such as Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) and Eye Movement Desensitization and Reprocessing (EMDR) are used to help process traumatic memories safely (California Department of Social Services', 2024). Ensuring a felt sense of safety is crucial for healing, as it allows the brain to integrate and modify traumatic memories effectively (Rothschild, 2017; Silberg, 2022; Warner et al., 2020).

The Neurobiology of Trauma

For the purpose of this paper, I am using the Polyvagal Theory to discuss the body and brain's neurobiological response to stress. Traditionally, science saw the stress response in binary terms. Either the stress response was triggered, or it was not. When the stress response was activated then a person entered a state of fight or flight (Porges, 2017). In 1994, this binary way of viewing the stress response was challenged when Stephen Porges (2017) introduced the Polyvagal Theory (B. Van der Kolk, 2015).

Mammals, including humans, have a biological need for safety. The nervous system of mammals requires a safe environment to perform biological and behavioural functions such as reproduction, nursing, sleep, and digestion (Porges, 2017). At birth, all mammals require care

from their mothers and as they grow and develop, mammals require long term social interdependence for survival: a safe community within their species. Therefore, it is crucial to be able to identify what is a safe environment and a safe community (Porges, 2017).

The Polyvagal Theory focuses on how the autonomic nervous system (ANS) perceives and responds to threat and safety. The ANS regulates internal organs and perceives threat without conscious awareness. It has two sub-systems called the sympathetic nervous system (SNS) and the parasympathetic nervous system (PNS). These systems are important because Polyvagal Theory suggests that there are three fundamental physiological states regulated by the ANS: the ventral vagal, sympathetic, and dorsal vagal states (B. Van der Kolk, 2015) (Porges, 2017). The sympathetic state is activated by the SNS and the ventral vagal and dorsal vagal states are activated by the PNS (Porges, 2017). It is the level of perceived safety that drives these three psychological states.

Neuroception is the unconscious neural process the brain uses to evaluate risk in the environment. The nervous system must determine that the environment is safe and be engaged in supporting health, growth, and restoration before it can support social behaviour, emotional regulation, and creativity (Porges, 2017).

Evolutionarily, the dorsal vagal branch of the PNS is the oldest of the systems within the ANS. It evolved with reptiles as an unmyelinated system. When triggered, this branch of the PNS will lower the heart rate and oxygen intake (Porges, 2017). In reptiles, this causes an immobilization state where the animal freezes or fakes death. In mammals, this can cause collapse, disengagment, fainting, dissociation, or a frozen state when the animal is unable to mobilize. In humans, the emotions often associated with dorsal vagal shut down are that of

exhaustion, sadness, hopelessness, shame, or a lack of motivation or capability (B. Van der Kolk, 2015).

As reptiles evolved so too did the ANS. The evolution of the SNS allows an organism to respond to a threat by mobilizing and either fighting or fleeing in defense. When neuroception senses danger the SNS engages a sympathetic state. When a sympathetic state is activated the brain is in a state of mobilization and is more attuned for defense rather than creating or responding to cues of safety. The body is ready to support fight or flight defensive behaviours (Porges, 2017). If it becomes apparent that the fight or flight behaviours are unable to restore safety, then the parasympathetic system engages the dorsal vagal system and the body and brain enter a state of shut down.

The newest system within the ANS is the myelinated branch of the parasympathetic nervous system. When the parasympathetic nervous system engages a ventral vagal state utilizing the myelinated branch of the PNS, the social engagement system is also engaged, and the brain and body are calm and sensing safety. The brain is able to create and perceive safe and trusting relationships. The sympathetic nervous system is inhibited by the ventral vagal and social engagement systems. This leads to opportunities for self-regulation and co-regulation that supports mental and physical health. The body's cardiovascular and metabolic needs are also being met. It is in this ventral vagal state that humans are able to connect with others, self-regulate, be creative, and learn new concepts (Porges, 2017).

The ventral vagal branch of the parasympathetic nervous system is unique to mammals and triggers the social engagements systems of our ANS. These are the nervous systems that control our ability to produce and perceive facial expression and vocal intonation. When humans are in a ventral vagal state, our neuroception perceives safety and our body is able to support

mental and physical health as well as connection to others. Our voice is higher and softer, our facial expression shows relaxation or happiness. In a ventral vagal state, humans are also able to perceive these social cues in others and we know that this is a person who is in a state where we can safely approach. If our neuroception does not pick up cues of a relaxed state from another person our neuroception senses danger and our ANS may shift into a sympathetic state where we want to either fight or get away from the other person.

The development of the Polyvagal Theory has had a profound effect on how we view the connection between the body and emotions, and on how we view behaviours, particularly atypical behaviours. Cognitive bias assumes that actions and reactions are voluntary and that atypical behaviours are learned. Treatments are often focused on behaviour modification, but Polyvagal Theory suggests that because neuroception is unconscious, humans have much less ability to control their response to stress (Porges, 2017).

Polyvagal theory also incorporates a physiological aspect to the threat response system. The ANS is not only responsible for the physiological response to threat and safety, but because the ANS also unconsciously controls the functioning of many of the body's organs, the body also experiences a physiological response to threat (Porges, 2017). The parasympathetic nervous system is linked to the digestive system. When a ventral vagal state is active digestion is optimal, but during dorsal vagal shut down, which is also activated by the parasympathetic nervous system, digestion is no longer optimal, and diarrhea or nausea can occur. The sympathetic nervous system is linked to the heart and the lungs and when the sympathetic nervous system activates a sympathetic state the heart rate and oxygen intake are increased in order to allow for our muscles to be utilized in a fight or flight situation (Porges, 2017).

The response to threat in mammals, including humans, is often lifesaving. The sympathetic nervous system allows us to run away from a wild animal and the dorsal vagal branch of the parasympathetic nervous system forces us to freeze when held at gunpoint and potentially avoid escalating the situation towards death. However, the stress response becomes problematic when it becomes activated by things that are not stressful or when a person become stuck in a dorsal vagal or sympathetic state. When the brain does not have the ability to feel safe this leads to mental and physical illness (Porges, 2017). When clinical mental disorders are viewed through a polyvagal theory lens, it redefines them as challenges with neural regulation. The brain is not able to turn off its defenses in order to allow for social engagement to occur (Porges, 2017).

The neurophysiological response to developmental trauma

The brains of children who have been exposed to trauma are both chemically and structurally affected. The exposure to persistent trauma only further hinders a young person's brain's ability to regulate and connect to others (Silberg, 2022). The right and left hemispheres are often unable to communicate effectively. This can lead to challenges integrating visual information and verbal encoding resulting in contradictory ways an individual may respond to challenges (Silberg, 2022). In brains that have been subjected to traumatic events, chemical imbalances in the hippocampus have been identified in the brains of children effected by developmental trauma. When the hippocampus is inflicted with excessive cortisol (a chemical released in the brain in response to trauma), the hippocampus loses its ability to turn off the amygdala (a part of the brain that is activated as a response to trauma) (Silberg, 2022). When this neurological fear pathway to the amygdala is repeatedly stimulated the amygdala becomes overly

sensitive. Stimuli that, to others would be benign, to a traumatized individual can trigger a sympathetic or dorsal vagal fear response (Silberg, 2022).

The prefrontal cortex is responsible for, among many things, the interpretation of current experiences and their relevance to past experiences; however, when the brain is in a sympathetic or dorsal vagal state there is limited access to the prefrontal cortex meaning that it is hard for the amygdala to calm down without the prefrontal cortex (Silberg, 2022). This is particularly true when corporal punishment is inflicted. When a child's brain is engaged in survival it is utilizing its resources to protect itself from threat and not to develop the prefrontal cortex. A child who has spent a significant amount of energy on staying in survival mode has an underdeveloped cortex, this affects their ability to observe themselves, talk about their experiences objectively, and put their experiences into context. These skills are the skills needed to self-regulate and manage traumatic events (Silberg, 2022).

The chemical and physical reactions in the brain of a child affected by trauma can cause an individual to become stuck in a sympathetic state or dorsal vagal shut down (Porges, 2017). Some of the symptoms observed in children who are stuck in a sympathetic state are hyper-activity, anxiety, impulsivity, sleep difficulties, and tachycardia (Silberg, 2022) all due to the lack of the "vagal break" provided by the ventral vagal branch of the parasympathetic nervous system (Porges, 2017). Children who are stuck in a dorsal vagal state are more likely to exhibit symptoms of decreased blood pressure, lower heartrate, and sensations of pain due to immobilization caused by the dorsal vagal state (Silberg, 2022). It is important for counsellors and therapists to recognize that these symptoms are a result of an unconscious reaction to trauma triggers (Porges, 2017). A child who is exposed to chronic or prolonged trauma will often have a hypersensitive neuroception and will sense danger even at the possibility of trauma (Porges,

2017). Usually, the child is completely unaware that their neuroception has sensed danger and has no control over their physiological reaction (Porges, 2017). The understanding that reactions to stress or danger are mostly unconscious is somewhat contradictory to contemporary views of behaviour that focus reaction as a choice. When children engage with adults who are supposed to help them, but the adult is approaching the child with skepticism, doubt, or discomfort, the child can often feel re-traumatized and trust in adults quickly deteriorates (Porges, 2017). It is imperative that those who have the responsibility of supporting children who have been exposed to developmental trauma shift their mindset about behaviour. They must recognize that how a child reacts to trauma or what triggers a trauma reaction is involuntary and unique.

Symptoms/Behaviours of developmental trauma exposure

There is a long list of impairments that children can exhibit as a result of prolonged or repeated exposure to traumatic experiences or events. Cook et al. (2005) released a comprehensive list of these impairments and divides them into seven domains: attachment, biology, affect regulation, dissociation, behavioural control, cognition, and self-concept.

Attachment

Children and adolescents who are exposed to developmental trauma often develop significant issues in the area of attachment building and the development of their psychological representations of self, others, and self in relation to others. This is especially true when the source of trauma is a significant caregiver in the child's life. Poorly attached children are known to underachieve in the areas of distress tolerance, curiosity, sense of agency, and communication. When these internal skills are compromised, children can become easily distressed and will often struggle to collaborate with others. Other possible symptoms of impaired attachment include problems with boundaries, distrust and suspiciousness, social isolation, interpersonal difficulties,

difficulty attuning to other people's emotional states, and difficulty with perspective taking. Impaired attachment is also known to be associated with physical disease and psychosocial dysfunction. This can take the form of increased susceptibility to stress, the inability to regulate emotions without external assistance, and altered help-seeking behaviour (e.g. excessive help-seeking and dependency or social isolation and disengagement).

Biology

Young children who have not been exposed to developmental trauma are learning to manage their responses to their internal and external environments. They are shifting from a reflexive response to one that relies on language, abstract reasoning, and long-range planning. This involves the brain learning to coordinate communication between the right and left hemispheres via the corpus callosum. When the brain is impaired in its ability to coordinate communication from right to left hemispheres, a child is left feeling disorganized cognitively, emotionally, and behaviorally and is prone to react with extreme helplessness, confusion, withdrawal, or rage.

In older children and adolescents, developmental trauma can affect the brain's ability to develop certain areas of executive function. These areas include one's awareness of self and ability to engage with others, their capacity to evaluate the significance and emotional tone of developmental experiences, and their ability to choose a course of action guided by past lessons, their own perspective, and others' viewpoints.

Affect Regulation

Affect regulation is a person's ability to interpret their internal emotional state by identifying the level of arousal, interpret that state, and apply a label that makes sense to self and others (happy, angry etc.). After an emotional state has been identified, a child then needs to be

able to express their emotions safely and to modulate or regulate their experience. It can be challenging for children and adolescents who have been exposed to developmental trauma to discriminate and label their affective states in both themselves and in other people, as well as to change or regulate their own state. Children who have been exposed to developmental trauma show impairment in areas of behavioural and emotional expression through their impaired ability to self-soothe. This impairment can look like dissociation, chronic numbing of emotional experience, dysphoria, an avoidance of scenarios or contexts where strong emotions or feelings are expected, and maladaptive coping strategies such as substance use. These children will often respond to minor stressors with extreme and rapidly escalating behaviours. There is a significant link between exposure to developmental trauma and an increased risk for major depression, and also to earlier onset, longer duration, and poorer response to standard treatments.

Dissociation

It appears that dissociation among children and adolescents who have experienced developmental trauma appears most often in these three forms, automatization of behavior, the disconnection of thoughts and feelings, and a lack of awareness of physical sensations. Children and adolescents who dissociate are more accident prone and often experience learning difficulties. Chronic trauma can increase a child's reliance on dissociation as a coping mechanism. This can translate into problems with behaviour management, affect regulation, and self-concept.

Behavioural Control

Children and adolescents who have been exposed to developmental trauma have been known to show aggressive behaviour and symptoms of oppositional defiant disorder. Other struggles with behavioural control can look like under-controlling or overcontrolling behaviour

patterns. Children who have had exposure to developmental trauma can often become very rigid in their behaviour patterns, sometimes compulsively complying with adult requests, resisting changes in routines, inflexibility with bathroom routines, and controlling of food intake. These children can also demonstrate behaviours that can be associated with re-enactments of specific aspects of traumatic experiences. This can look like aggression, self-harm, sexualized behaviours, and controlling relationship dynamics. The behaviours often serve a purpose for the child who has been a victim of developmental trauma. The child can be consciously or unconsciously reacting to reminders of trauma and demonstrating compulsive avoidance behaviours, attempting to gain a sense of control, avoiding intolerable levels of emotional arousal, or attempting to gain closeness or intimacy.

Cognition

Impairments in cognitive functioning have been known to show up in abused children as early as late infancy with neglect causing particularly detrimental effects to the sensory and emotional development of children. Neglected children will often show delays in expressive language development and overall IQ. They also show less cognitive flexibility and creativity when using problem solving skills and show deficits in attention, abstract reasoning, and executive functions skills. These cognitive deficits and delays mean that children who have been exposed to developmental trauma often end up in remedial or special education classes due to low academic achievement. The dropout rate of children who have been exposed to developmental trauma is three times greater than that of the general population.

Self-Concept

A child's early experiences and level of caretaking have a significant impact on how a child develops and integrates their sense of identity. Children who have had positive experiences

and stable, responsive, and sensitive caring will likely develop positive ideas about their self-worth and competence. However, children who have been exposed to developmental trauma have likely experienced harm and rejection from a significant caregiver. This exposure can lead a child to feelings of being helpless, powerless, unloved, deficient, and incompetent. These children begin to expect rejection from others and will blame themselves for their negative experiences. Often this can lead to struggles seeking and responding to support.

Memory Encoding in the Traumatized Brain

To understand trauma, it is important to know about two different forms of memory encoding called explicit and implicit memory. Explicit memory can be divided into episodic memory, which is autobiographical memories, and semantic memory, which is the ability to recall general facts. Explicit memory needs conscious awareness to be encoded and the brain structures required to do so are not developed after birth. This is why people are unable to remember anything from their early infancy (Siegel et al., 2021). At around 12 to 18 months old, babies will begin to develop bits of explicit memory but the ability to remember entire narratives does not develop until around 4 or 5 years old further explaining why memories before grade school are very fragmented (Siegel et al., 2021). When people think of the act of remembering we usually associate it with explicit memory recall. Remembering significant dates, mathematical procedures, how to drive to the store, what happened at work earlier today, or the order of events in your favourite movie, are examples of explicit memory (Siegel et al., 2021).

Implicit memory is the recollection of the feelings as though they are happening right now. When a person remembers their wedding day, they may remember the feeling of joy and excitement. They may smile, remember the smell of the flowers, and have the urge to hug their spouse. Implicit memory includes emotional reactions, behavioural urges, bodily sensations, or

sensory fragments that we experienced in reaction to what was going on at that time. Implicit memories that are not encoded alongside and explicit memory will not carry a marker of time, and therefore when an implicit memory is recalled it is as if the original event is occurring. These memories are recalled when something happening presently is felt similarly to a past experience (Siegel et al., 2021).

The understanding of implicit memories is important for those trying to understand trauma because so much of a traumatic experience is stored in implicit memory (Siegel et al., 2021). For example, if a child is physically and verbally abused by his father as a young child he may learn to avoid the abuse by hiding the moment he hears his father shouting. When the child gets older, he may not explicitly remember the abuse but finds that when he hears a teacher in the next room yelling at school, he has a sudden urge to elope from the building. This is an example of how implicit memories can intrude in the present lives of people without them being aware of why this behaviour is happening (Siegel et al., 2021).

When sensations arise within a person in response to an implicit memory, without understanding that they are responding to past sensations, they will often attempt to justify the felt sensations (Siegel et al., 2021). The child who eloped from the class may justify his actions saying the school sucks and he just had to leave. The left hemisphere brain is where people make sense of what is happening and because trauma is stored in the right hemisphere this child's brain is only able to draw on what it is currently sensing to make sense of the situation. He will not be able to understand that his desire to run comes from past experiences and may not even know that it was the teacher in the next room that triggered the desire to run. The left brain will then build a justification (Siegel et al., 2021).

Our earliest experiences and even our experiences inutoro form implicit memories. We know that whether or not our brain encodes an event as trauma is not dependent on the event itself, but rather on the response of others to the event. When an infant is hungry, and they experience the discomfort of hunger if the grown-ups respond to the discomfort with comfort and nourishment the infant encodes the event implicitly and begins to learn that the big people it his life will provide for them and take away discomfort. Bonnie Badenoch (2021) uses the term "embodied anticipations" to explain the expectation that is learned from the experiences. However, when the big people are unable to provide the necessary needs and comforts to relieve the distress then the infant develops an embodied anticipation that there are no reliable resources in its life.

Diagnosing trauma exposure

According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR) (American Psychiatric Association, 2022a), exposure to a traumatic or stressful event can cause a person to develop symptoms that lead to a diagnosis of a trauma or stressor related disorder (American Psychiatric Association, 2022b). Within the category of Trauma and Stressor Related Disorders of the DSM-5-TR (American Psychiatric Association, 2022a) one can find diagnostic criteria for a variety of trauma related disorders including Post Traumatic Stress Disorder, Acute Stress Disorder and others. Most of the disorders in this category are etiologically connected through an exposure to a traumatic event. Other disorders such as anxiety or depression do not necessarily carry that same distinction (American Psychiatric Association, 2022b). The category of Trauma and Stressor Related Disorders also includes diagnostic criteria for Reactive Attachment Disorder (RAD). Although RAD shares many of the same symptoms as the other disorders in this category, the diagnostic criteria does not include exposure to a traumatic event

and instead focuses on attachment-related behaviours (American Psychiatric Association, 2022b).

For many years now a number of prolific researchers in the field of psychology have felt that the DSM-5-TR (American Psychiatric Association, 2022a) does not do an adequate job of addressing the developmental factors related to chronic trauma exposure. Bessel Van der Kolk (2015) as well as many of his colleagues with whom he collaborates regularly through the Trauma Research Foundation and other organizations, feel that there is a gap in the diagnostic criteria for children and adolescents who have been exposed to chronic interpersonal trauma. The DSM-5-TR (American Psychiatric Association, 2022a) provides a variety of diagnostic criteria to addresses the psychological issues within individuals who have been exposed to trauma but does not address interpersonal or social causation of these experiences. The DSM-5-TR (American Psychiatric Association, 2022a) also fails to acknowledge any developmental issues that may arise from exposure to developmental trauma. A diagnosis of PTDS for example, focuses mostly on hyperarousal and the re-experiencing traumatic event(s) (Knefel et al., 2023) and the individual must be able to identify the traumatic event (Babette Rothschild, 2017). This criteria can be problematic when some of the symptomatic features of the disorders within DSM-5-TR's the chapter on Traumatic and Stressor Related Disorders (American Psychiatric Association, 2022b) includes language delays, difficulty with interpersonal relationships, dissociative symptoms, and the inability to remember key aspects of the traumatic event.

In Canada and the United States, the DSM-5-TR (American Psychiatric Association, 2022a) is the standard for diagnosing psycological conditions; however, other parts of the world use the International Statistical Classification of Diseases and Related Health Problems (ICD-11) distributed by the World Health Organization (WHO) (2022). The current edition of the ICD-11

includes diagnostic criteria for Complex Post Traumatic Stress Disorder (CPTSD). This diagnostic criteria includes much of the same criteria for PTSD with the addition that the trauma exposure is prolonged or repetitive. Other symptoms include the presence of problems in affect regulation, feelings of defeat, worthlessness, shame, guilt, or failure related to the traumatic event, and difficulties in sustaining relationships. While this definition fills in some of the diagnostic gaps left by the DSM-5-TR (American Psychiatric Association, 2022a) of developmental trauma exposure, it fails to deal with the developmental issues in children who have experienced developmental trauma.

In response to the lack of diagnostic criteria for children who have experienced developmental trauma, Van der Kolk (2015) and his team have developed a diagnosis they are calling Developmental Trauma Disorder (DTD). This diagnosis differs from other disorders in the DSM-5-TR (American Psychiatric Association, 2022a) in that it is deals with traumatic events that impact early childhood development. The consensus for the proposed criteria for Developmental Trauma Disorder includes:

A. Exposure to the trauma is prolonged or repeated over the period of at least one year beginning in childhood either in the form of interpersonal violence or disruptions to protective caregiving.
B. Affective and Psychological Dysregulation including two of the following:
    1. Inability to tolerate or manage extreme affect states
    2. Disturbances in regulation in bodily functions
    3. Diminished awareness/dissociation of sensations, emotions, and bodily states
    4. Impaired Capacity to describe emotions of bodily states
C. Attentional and Behavioural Dysregulation including at least three of the following:

1. Preoccupation with threat, or impaired capacity to perceive threat
2. Impaired capacity for self-protection or risk-taking behaviour
3. Maladaptive attempts at self-soothing
4. Habitual or reactive self-harm
5. Inability to initiate or sustain goal-directed behaviour

D. Self and Relational Dysregulation including three of the following

1. Intense preoccupation with safety of the caregiver or other loved ones
2. Persistent negative sense of self
3. Extreme and persistent distrust, defiance, or lack of reciprocal behaviour in close relationships
4. Reactive physical or verbal aggression toward towards peers or caregivers
5. Inappropriate attempts to get physical intimacy
6. Impaired capacity to regulate empathetic reactions

E. Exhibits symptoms of PTSD

F. Duration of symptoms are present for at least six months

G. Functional impairment in at least two of the following areas:

1. Academic
2. Family
3. Peer relations
4. Legal
5. Health
6. Employment

(B. Van der Kolk, 2015, p. 362-364)

In May of 2011 the DSM committee of the American Psychiatric Association (APA) rejected the proposed diagnosis for DTD stating that there is not enough evidence to back up the notion that adverse childhood experiences (ACE) can lead to developmental disruptions, yet Van der Kolk et al. (2015) submitted a variety of studies and research to prove the link between ACE and developmental disruptions (DePierro et al., 2022; Ford et al., 2021, 2022; Knefel et al., 2023; Spinazzola et al., 2018, 2021; B. A. van der Kolk, 2005). The APA also believes that the current criteria listed in the DSM-5-TR (American Psychiatric Association, 2022b) for PTSD is sufficient and can cover the "diagnostic niche" that includes the millions of children who are exposed to developmental trauma every year (B. Van der Kolk, 2015).

Researchers continue to push for a new diagnosis to address childhood exposure to trauma. A clear diagnosis for children and adolescence who are experiencing difficulties with regulation, attention, and peer relationships due to their exposure to developmental trauma, means that individuals can be diagnosed with one issue rather than a whole myriad of diagnosis that deals with the symptoms plaguing the individual but does nothing to address the long-term development issues nor the origin of these problems. A single diagnosis to address the effects of developmental trauma also means that research and treatment can be streamlined and gain new focus and funding (B. Van der Kolk, 2015). In a more recent study, researchers studied clinical notes and found that using DTD criteria for diagnosing children who have experienced difficulties due to developmental trauma exposure, provided a clearer diagnostic picture of functional impairment and trauma exposure burden than using the diagnostic criteria for PTSD (DePierro et al., 2022). They claim that because of the complex variants associated with DTD, it makes more sense to have DTD as its own distinct syndrome rather than simply a more severe form or subtype of PTSD. In another follow up study, researchers were able to replicate the

results of the initial DTD field study further solidifying the need for DTD as a separate diagnosis from PTSD (Ford et al., 2022). The study also found that one out of every eleven children who meets the criteria for DTD did not meet the criteria for PTSD and would therefore not be eligible to receive trauma-focused treatment or support (Ford et al., 2022).

Effects of developmental trauma exposure into adulthood

Not only are children who have had experienced developmental trauma at a greater risk of behaviour problems, but more research is revealing the long-term, devastating effects that childhood trauma can have on people even into adulthood (Lanius et al., 2010). The effects of trauma on a person are even more significant and long-lasting if the trauma came from a significant attachment relationship such as a caregiver, or if the abuse came in the form of a "violation of the self," meaning sexual or emotional abuse. Symptoms in adults of developmental trauma from childhood can include heightened anxiety, depression and suicidality, addiction, antisocial or violent behavior, serious mental illness, and sexual disorders. The earlier the onset of abuse occurs, the greater the risk that the trauma will have a lasting impact and symptoms will be more intense. (Lanius et al., 2010).

Into adulthood, those who have suffered developmental trauma exposure are 50 to 75% more likely to develop post-traumatic stress disorder (PTSD) (Lanius et al., 2010). These adults are also known to show less ability to regulate their emotions and impulses often leading to a diagnosis of Attention Deficit Hyperactive Disorder (ADHD). Adults who have had developmental trauma exposure as children are also at risk for a number of other psychological disorders including anxiety, affective, regulatory, major depressive, and attachment disorders (Lanius et al., 2010).

There is also a strong coloration between adults who suffered developmental trauma exposure and those diagnosed with cluster B personality disorders (Lanius et al., 2010). Cluster B personality disorders include antisocial, borderline, histrionic, and narcissistic personality disorders. People with these disorders are often described as dramatic, emotional, or erratic (American Psychiatric Association, 2022b). Researchers have found that of the cluster B personality disorders, developmental trauma exposure in childhood is most closely aligned with borderline personality disorder (BPD) (Lanius et al., 2010). BPD can cause disruption to identity development by promoting hypervigilance and focusing on others, while simultaneously discouraging self-awareness when forced to bring attention to distressing internal experiences (Lanius et al., 2010).

Executive functioning is known to be impaired in adults who have been exposed to developmental trauma. The areas of executive functioning most commonly effected by developmental trauma exposure are affect and impulse regulation, attention, cognition, awareness, self-perception, systems of meaning and interpersonal relationships (Lanius et al., 2010).

There are also many physiological issues related to the chronic stress caused by developmental trauma exposure. These include gastrointestinal, metabolic, cardiovascular, immunological illnesses, and somatization (Lanius et al., 2010). There is also evidence that those who have suffered developmental trauma exposure are likely to overutilize emergency and specialty medical care and at the same time underutilize routine healthcare (Lanius et al., 2010).

Adverse Childhood Experiences Study

In the late 1990's, a study began in collaboration with Dr. Robert Anda, Dr. Vincent Felitti and a number of colleagues, along with the Centre for Disease Control and the Department

of Preventive Medicine at Kaiser Permanente (Anda et al., 2006). This study, known as the Adverse Childhood Experiences (ACE) study, examined the correlation between adverse childhood experiences and adult health. Anda and colleagues examined a variety of types of adverse childhood experiences:

Three main types of abuse

- Psychological abuse
- Physical abuse
- Sexual abuse

Exposure to household dysfunction

- substance abuse
- mental illness
- violence towards the mother
- Divorce
- criminal behaviour in the household.

In 2005, two more experiences were added to the list of ACEs, physical and emotional neglect.

The results concluded that the more ACEs a person is exposed to the more likely they are to experience health complications, alcoholism, mental health issues, and suicide. The most striking revelation of the ACEs this study uncovered that of the more than 17,000 people studied in the ACE study 64% or 2/3s of people surveyed had experienced at least one ACE between at some point between 0 to 18 years of age (Anda et al., 2006).

High ACE scores have been linked to learning and behavioural problems in schools, high workplace absenteeism, financial problems, and lower life-time income. ACEs also impact a

person's psychological health attributing to chronic depression and suicide attempts, alcoholism and drug use, and a higher likelihood of being involved in domestic violence. Physical health and high ACEs scores also have a strong correlation. There is a greater chance of developing chronic obstructive pulmonary disease, heart disease, liver disease, cancer and emphysema. The ACEs study revealed that childhood trauma contributes to many of the leading health concerns in North America (Van der Kolk, 2015).

Treatment for children with developmental trauma exposure

With the amount of research that has gone into trauma exposure affects and treatments, particularly in children, a number of trauma specific treatments have emerged in recent years. Some treatments take on a systematic approach involving family, school, and the community as supports, while other treatments focus more on the individual processing of trauma(Warner et al., 2020). Usually, these treatments involve processing and making meaning of traumatic sources and experiences. Traumatic experiences can either be addressed explicitly, through displacement and metaphor, or through bodily experience and movement (Warner et al., 2020).

According to the California Department of Social Services' (2024), the well-supported and researched trauma treatments that deal with traumatic experiences explicitly are Eye Movement Desensitization and Reprocessing (EMDR), Prolonged Exposure Therapy for Adolescents (PE-A), and Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT). In EMDR therapy, the therapist, utilizing standardized procedures, has the client recall emotionally distressing material in small and sequential doses. This can include the client's beliefs, emotions, and bodily sensations associated with the event while simultaneously focusing on an external stimulus. Often the external stimulus used is directed bilateral eye movements but will often include other stimuli as well (California Department of Social Services', 2024).

PE-A is a treatment designed for adolescents from 12-18 years old. They are encouraged to repeatedly attempt to deal with situations or activities they are avoiding because they trigger traumatic memories. They may also revisit the traumatic memory several times by recalling it. Learning about common trauma reactions as well as breathing exercises are important parts of the process. The ultimate goal of the treatment is to teach the client to safely recall the trauma and face trauma triggers. They learn that the distress caused by these reminders decreases over time, and they are capable of tolerating some distress (California Department of Social Services', 2024).

TF-CBT is a conjoint therapy that includes both the child and the caregiver. The overall goals of the therapy are to enhance parent-child communication, attachment, and ability to maintain safety. It is also designed to improve the child's trauma exposure symptoms, any externalizing behaviour problems, and adaptive functioning. TF-CBT also supports the caregiver's parenting skills to be able to support the child and reduce parental stress (California Department of Social Services', 2024).

Play therapy can be used to both directly and indirectly to processes trauma exposure. Trauma-Focused Integrated Play Therapy (TFIPT) is a program that allows a child to explore the thoughts and feeling associated with trauma exposure. It teaches coping strategies, self-regulation, and enhances the child's self-esteem and sense of competence (California Department of Social Services', 2024).

The most important feature in all forms of trauma treatment is that the client experiences a felt sense of safety. All forms of trauma treatment will offer what is known as a disconfirming experience. When a traumatic implicit memory is triggered it can be modified when matched with a disconfirming experience (Badenoch & O'Mahony, 2021; Rothschild, 2017; B. Van der

Kolk, 2015; Warner et al., 2020). This is when a client if offered what was needed but was not available at the time of the traumatic experience. It is important to note that the memory being triggered cannot simply be an explicit memory without the presence of an implicit memory. When only an explicit traumatic memory is triggered the client is experiencing the memory without strong the emotions associated with it. They are detached from the memory. For trauma to heal, the memories stored in the right hemisphere of the brain must be activated (Badenoch & O'Mahony, 2021). This is why it is so important that therapists working with people who are navigating traumatic experiences have proper training and are able to guide the client throughout the healing process with a continued sense of safety (Badenoch & O'Mahony, 2021).

Summary

Repeated exposure to traumatic events during childhood, can be referred to as developmental trauma. Developmental trauma can significantly affect brain development, emotional regulation, and social functioning (*What Is Developmental Trauma ACEs*, 2025). The Polyvagal Theory explains how the autonomic nervous system (ANS) responds to threat and safety, showing how childhood trauma can lead to an overactive amygdala and an underdeveloped prefrontal cortex. This can cause children to become stuck in hyper-arousal or shutdown states, displaying anxiety, impulsivity, or dissociation (Porges, 2017). Children with developmental trauma often struggle with attachment, emotional regulation, cognition, and self-identity, increasing their risk of PTSD, depression, and anxiety in adulthood (Anda et al., 2006; Cook et al., 2005; Rothschild, 2017; Silberg, 2022). Existing PTSD criteria does not fully address these developmental impacts, prompting researchers to propose criteria for a more accurate diagnosis of Developmental Trauma Disorder (DTD) (DePierro et al., 2022; Ford et al., 2021, 2022; Knefel et al., 2023; Spinazzola et al., 2018, 2021; B. A. van der Kolk, 2005).

Currently, effective treatment for developmental trauma involves addressing both the child and their environment. Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) and Eye Movement Desensitization and Reprocessing (EMDR) help process trauma, with safety being a key factor in healing (California Department of Social Services', 2024). Establishing a sense of safety is essential for healing, as it enables the brain to integrate and reprocess traumatic experiences more effectively.

Sandtray Therapy

Introduction

Sandtray therapy is a versatile, expressive psychotherapeutic technique that enables clients to explore complex emotions and issues nonverbally using miniature figurines in a sand tray. This approach facilitates access to the subconscious, fostering insight and transformation under the guidance of a trained therapist. The technique's kinesthetic and tactile nature provides a safe space for clients to express themselves, making it particularly effective for individuals who find verbal communication challenging (*Canadian Sandtray Institute*, 2023; De Little, 2019; Grayson, 2022; Homeyer & Sweeney, 2023).

Originally developed by Margaret Lowenfeld, sandtray therapy can be integrated with various psychotherapy theories to cater to diverse client needs (Homeyer & Sweeney, 2023). It supports individuals across the lifespan, from children to adults, and is especially beneficial for trauma processing. The method enhances therapeutic relationships by promoting emotional safety and control, crucial elements for client change and growth (De Little, 2019; Homeyer & Sweeney, 2023).

Sandtray therapy utilizes a structured protocol, from preparing the room and introducing the sandtray to processing and documenting the session. This structured approach ensures that

the therapeutic environment remains conducive to exploration and healing (De Little, 2019; Homeyer & Sweeney, 2023). Moreover, sandtray therapy can be effectively combined with other therapeutic approaches, such as Cognitive-Behavioral Therapy, Gestalt Therapy, Satir Therapy and Solution-Focused Therapy, thus enhancing these theories' accessibility for clients with verbal communication barriers (Homeyer & Sweeney, 2023).

Sandtray therapy offers a unique, nonverbal avenue for emotional healing and self-discovery, emphasizing the importance of a safe therapeutic environment and a strong therapist-client relationship.

What is sandtray therapy?

Sandtray therapy is a cross-theoretical form of expressive psychotherapy where a client chooses from a collection of miniature figurines and uses them in a tray of sand as a nonverbal form of communicating and processing complex emotions and intra/interpersonal issues. The sandtray environment allows clients to gain access to their subconscious and to use metaphor in order to develop new insights and experience personal transformation and growth. The process is facilitated by a therapist trained in psychotherapy and in sandtray therapy and allows the client to explore emotionally charged issues in an environment that promotes safety and control. (*Canadian Sandtray Institute*, 2023; De Little, 2019; Homeyer & Sweeney, 2023)

Sandtray therapy is a flexible and yet structured technique that can be adapted to many different psychotherapy theories and a variety of client needs. Because of the kinesthetic and tactile nature of the sand, miniatures, and the tray, a client is able to share their presenting issues or their story with a therapist with or without the use of verbal support (De Little, 2019; Homeyer & Sweeney, 2023). Sandtray therapy can be used across the lifespan with individuals, groups, and families and because sandtray therapy is a technique, it can and should be used in

conjunction with counselling theories that fit both the client and the therapist. In this paper, I will only be discussing individual sandtray therapy, as much of the work done in the school setting with students experiencing developmental trauma is done individually; however, sandtray therapy can be used in group therapy settings as well.

For this paper I will be using the word “sandtray” as one word when referring to the therapeutic method. In the sandtray therapy literature there is a variety of terms used interchangeably to describe the use of sand in therapy. A common usage is beginning to emerge for these words and terms; however, this is a relatively new movement within the sand therapy community and the literature is still catching up. Homeyer and Lyles (2022), and Homeyer and Sweeney (2023) advocate for the following terms to become more standardized in the sand therapy literature.

- sand therapy: a broad, all-encompassing term used to describe therapeutic interventions involving sand, a tray, and sometimes small figurines.
- World Technique: used to describe Lowenfeld’s original sand therapy approach.
- Kalffian Sandplay Therapy: refers specifically to Dora Kalff’s Sandplay method based in Jungian Theory, also called Kalffian-Jungian Sandplay Therapy.
- Sand Tray Therapy, sandtray therapy: is a generic term used for all non-Kalffian approaches to sand therapy, initially developed by Margaret Lowenfeld
- Sandplay therapy or sandplay: also refers to the Kalffian Sandplay method
- Sandtray Play Therapy: refers to when sandtray therapy is used in a play therapy process or setting
- sand tray: used when referring to the tray only and not the therapy or the therapeutic use of the tray

- Miniatures/figurines/figures/toys/symbols: the small items used in the sand to create a scene.

Rational for using sandtray therapy

Sandtray therapy allows a client to safely use non-verbal expression to communicate emotions, issues or events. For many clients it is less intimidating than art therapy as no creative or artistic ability is needed (Homeyer & Sweeney, 2023). The figurines, objects, and the sand itself can express concrete or abstract thoughts or images. The client directed nature of sandtray therapy allows the client to fully express themselves and experience a fully accepting therapeutic relationship, which is crucial in order for the client to experience change (De Little, 2019; Homeyer & Sweeney, 2023).

There is a kinesthetic quality to sandtray therapy. When a client engages in the sensory experience of working with the sand, the basic need for kinesthetic encounters is being met. In combination with the relationship building experience provided by the therapeutic relationship, the basic elements of an attachment building experience are met for the client. When a client moves and manipulates the sand, the client can encounter a tactile, calming, and anxiety reducing therapeutic experience (De Little, 2019; Homeyer & Sweeney, 2023).

When a client is experiencing strong emotions or are in an emotional crisis it can often be challenging to find the words needed to express their pain. The sand tray can provide therapeutic distance for the client to be able to express their pain through the figurines and what has been built in the tray. The client is able to separate themselves from their painful story allowing for space to process emotions implicitly and make meaning for what they are expressing rather than get caught in the struggle to find words (De Little, 2019; Homeyer & Sweeney, 2023).

The verbal abilities of adults and children vary greatly and depending on their developmental stage, verbal abilities can even vary among children too. For families, sandtray therapy evens the therapeutic process by removing the potential barrier of verbalization for all involved in the therapeutic process. With this barrier removed, each family member has an opportunity to express themselves (Homeyer & Sweeney, 2023).

Boundaries are crucial for clients, and especially children, to feel safe. Sandtray therapy provides natural boundaries and limits through the therapy environment, the use of carefully selected figurines, the size of the sand tray, and any prompts provided by the therapist all contribute to the felt sense of safety for the client. Without this feeling of safety, children are unable to experience learning or growth (Homeyer & Sweeney, 2023).

Novel metaphors are those generated by the clients. The creation of metaphors within the therapeutic process allows clients to access information stored in the right hemisphere of the brain (Badenoch & O'Mahony, 2021; De Little, 2019; Homeyer & Sweeney, 2023). Homeyer and Sweeney (2023) caution against trying to interpret the client's metaphor. A therapist can only make an interpretation based on their own thoughts, feelings, and experiences and in a sandtray session it is the client's meaning that is the most important. It is in fact not necessary for interpretation to happen in order for the client to experience healing. This is when sandtray therapy experts will remind therapists to trust the process (De Little, 2019; Homeyer & Sweeney, 2023).

Children and adolescents are often referred to counselling by parents or teachers. Because these students are not self-referring, school counsellors will often face resistant clients. Sandtray therapy can be effective with resistant clients due to the fact that communication is focused in the tray rather than on the client. For children, sandtray therapy can feel quite natural as play is

considered the natural language of children. In sandtray therapy, children are being asked to communicate through the familiar and often comfortable activity of play (De Little, 2019; Homeyer & Sweeney, 2023).

Many clients can struggle with verbal skills in therapy. It is important for children and even adults to have access to nonverbal means of communication in a therapy setting. People with developmental language delays, social or relational struggles, neurodivergence, physical differences, and other barriers will all benefit from having alternative ways to communicate and express themselves. When a person is unable to express their needs, they can become frustrated, and this can cause challenges with a variety of relationships in a client's life (Homeyer & Sweeney, 2023). Bilingual and non-English speaking clients can also benefit from nonverbal strategies in therapy. These clients will often prefer to express themselves in their first language and sandtray therapy allows the language of symbolism to facilitate the therapeutic process (Homeyer & Sweeney, 2023).

For clients with high verbal skills, verbalism can often be used as a defense in a therapeutic setting. These clients will often communicate on an intellectual level and use rationalization or storytelling defensively. When working in the sandtray and using metaphor to express themselves these clients are better able to put down their defenses and access the feelings needed for the therapeutic process to happen (Homeyer & Sweeney, 2023).

The issue of transference is one that commonly arises in the therapeutic setting. Sandtray therapy can provide a vessel for that transference allowing the transference to happen between the client and the tray rather than the client and the therapist(Homeyer & Sweeney, 2023). There are times when the figurines can become the object of transference or transference can be addressed safely in the sand tray (Homeyer & Sweeney, 2023).

Sandtray therapy is a means for clients to access underlying or unconscious issues quicker and more thoroughly, however, the therapist needs to be prepared for this to happen. The client, who has likely been holding on tightly to these issues just outside of conscious awareness, can be thrown off guard and may need support, empathy, and encouragement to deal with what has surfaced (Homeyer & Sweeney, 2023).

Clients and therapists have access to cultural awareness and expression in sandtray therapy because the nature of the process can hold space for discussions around issues of race, culture, diversity, and multiculturalism. It is therefore vital that clients see themselves represented in the figurines offered as options for use in the sandtray.

Sandtray therapy facilitates the therapeutic relationship and allows therapist and client to experience right brain bonding. “People experience emotional healing when they encounter someone and when they encounter self” (Homeyer & Sweeney, 2023, p. 20).

The History of Sand Therapy

Margaret Lowenfeld was the first clinician known to use sand in her therapeutic practice. Lowenfeld was a medical doctor and pediatrician from London. In the 1920 she worked in Poland during the Russo-Polish War providing medical care to those in prisoner of war camps in Poland. She was also a relief worker in Poland for students suffering from the effects of war (Homeyer, 2024; Homeyer & Sweeney, 2023).

Upon returning to London, Lowenfeld observed that many children in London suffered from the same symptoms as the children she had helped in war-torn Poland. She was encouraged by these events to develop a method to support children’s mental health issues and help them to share their “inner worlds.” Lowenfeld opened the “Clinic for Nervous and Difficult Children” in 1928. Here she developed the World Technique. Lowenfeld provided her clients with trays of

sand and small toys or figurines and encouraged her clients to express feelings and events in the sandtray that are too painful to express verbally (Homeyer, 2024; Homeyer & Sweeney, 2023).

In 1956, a Jungian analyst named Dora Kalff studied with Lowenfeld and adapted her sand therapy method, incorporating a Jungian approach. Kalff called her new method Sandplay. It is also called Kalffin-Jungian Sandplay (Homeyer, 2024; Homeyer & Sweeney, 2023). Since the mid-1980s Sand therapy has slowly been gaining momentum as a strong evidence-based technique in the world of psychotherapy (Homeyer, 2024). In 1985, Kalff developed the International Society for Sandplay Therapy at her home in Switzerland. Kalff and her colleagues saw a need for more structure to the study and practice of Sandplay (Kalff, 2024). Since then, numerous professional associations focused on sand therapy have emerged around the word (Homeyer, 2024). These associations promote research and education in the various fields of sand therapy ensuring that this technique remains strongly rooted in evidence-based practice and that therapists have access to quality training. Sandtray therapy can be used with a variety of theoretical approaches. Homeyer and Sweeney (2023) encourage therapists to continually grow their practice by seeking ongoing training and supervision in sandtray therapy guided by a theoretical approach that aligns with their philosophies as a therapist. They believe that "Theory alone is inadequate – in fact, theory without technique is merely philosophy. The opposite is an equally important concern: Techniques without theory are reckless, perhaps even dangerous" (Homeyer & Sweeney, 2023, p. 14).

General Protocol for running individual sandtray sessions

Homeyer and Sweeney (2023) and Homeyer & Lyles (2022) have outlined a six-step protocol for running an individual sandtray therapy session. De Little (De Little, 2019) too, has developed a similar routine for sandtray sessions; however, she includes opportunities for clients

to experience transformation in the sandtray by integrating aspects of Transformational Sestemic Therapy into the sandtray protocols. These protocols provide the clinician with a framework to guide the therapist and client through a session; however, the nuances of how each step is implemented will vary from therapist to therapist based on their preferred clinical theory and the person of the therapist. Homeyer & Sweeney (2023) stress that the steps may need to be adapted for the client and the setting and that "being attuned to the client, sensing what is needed at the moment is more important than moving through the protocol" (Homeyer & Sweeney, 2023, p. 51).

To conduct a sandtray therapy session the following material are needed: a sandtray (the standard size is 30 inches by 20 inches by 3 inches, but this is flexible) half filled with play sand, a collection of miniature figurines from a variety of categories including people, animals, buildings, vehicles, vegetation, fences, fantasy creatures, religious symbols, medical items etc. The six-step protocol for conducting a sandtray therapy session as per Homeyer and Sweeney (2023) and Homeyer & Lyles (2022):

Step One: Preparing the room and the therapist

The therapist needs to make sure that the environment is ready to receive the client. If possible, there should be no traces of previous clients. The therapist needs to be sure that all of the figurines are in place and that the sand is free of figurines. When a client discovers a figurine hidden in the sand this can disrupt their creative process. Smooth out the sand so that it is level and generally smooth but not too smooth. Some clients can find it challenging to disturb a perfectly manicured sand surface. The therapist's chair should be close enough that they can observe the creative process but not so close that they are intrusive. The path from the figurines display to the sand tray should be unobstructed so that clients can safely and comfortably collect

more figurines during their creative process. Ideally, the client should be able to walk around all sides of the tray so that they can view their creation from a variety of perspectives.

The therapist also needs to ensure that they are prepared to facilitate a session with a client. Each therapist will have their own strategies of self-care to ensure that they can be fully prepared to welcome and focus the client to the sandtray therapy process, even before the client enters the room. Some therapists will do their own sandtray therapy work in the morning before seeing clients and some will do their own work at the end of the day to relieve themselves of their work before returning to the rest of their life. It is important that each therapist develop their own person-of-the-therapist within the sandtray context and nurtures that person-of-the-therapist in their own unique way.

Step Two: Introducing the sandtray and the figurines

In the initial introduction of the sandtray therapy experience should be unique to the therapist and to the client. Some clients may want to be the first to touch the sand others may need some encouragement by watching the therapist interact with the sand first. In some initial sessions the client may only want to interact with the sand. For this reason, it is a good idea for the therapist to provide the client with small tools such as a rake, a shovel, a sifter etc. to manipulate the sand and for the therapist to remember that just the act of manipulating the sand can be a therapeutic experience for some clients.

The therapist can then begin discussing the figurines and point out some of the categories. Clients can be invited to collect figurines in a small basket and carry them to the sand tray. Some clients, especially those with autism spectrum disorder, may struggle with what to do with the figurines in the sandtray. In this case the therapist may feel that it is appropriate to place a figurine into the tray and have the client then copy the therapist.

There are two types of prompts that a therapist may choose to use in a sandtray therapy session. A nondirective prompt is when no specific instruction is given to the client about what they are creating in the sandtray. This allows the client to create a scene based on their own intuition and interactions with the figurines and the sand. It can allow the client to deeply explore their internal worlds. In this case the clinician may ask the client to create a world, scene, story etc. to introduce this activity. Therapists need to decide what works best for them and their clients.

A directive prompt is good to use with clients who seem to be overwhelmed with the unstructured experience. It can also be that the therapist's own clinical theory is more directive in nature or that the therapist is attempting to tie the sandtray experience to an ongoing issue that the client is exploring in therapy. In any of these situations a more directive prompt may be necessary. Homeyer & Sweeney (2023) use an example of a young adult client struggling with roommate problems, and provide the following prompt "make a scene in the sand that expresses how you feel when you come home after class to find that you roommates have broken the house rules again" (p. 54)

Step Three: The Creation in the sandtray

This is the client's time to build their scene in the sandtray. It is the therapist's responsibility to monitor the time for the client. This could look different depending on the theoretical approach the therapist uses in their practice. Personally, I believe that when the client is building it is the therapist's job to be attuned to the client. The therapist should be observing what the client is touching and not touching in their creative process and building rapport with the client while using minimal verbal interactions, within the client's level of comfort. The therapist should also be observing their own and the client's somatic reactions as the client is

building their scene, noting any somatic changes that happen during the process. Homeyer & Sweeney (2023) note the challenge of being fully present without talking but invite therapists to "trust the process." They state that "to learn to be attuned and fully present, with the willingness to resonate with the client, while maintaining the free and protected space, observing the client's process while building and creating the sandtray may take a bit of time and practice. But it's mandatory!"

There are times when a therapist may find that talking during sandtray creation is appropriate. With young children, it may be more appropriate to verbally track the child's play as a play therapist would do. Young children are more likely to use the figurines as toys and create active and dynamic scenes. This is age appropriate and tracking this kind of play is how play therapists create attachment and rapport with the young child-client. Sometimes, a therapist may choose to use the sandtray with clients who are more withdrawn and are struggling to relax in therapy. In this case, if a client is choosing to open up and talk the therapist will want to support the client by participating in the dialogue with the client. However, for some clients who are working on developing self-regulation and their tendency is towards over-verbalization, a therapist may choose to encourage discussion only after the sandtray is finished. It is important for the therapist to know what the intention is behind using sandtray therapy so that they can tailor responses and interactions appropriately.

Observing the process of the sandtray creation is very important to sandtray therapy. Homeyer & Sweeney (2023) equate it to observing a client's non-verbal communication in traditional talk therapy. The therapist should be looking for dynamics such as is the building process easy or difficult? Is the client showing hesitation or determination during the selection or building process? Is the client able or unable to be fully involved in the building process? Is their

work purposeful or random? And does the client plan ahead or allow the construction to unfold? It is also important to note what figurines are being used in the sandtray. Are certain figurines being ignored or perhaps considered then left behind? Are some figurines being stroked or handled with an abundance of care? Recognizing the client's approach to their creation provides the therapist a window into what is going on for the client and also gives the therapist points of discussion during the processing of the sandtray.

Step Four: Sandtray Processing

The first part of this step allows for both the therapist and the client to do a general observation of the sandtray. The therapist takes a moment to view the completed tray and points out simply what is there without judgement. They can also ask the client about sensations or feelings that are arising at this moment. This supports to client to move from the right-brained work of creating the sandtray to the left-brained work of talking about the sandtray.

It is in this step that therapists may attempt to interpret and analyze a client's creation. It is the meaning that the client sees in their creation that is most important. The therapist's job is to be curious and ask skillful questions that help the client to explore their own insights within the sandtray. This process will be heavily informed by the therapist's own theories about psychotherapy and the purpose for using the sandtray therapy technique. Some therapists may choose not to verbally process the tray at all, allowing the creative process to activate the client's internal healing process. Others will use the creation as a springboard for discussion or to work with the metaphor the client has created in the tray.

It is important to explore the emotional content of the sandtray for both the client and the therapist. The therapist needs to gauge the amount of self-disclosure to use with a client when discussing the emotional content of the sandtray. Some clients will be quite sensitive to a

therapist's emotions and may choose to edit or sensor their emotions in order to preserve their relationship with the therapist.

Organization within the sandtray

The way a client uses space in the sandtray can be a very informative way to process and understand a client's world. An empty world (a tray with lots of excess space and few figurines are used) can reflect how the client sees their own world as unhappy or empty. Perhaps they feel rejected or want to escape, or perhaps their creativity is dampened by depressive symptoms. A tray without people (or animals as people) can also be an empty tray, possibly reflecting negative feelings towards people. It is important to note that unless the client is part of a military community, soldiers are not usually considered people in a sandtray creation. They are usually used as symbols of aggression and violence.

Some clients will create distorted worlds within their sandtray. According to Homeyer & Sweeney (2023) there are subtypes of distorted world organizations: closed/fenced, disorganized, and ridged. When a client closes off or divides a scene in the sandtray this is considered a closed world. Worlds can be closed using fences or any other object that divides the tray. It is therefore important to include fencing and other types of barriers in the figurine collection so that clients can use them as necessary. Barriers can be a sign of anxiety in a client and speaks to their need for protection. When most of the figurines are found within the enclosed area the scene is considered closed. Closed arrangements could be a sign that the client is expressing the need for protection, self-isolating, identifying with the figurines within the enclosure, or confining symbols of danger. If the majority of the figurines are outside the enclosure the scene is considered to be fenced. Fenced organization can point towards a client's fear of their own inner

impulses and a need for external controls, a need to compartmentalize (often to manage anxiety), or to close out dangers.

Rigid scenes appear as arrangements of figurines in unrealistic and often ridged formations. The figurines often appear in rows or in a geometric pattern. This can be seen as a client's need for extreme order, perfectionism, or self-control. Sometimes clients with Attention Deficit Hyperactive Disorder (ADHD) will create rigid scenes when they are communicating their need for order and organization in a brain that is often riddled with disorder.

Another subtype of distorted organization within sand trays is disorganized. Sometimes these trays look messy, impulsive or chaotic. Sometimes a client will start out developing their sandtray in a deliberate and playful way but begins to lose control and the tray spirals into chaos. This type of sandtray can point towards clients who are communicating their own confusion, reflecting chaos, or are unable to maintain self-control. Disorganization in the sandtray can also look like anomalies such as a house in a lake, or a tiger in a living room. It is important that a therapist approach these anomalies with curiosity and non-judgement if they are looking to learn more about it.

Another category of tray organization is the aggressive world, which can be identified by figurines used in defensive, confrontational, or an antagonistic way. Some examples would be a battle scene, vehicle crashes, and animal attacks. Aggressive worlds are communicating aggression. Clients may use aggressive scenes as a way of expressing internalized anger in a safe and contained environment. It has been found that the more incidents of aggression that are found in a single tray, the more profound the aggressiveness is for the client.

When processing a sandtray a therapist may decide to look for themes within the sandtray. Depending on the clinical theory the therapist is drawn to, the therapist may want to

look for themes of control, congruency, boundary disruptions, or insights on the client's personality. There may also be some symbolism held within the figurines. Homeyer & Sweeney (2023) believe that it is important that the client identify any themes, symbols, or metaphor that may arise within their creation. Some therapists, like De Little (De Little, 2019), prefer to work within the metaphor of the sandtray and although the figurines may hold symbolism for the client, often young clients will not even be able to recognize this symbolism. This does not mean that the metaphor is lost on younger clients. In fact, it means that by using the metaphor, clients can work on internal struggles and incongruency without having to verbalize that with which they may not feel comfortable or be cognitively able to process. Processing in this way, allows clients to process events and feelings indirectly, offering the client a gentler session where the client can feel more regulated and in control.

It is during this stage in the therapy session that a therapist might help the client look for opportunities to transform unhelpful beliefs the client is showing within the sand tray or to resource any of the figurines within the tray so that they have the ability to support themselves. Transformation within the sandtray is dependent jointly on the philosophies of the therapist and the needs or desires of the client.

Homeyer & Sweeney (2023) provide possible windows into the client's inner world by providing descriptions of classical figurine organization within sandtray and possible insights to inform their work with the client. These insights are not to be offered to the client as analysis into their world; rather, they can be used to inform a therapist's documentation, aid in the development of hunches, and provide a common language for use with other sandtray therapists. As previously stated, it is the client's interpretation of the sandtray that holds the key to healing and therapeutic change.

Step Five: Sandtray Cleanup

Some therapists will work with the client to clean up from a sandtray session. However, most sandtray therapists believe that cleaning up from a sandtray session should be done after the client has left. It allows further time for the therapist to process the sandtray. It also leaves the image of the completed sandtray in the client's mind, allowing them to further process their experience even after leaving the therapy room. This is especially important if a therapeutic transformation has happened in the sandtray. Most importantly, leaving the sandtray intact at the end of the session communicates to the client that their work is respected and honoured. The visual process of cleaning up a client's emotional work can communicate that their emotional expression contains an aspect of unacceptability that needs to be put away. Sandtray therapy is not a time to teach manners and the self-regulation associated with cleaning up after oneself. That is a skill reserved for environments outside the therapy room.

Step Six: Documenting the Sandtray therapy session

Documentation is both an ethical and legal part of the therapist's job. The process of documenting a session allow the therapist to reflect on the time they spent with that client. Therapists should include details of the session, conceptualization of the client through a theoretical lens, and assessment of the client's progress. Other considerations for documentation could include any prompts used, the client's approach to building their tray, the organization of the tray, any verbal or non-verbal communications made during the building process, if a title or theme was assigned to the tray, and a summary of the discussion. The therapist can then add details about what they learned during the processing of the sandtray.

The therapist may also want to include photographic documentation of the session. Some therapists will choose to use the photos only in their documentation while others may choose to

go through the photos with their clients to review progress over time. This can be a helpful process at the termination of the therapeutic journey with the client.

Sandtray therapy and neuroscience

As mentioned in the previous section on trauma, the brain encodes trauma as implicit memories (Siegel et al., 2021). For psychotherapeutic healing to occur it is important that therapists are able to help a client access their painful experiences. This often proves to be quite challenging because these memories are stored outside of consciousness and a client may not even know when an implicit memory is being triggered. Instead, all the client is able to recognize is their feelings of discomfort, pain, and perhaps even overwhelm (Grayson, 2022; Siegel et al., 2021).

Sandtray therapy is one way that a client can access the right hemisphere of their brain and the implicit memories stored there in a way that provides the client with a sense of safety and control. Simply engaging with the sand is enough to calm the mind and provide the client with the neuroception of safety in the therapy setting (Grayson, 2022). As the client become more relaxed in the process of a sandtray session their implicit world is revealed through the figurines and images they are using in the tray (Grayson, 2022; Sweeney, 2017).

When a therapist initially introduces the idea of sandtray therapy to a client it is important that the introduction is done in a way that leaves the client feeling like they are in control of the therapeutic process and that they are safe to steer the therapy in any way that feels comfortable to them (De Little, 2019; Grayson, 2022). If a client is not yet ready to explore the sandtray with the therapist, the client must feel safe in making this decision. Because of the deep connection developed during therapy some clients may choose to use the sandtray before they feel safe to do so. If a client senses that the therapist really wants them to use the sandtray, the client may

comply, but their reasoning may not be because they feel comfortable, but rather because they want to maintain the connection with the therapist. It is therefore important that therapists have a few different tools that a client can use during their therapeutic process, but ultimately, it is the client-therapist relationship that is the keystone to therapeutic healing (Grayson, 2022).

The left hemisphere of the brain tends towards creating clear narratives of certainty, and prefers to activate prior knowledge when it is processing an experience, and to find a single solution based on that prior knowledge. On the other hand, the right hemisphere of the brain processes new experiences. Because each session in the sandtray is a new encounter, the right hemisphere takes the lead in sandtray creation (Grayson, 2022).

During the creation process it is the therapist's job to do what is known as "holding the space." From a neurobiological perspective, "holding the space" activates what is known as mirror neurons in the brain. Grayson writes about the work of Marco Iacoboni et al. (1999) who wrote about the existence of mirror neurons to support people in being able to read and connect with the intentions of others. Mirror neurons help to interpret facial expressions and body language and influence how we respond to what we are observing, thereby supporting successful social interactions. It has been found that when emotionally deep communication is occurring between two people the brains of the two participants begin to mirror each other. It is therefore vital that the therapist maintains a ventral vagal state throughout the therapeutic process. Even the sense that there is someone holding the space as the implicit memories are drawn out can be enough to create a disconfirming experience for the client. What was often missing in the initial experience was a safe connection to another person (Badenoch & O'Mahony, 2021; Grayson, 2022).

When the client has completed their sandtray it is important not to jump into discussion and processing too quickly. The brain needs time to slowly transition from the right hemisphere of the brain where implicit memories have surfaced as images and metaphors in the sandtray, to the left hemisphere where the verbal processing can begin to take place. The therapist should therefore discourage any analyzation of the sandtray creation and instead encourage the client to describe the scene preferably while staying in the metaphor (De Little, 2019; Grayson, 2022). While the client is processing their work, it is important that the therapist is able to recognize that they have had their own experience during the work and that their own implicit memories may be triggered at this point. It is therefore important that the therapist withhold their own perception about what is happening in the tray as it is the client's experience that matters (De Little, 2019; Grayson, 2022).

As the client begins to describe what is happening in the sandtray, the therapist can repeat the client's words back to them paying special attention to any words that describe feelings. As the therapist reflects the client's words back to them, the left hemisphere of the brain receives the information and then the right hemisphere may offer further insight to what has been said. This passing of information between right and left hemispheres within the neuroception of safety created by the therapist's presence and the sandtray experience, encourages bilateral integration of the brain and strengthens the corpus callosum (the structure acting as a highway for information to be passed between the right and left hemispheres of the brain) (De Little, 2019; Grayson, 2022; Sweeney, 2017).

Sandtray therapy and trauma

For clients who have experienced or are coping with trauma, sandtray therapy can be an effective intervention by providing the necessary safety needed for clients to process or release

the trauma and repressed emotion. Verbal interventions in therapy can be ineffective for clients who have experienced and encoded trauma (De Little, 2019; Grayson, 2022; Homeyer & Lyles, 2022; Warner et al., 2020). The brain protects an individual who has experienced trauma by encoding it in the right hemisphere of the brain and storing it as feelings, sensations, and images. Communicating these implicit memories as a verbal narrative can be almost impossible and even harmful for many clients. Attempting to verbalize terror can lead to an increase in anxiety, and that coupled with the already diminished ability of the brain to create verbal communications, can lead to primitive behaviour or acting out in a therapy session (Grayson, 2022). This is even more true for young clients whose brains are not yet fully able to process and organize information (Grayson, 2022; Homeyer & Sweeney, 2023; Sweeney, 2017).

Many other forms of therapy rely on the client being able to recall narratives about events using the left hemisphere of their brain, as well as be able to discuss the sensations and feelings of the implicit memories associated with the trauma which is sorted in the right brain. The corpus callosum is the brain structure that acts as a highway connecting the left and right hemispheres (Grayson, 2022; Sweeney, 2017). A brain that has been damaged by trauma is less able to allow information to flow between these two areas of the brain complicating the use of talk-therapy to treat trauma. The process of talk-therapy also requires the use of the frontal cortex but for many, the recall of traumatic events can push a client into a sympathetic state causing them to lose access to the cortical region of the brain further complicating the use of talk-therapy in trauma treatment. Non-verbal interventions can allow a client to work in the right hemisphere of the brain without activating the sympathetic nervous system (De Little, 2019; Grayson, 2022; Homeyer & Sweeney, 2023; Sweeney, 2017).

Because sandtray therapy activates the right hemisphere of the brain and allows it to take control of the sandtray building process, access to traumatic memories is more available yet does not need to be expressed as a verbal narrative. According to Homeyer & Sweeney (2023), in 1996, Rothbaum and Foa stated that 2 conditions must be met in order to treat PDST, the traumatized person needs to activate trauma related memories and the therapeutic process must reverse the initial felt sense of danger. This is confirmed by Badenoch's (Badenoch & O'Mahony, 2021) research on disconfirming experiences: a traumatic event's felt impact on a person is altered by joining the implicit memory of the trauma and what the client needed at the time of the trauma. In sandtray therapy, this need is being met by the therapeutic environment, the therapist's therapeutic presence, the therapeutic relationship, the process of sandtray therapy, or a combination of these elements (Grayson, 2022; Homeyer & Sweeney, 2023).

Sandtray therapy can also provide clients with a sense of control that they are lacking due to their trauma exposure. Clients who have experienced trauma have experienced a loss of control. This loss of control can happen emotionally, psychologically, and even physiologically. It can be painful and upsetting. In the sand tray, clients can begin to feel their sense of control returning to them. The safe boundaries and freedom provided by the sand tray allow the client to feel and sense of responsibility and control for what is being created and destroyed in the sand tray. When the client is able to give definition and shape to the trauma, they can begin to exercise control over it and start the healing process (De Little, 2019; Grayson, 2022; Homeyer & Sweeney, 2023).

Using sandtray therapy in conjunction with clinical theories

In their (2023) publication, Homeyer and Sweeney state multiple times that some of the aspects that make sandtray therapy so accessible is its cross-theoretical and cross-technical

quality. Sandtray therapy aligns with a variety of theoretical frameworks, and it hardly needs to be said that every therapist's practice should be rooted in a clinical theory. The theory serves to provide a framework for the therapist to lean on when conceptualizing clients. It shapes the purpose of therapy sessions, defines the role of the therapist, and clarifies what needs to occur for the client. Within the context of the sandtray, clinical theory will inform how the therapist views their role within the continuum of directive vs. nondirective facilitator. Clinical theory will also inform any techniques, prompts, or questions that the therapist chooses to employ during therapy sessions (Homeyer & Sweeney, 2023).

Sandtray therapy can also be used in conjunction with a variety of therapeutic approaches. The nonverbal aspect of sandtray therapy increases the versatility of other therapeutic approaches allowing clients who struggle with verbal expression to experience the benefits of therapies that are traditionally rooted in a more talk-therapy style (Grayson, 2022; Homeyer & Sweeney, 2023; Sweeney, 2017). Here are a few ways that sandtray therapy can be combined with other therapeutic approaches. In Solution-Focused Therapy sandtray therapy can support the creation of representations of the client's desired future, allow the client to explore possible solutions to their concerns, or discover personal and contextual resources available to them (Homeyer & Sweeney, 2023). In Rational Emotive Behaviour Therapy (REBT), the client's emotional, behavioural, and relational problems are seen as coming from the client's belief about an event rather than from the event itself. When employing sandtray therapy with REBT sand trays can be created around the activating event, the client's beliefs, the outcomes of the event, or new ways of accepting and responding to the event (Homeyer & Sweeney, 2023). When Gestalt Therapy is combined with sandtray therapy, the sand tray provides an environment for the client to become more self-aware by connecting in the tray with the here-and-now. The

therapist can encourage the client to acknowledge their current mind, body, and emotional connection to their creation and invite clients to explore any feelings or moods that are less desirable (Homeyer & Sweeney, 2023). In a family therapy context, the sand tray can be used to explore and improve relationships in an experiential and kinesthetic way that is lacking when using talk-therapy alone (Homeyer & Lyles, 2022; Homeyer & Sweeney, 2023). When sandtray therapy and Person-Centred Therapy are used in conjunction, sandtray therapy is more non-directive in nature. The therapist provides non-directive and open prompts, empathy, unconditional positive regard, and congruence (Homeyer & Lyles, 2022; Homeyer & Sweeney, 2023; Rogers, 1951). In Cognitive-Behavioural Therapy, clients can use the sand tray to visualize cognitive distortions or work on restructuring symbolic representations of their unhelpful thoughts of beliefs (Homeyer & Lyles, 2022). There are still many more ways that sandtray can be used in conjunction with other approaches in a therapeutic setting. Homeyer and Sweeney (2023) stress that rooting therapeutic practice in theory is of utmost importance to maintain the integrity of the profession. They also believe that "techniques without theory are reckless and have potential to be damaging." (p. 1). Clinical theory is the anchor that the therapist can come back to when deciding how best to proceed with a client, but when it comes to therapeutic approach it is important to remember that not all approaches will work with all clients. Therapists need to have a variety of approaches and techniques that they are able, trained, and willing to use with clients, and remember that professional growth means learning new ways to meet clients where they are at and with what they need (Homeyer & Sweeney, 2023).

Therapists must remember that no amount of theory, technique, or tools will heal a client (De Little, 2019; Homeyer & Sweeney, 2023). Even though sandtray therapy has a long history in the world of play and experiential therapies in the end it is just some toys in a sandbox and has

no therapeutic value without the knowledge and experience of the therapist. The most important tool in sandtray therapy and in most forms of psychotherapy the relationship that passes between the therapist and the client. When the therapist is able to create a physically, psychologically, spiritually, and emotionally safe space for the sandtray process, and a mutual connection is shared between therapist and client; the power of this expressive technique can be fully experienced by the client (De Little, 2019; Homeyer & Sweeney, 2023). In the end, the person of the sandtray therapist is one of the most important tools in the sandtray because, according to Carl Rogers, in order for change to occur the counsellor must provide certain conditions: empathy, unconditional positive regard, and congruence (Rogers, 1951). When these conditions are met within the counselling relationship then change is possible.

Summary

Sandtray therapy is an expressive, nonverbal, psychotherapeutic approach that helps clients explore emotions and experiences using miniature figures in a sand tray. This tactile approach allows clients to express deep-seated emotions and trauma through metaphor, bypassing the need for verbal articulation (*Canadian Sandtray Institute*, 2023; De Little, 2019; Grayson, 2022; Homeyer & Sweeney, 2023). Sandtray therapy facilitates subconscious processing, fostering insight and transformation, and provides a safe space for expression. It is especially beneficial for individuals who struggle with verbal communication, including trauma survivors (De Little, 2019; Grayson, 2022; Homeyer & Lyles, 2022). Sandtray therapy is cross-theoretically flexible and can be integrated with a variety of psychotherapies (Homeyer & Sweeney, 2023). Additionally, it strengthens the therapeutic relationship by promoting emotional safety and client control. Ultimately, sandtray therapy offers a powerful, nonverbal path to

emotional healing and self-discovery, emphasizing the importance of a secure therapeutic space and a strong therapist-client connection.

Play Therapy in School Counselling

Introduction

There is very little research and writing about how sandtray therapy is used in schools. There is however some literature that discusses the use of play therapy in schools and because sandtray therapy is a subsection of play therapy. I have chosen to review the literature on the use of play therapy in schools in order to better understand the potential uses, benefits, limitations of sandtray therapy in schools.

School counsellors play a vital role in supporting students' emotional, social, and academic well-being. Given that children often have a hard time finding the words they need to articulate their thoughts, emotions, and issues verbally, children have shown to be able to express and process complex emotions and issues through play. Play therapy helps children to process their experiences, build coping skills and overcome emotional and behavioural challenges. When school counsellors integrate play therapy into their comprehensive counselling program, it not only aligns with the natural way that children learn and communicate, but it also enhances their ability to find success in school. However, there are various challenges and barriers to implementing play therapy in a school counselling setting, including time constraints, lack of training, limited resources, and widespread misconceptions among administrators and teachers. There is a current need to educate the school community about the benefits of play therapy in a school setting. There is also a need to bring to light the barriers that counsellors face, the ethical considerations, and the need for inclusive practices to ensure that all students who need it can benefit from play therapy in the school setting.

Research and data show that play therapy is an appropriate and effective intervention to use with children from a wide variety of backgrounds and abilities (Harper, 2024; Ray et al., 2015). It, therefore, makes sense that school counsellors would want to incorporate play therapy into their practice. A meta-analysis of 93 play therapy studies conducted by Bratton, Ray, Rhine, and Jones (2015), concluded that play therapy was an effective intervention for children across modalities, settings, age, gender, clinical and non-clinical populations, and theoretical schools of thought. This data supports the rational that play therapy can be used for counselling children in schools. For most children, the school day is structured to allow for times of learning and for breaks. Play is often incorporated in both learning activities and break activities. Drewes & Schaefer (2010) remind us that "play is universal and the natural language of children." (p. 64) Because of the way that play is already incorporated into school settings, using play in school counselling makes sense, as this is a language and modality that many children understand and are comfortable with. Landreth (2024) explains that children's cognitive abilities are more developed than their verbal abilities. He states that "play is the child's symbolic language of self-expression and can reveal what the child has experienced, reactions to what was experienced, feelings about what was experienced, what the child wishes, wants, or needs, and the child's perception of self." (p.14) For children to play out their experiences and feelings is a natural, dynamic, and self-healing process in which children can engage. Play therapy meets the child where they are at developmentally in a way that is natural, comfortable, and engaging to the child.

Landreth (2024) believes that the purpose of using play therapy in schools is so that children can be better prepared for learning in the classroom. According to Risë Vanfleet (2025) school counsellors use play therapy to communicate with students, and help students build a

wide range of skills. Play therapy can also improve students' adjustment to classroom and other school environments, improve peer relationships, address the needs of at-risk students, remove emotional and behavioral obstacles to learning and prevent bullying, school violence, and other serious problems.

Educating the school community about play therapy

There are many stakeholders involved in the public education system. Parents, teachers, administrators, community members, the school board, and the students themselves all play a role in the education system. School counsellors serve and a liaison between these groups as well as an advocate for the needs of the student and for play therapy. It is for this reason that school counsellors may find themselves needing to educate others about the school counselling program, their role as counsellors, and the benefits of play therapy. When the stakeholders buy into your school counselling program, they become advocates for your program and your students (Drewes & Schaefer, 2010; Kaempf, 2022; Trice-Black et al., 2018).

Drewes & Schaefer (2010) provide some suggestions for ways to onboard the stakeholders in your community. They recommend conducting a presentation for the school board outlining the advantages of play therapy in the school setting, the cognitive development of children, and how play and toys are the language of children. They also recommend describing the function of play therapy through the lens of the school/district improvement plan and incorporating research data regarding play therapy. Drewes & Schaefer (2010) also recommend adapting the school board presentation for the teachers and school administrators. These groups will likely need more information about play therapy methods and their impact. They also suggest conducting an experiential activity that allows the adults to experience the play for themselves, but during this experience remind the attendees that the purpose of the experience is this is not for therapy but

an opportunity to increase the awareness of play therapy. It may also be helpful to present a case study allowing participants to get an idea of how play therapy works and the impact that it can have on students in the context of the school setting.

Drewes & Schaefer (2010) stress the importance of corresponding with parents. They suggest regular communication with parents that includes information about the play therapy process, suggestions for how to support their children at home, resources that parents can use with their children, resources to access more information, advertisements for upcoming parenting classes or groups, items needed for the counselling room. They also recommend that school counsellors be available and visible during the school open house events so that parents can see the counselling room and ask questions.

Limitations, challenges, and barriers for counsellors in the school setting

There are several limitations, challenges, and barriers facing counsellors in today's public school setting, and these can be categorized as relating to time, training, resources, and support (Drewes & Schaefer, 2010; Trice-Black et al., 2018). These challenges increase when counsellors attempt to incorporate play therapy into the school setting.

School counsellors are faced with significant time constraints that can put a strain on a counsellor's ability to manage time with the students on their caseload (Drewes & Schaefer, 2010). In most schools, only cases of extreme mental health struggles will be supported by the counsellor and even in those cases the school counsellor is often referring the students to outside resources for support. School counsellors are aware, they are not able to provide the consistency, session duration, and number of sessions needed to see significant change for these students. When families are unable to provide for counselling services outside of the school due to transportation, time, or financial limitations, students are often left with only the usually

underfunded school counselling program to have their counselling needs met. A far cry from what students actually need to experience significant growth, healing, and transformation. Still, most counsellors, due to the passion and commitment they have for their job and their students, will do whatever they can to provide their students with the best care possible with whatever limited time and resources they have.

Time also becomes an issue when school counsellors need to transition students from the counselling setting to the classroom. Many counsellors, especially in a play therapy setting, will hurry students out the door, due to the limited number of school hours in a day (Drewes & Schaefer, 2010). This rush to wrap up a session does not provide the student with the time needed to prepare themselves to reenter the classroom. Many of these students, especially those who have been able to feel safe and supported in the counselling room, need to "armor up" before returning to class so that they are able to face the daily challenges of the classroom, their home life, or their social circle.

Further challenges that time limitations bring to the world of school counselling are the shortened time for sessions that counsellors are able to provide students. In a private counselling setting, children are often provided with 45 to 50 minutes for their therapy sessions. In a school counselling setting, students are often provided with only 20 to 30 minutes for a session, significantly diminishing the number of minutes spent with the counsellor. On top of having shorter sessions, school counsellors are often only able to provide students with at most one session per week or even less sometimes depending on the needs of the individual and also the needs of the school community (Drewes & Schaefer, 2010).

Training

Training for play therapy is not often given to counsellors. Despite the body of evidence that shows that play is how children naturally express themselves (Drewes & Schaefer, 2010; Harper, 2024; Landreth, 2024; Ray et al., 2015) and the growing body of research that support the use of play therapy with children (Bratton et al., 2005; Drewes & Schaefer, 2010; Landreth, 2024; Trice-Black et al., 2018), many school counselling programs are not offering courses in play therapy (Drewes & Schaefer, 2010). In the two major universities in the lower mainland, play therapy is not offered to students studying to be school counsellors despite the fact that many of these graduates will go on to work with children in the school setting (*MA, MEd in Counselling Psychology*, 2025; *School Counselling (M.Ed.)*, 2025). The lack of training offered to school counsellors during their master's level training is a primary reason that school counsellors do not practice play therapy in the school setting (Drewes & Schaefer, 2010; Harper, 2024; Kaempf, 2022; Ray et al., 2015; Van Horne et al., 2018). They feel incapable of offering play therapy and feel it is unethical to attempt therapy for which they have no training.

Resources including access to play materials

Like most professionals in the education setting today, school counsellors are lacking in the resources necessary to provide a comprehensive program (Drewes & Schaefer, 2010). Ray (2011) and Landreth (2024) believe that playrooms in the counselling setting should include toys from a variety of categories including dolls, doll houses, animals, puppets, stuffies, scary toys (monsters, dinosaurs, snakes, spiders), aggressive toys (weapons, punching bags, military toys), art and craft supplies, pretend or fantasy toys (wands, dress up clothes, knights and castles), and medical toys. On top of that it is recommended that shelves be placed because they are beneficial for placing toys above the floor and allowing more room for free movement. Other features can

include access to water through a sink, non-carpeted floors, and durable wall paint so that walls can be washed.

The cost associated with renovating a school room and purchasing the necessary tools and toys to make play therapy possible can be debilitating for anyone trying to get a play therapy program off the ground in a school. With the limited financial support given to schools to provide counselling services, many counsellors who are attempting to provide play therapy to students, are supplementing their programs with materials they purchase themselves or are able to take from home once their own children grow out of these toys.

Space limitations

With the financial constraints being placed on school districts these days, schools are being filled with more and more students allowing for less available spaces for students to receive any services outside of the classroom (Drewes & Schaefer, 2010). The confidential nature of counselling requires that counsellors have a private space to provide their students with counselling. These spaces are often small and shared with other professionals such as school psychologists, speech and language pathologists, and learning support teachers who may find that working with students in a room full of toys difficult and distracting to the students. Some counsellors do not have their own space at all are find themselves doing counselling in the nurse's room (Drewes & Schaefer, 2010; Landreth, 2024; Ray, 2011); hardly a place for students to find safety and comfort and certainly not a place for students to play freely.

Support for play therapy

Many counsellors find there is a lack of support from their school administrators and staff in implementing play therapy into the school counselling program. Administrative support is crucial to the success of a play therapy program in school because generally it is administrators

who set the tone for the school. An administrator who understands the importance of counselling and play therapy will embed this belief in the school culture and this embedded belief will permeate throughout the school staff; however, the equal and opposite is also true. An administrator who does not see the importance of counselling and play therapy will become a barrier to students receiving the counselling they need as priorities will be placed on other services and supports for students (Drewes & Schaefer, 2010; Ray, 2011). Some administrators will even forbid play therapy from happening in their school, stating that counselling should not function as a reward for children who are not attending class (Drewes & Schaefer, 2010).

The lack of support from administrators often comes from the misconceptions and misunderstandings surrounding counselling in general and play therapy specifically. One misconception about play therapy in schools comes from a misconception about counselling in schools in general. It is sometimes believed that school counsellors participate in administering consequences, and providing children with "playtime" will only confuse them (Drewes & Schaefer, 2010). In fact, the school counsellor role should not at all involve administering consequences. This is to preserve the sanctity of the counselling relationship, trust, and confidentiality. Therefore, play therapy conflicting with the administrating of consequences becomes a non-issue. Another misconception that stems from the counsellor role in general is the idea that the school counsellor's job is to provide vocational counselling only (Drewes & Schaefer, 2010). Vocational counselling is one aspect that can come into play in a comprehensive school counselling program. However, providing counselling services is also another aspect of the job and most school counsellors have the ability to choose methods that work for themselves and the students they are working with.

Another common misconception about play therapy is that it is only for young children; however, play therapy can be a very effective method even when working with adolescents in the secondary setting (Trice-Black et al., 2018).

Ethical Considerations in the school setting

School counsellors are required to adhere to two codes of ethics, the code that governs their profession as educators as well as the code that governs local counselling professionals (Drewes & Schaefer, 2010; Landreth, 2024; Ray, 2011). School counsellors must know when to keep or break confidentiality, when and how to consult with other professionals, to whom counselling records belong, and when those records can legally be subpoenaed. School counsellors need to not only consider their students when making a decision, but also the rest of the school community and even the broader community. We are reminded that the ethical codes that school counsellors must adhere to must be considered when making the best and most ethical decision for all involved (Drewes & Schaefer, 2010; Landreth, 2024; Ray, 2011). Drewes & Schaefer (2010) also assert that it is ethically best practice that counsellors using play therapy should receive training specific to play therapy. They also caution the use of the word therapy in some settings as there can be certain liability implications pertaining to the use of the word therapy. It is important for counsellors to know the preferred language of their school district and adjust their own language accordingly perhaps employing words like “play counselling” when necessary (Drewes & Schaefer, 2010; Landreth, 2024; Ray, 2011).

School counsellors, as with all counsellors, must consider instances of dual relationships. These can be particularly prominent in smaller communities and may not be avoided. Therefore, school counsellors in these types of communities must be particularly vigilant when it comes to dual relationships and pay special attention to maintaining the confidential nature of their

position (Drewes & Schaefer, 2010). Consultation can be especially helpful in these situations and can help a counsellor know when and how to step away.

It is also important for school counsellors to remember that they are mandated reporters and must report suspected abuse or neglect to the authorities. This is another reason that school counsellors using play therapy receive proper training in this area, so that they are better able to recognize abuse in the play setting and how to handle and communicate this information when necessary (Drewes & Schaefer, 2010).

Considerations for inclusion in the school setting

School counsellors are required to learn about the students they are providing service to and to understand how to best work with students from diverse cultural, ethnic, sexual, and socioeconomic backgrounds. Students from a diverse range of cultures, socio-economic, and academic backgrounds are able to communicate through play (Trice-Black et al., 2018). Active cross-cultural competence means consistently taking the time to build sensitivity and understanding and obtaining knowledge responsibly to ensure that students are understood, seen, and represented in play therapy (Drewes & Schaefer, 2010).

School counsellors also need to educate themselves on how best to work with students with unique physical, mental, and emotional needs. They need to ensure the play space contains not only representations of the diverse cultures of students but also the diverse physical needs of students. This can look like including medical toys or dolls with hearing aids or leg braces etc. Counsellors should also consider arranging the room so that toys are accessible for children in wheelchairs and ensure there are wide spaces for movement (Drewes & Schaefer, 2010; Harper, 2024; Landreth, 2024; Ray, 2011).

It is best for counsellors to plan ahead for students and talk with them and their parents about their specific needs and look to acquire and maintain the skills and knowledge to work appropriately with clients who have disabilities or who come from cultures unfamiliar to the counsellor (Drewes & Schaefer, 2010; Harper, 2024). Finally, the counsellor should also be aware of any biases and wary of comments that convey value judgements.

Summary

Even with the additional hurdles that play therapy can bring to the already taxed school counselling setting, the benefits of using play therapy in school counselling are not diminished in the least. Play therapy is a powerful intervention that supports students to express and process emotions and overcome challenges in a way that is developmentally appropriate (Drewes & Schaefer, 2010; Landreth, 2024; Trice-Black et al., 2018). Despite the benefits of play therapy, school counsellors are faced with barriers to implementing play therapy including time constraints, lack of training, limited resources, and a lack of support (Drewes & Schaefer, 2010; Harper, 2024; Kaempf, 2022; Ray et al., 2015; Van Horne et al., 2018). Addressing these issues requires changes that include advocacy and the education of those involved in the school system to foster a deeper understanding of the benefits of play therapy for children of all ages, cultures, and abilities. When counsellors work with teachers, administrators, students, parents, and the rest of the education community, they are able to provide children with the support they need to thrive in the school environment and beyond (Drewes & Schaefer, 2010; Kaempf, 2022).

Summary

The high prevalence of children coping with developmental trauma in schools presents a challenge for school counselors, who must find effective therapeutic interventions while managing the constraints of their role. With 300,000 Canadian children investigated for

suspected maltreatment in 2022, and 61,000 children living in out-of-home care due to abuse or neglect in 2024 (Raising Canada, 2024), the presence of students navigating the effects of developmental trauma in our school system is certainly a reality today. While it is often suggested that these students are referred to outside agencies to get support for their mental health challenges, the reality is that many are unable to access these agencies(Reardon et al., 2017). This makes school counsellors one of the first lines of support for students coping with developmental trauma. However, due to the responsibilities and expectations placed on school counsellors, many of them struggle to provide the necessary counselling support these children need (Drewes & Schaefer, 2010; Trice-Black et al., 2018; Van Horne et al., 2018).

Sand tray therapy is one therapeutic approach that could be particularly beneficial in school settings. This non-verbal technique allows clients to express thoughts and emotions using miniature figures in a sand tray, making it effective for children, trauma survivors, and others with oral communication difficulties (De Little, 2019; Homeyer & Sweeney, 2023).

Although there are a number of barriers facing counsellors who integrate any form of play therapy into a counselling setting, sandtray and play therapy offer school counselors a valuable tool to support students coping with developmental trauma. The benefits of using developmentally appropriate experiential therapies like these into the school counselling setting are worth the necessary advocacy, education, and personal training school counsellors must undertake to provide these therapies.

Chapter 3: Summary, Recommendations and Conclusions

Summary of the Literature

Chapter 2 examined the topics of developmental trauma in children, sandtray therapy, and how play therapy is used in school counselling including the limitations, barriers, and challenges counsellors face when using play therapy in schools. Polyvagal Theory is a lens commonly used to understand the neurobiology of people navigating developmental trauma and to make sense of the behaviours often associated with developmental exposure. Because developmental trauma exposure affects cognitive processing, emotional regulation, and social connection, children exhibiting frequent hyper-arousal or shutdown states triggered by prolonged trauma exposure exhibit signs of anxiety, impulsivity, or dissociation. They also struggle with attachment, emotional regulation, cognitive function, and self-concept. These challenges often extend into adulthood. With 60% of Canadians reporting maltreatment prior to the age of 15, it is highly likely that today there are children in Canadian schools coping with developmental trauma exposure in need of support.

Sandtray therapy is a psychotherapeutic technique that aids clients in exploring emotions and experiences through the use of miniature figures in a sand tray (*Canadian Sandtray Institute*, 2023; De Little, 2019; Homeyer & Sweeney, 2023). Because verbal expression is hindered by trauma exposure, many people navigating developmental trauma find talk-therapies difficult. Sandtray therapy provides a safe space for expression and subconscious processing without relying on verbal solely on verbal communication or the need to bring traumatic event into explicit memory (Homeyer & Lyles, 2022; Homeyer & Sweeney, 2023).

When counsellors have access to sandtray therapy materials they are able to provide students with a means of processing traumatic events within the safety of the boundaries of the

sand tray. They are able to work through implicit traumatic memories and then physically leave them in the sand tray and return to class. The physical act of leaving these memories in the sand tray allows a student the potential to be more regulated and to attend to academic material without being stuck in a sympathetic or dorsal vagal state. There are, however, some challenges that school counsellor often face when including play therapies like sandtray therapy into the school counselling setting. Barriers such as time constraints and limited resources, necessitate the need for school counsellors to educate educational stakeholders on the benefits of sandtray therapy. To use these techniques with the confidence and consistency necessary for this technique to be effective, school counsellors need the support of the community.

Recommendations

Based on the literature review of Chapter 2, I have developed a professional development workshop designed to inform counsellors about developmental trauma and how sandtray therapy can be used in the school counselling setting to support students navigating developmental trauma. The barriers that school counsellors face in implementing expressive therapies such as sandtray therapy are similar to the barriers faced when implementing play therapy. The research conducted about the barriers to play therapy in school counselling can be used to understand the barriers that school counsellors face regarding the implementation of sandtray therapy. I am therefore extrapolating on the research conducted about play therapy in schools and applying it to my recommendations about using sandtray therapy in schools.

I have included the notes that I use to deliver the presentation that cover any information that may not be included on the slides but that I feel is still important to share. To increase audience engagement during the presentation, it may be helpful to bring in some mini sand trays

and an assortment of figurines that attendees can use to better understand and visualize the sandtray process. It may also be helpful to provide a short demo session during the workshop.

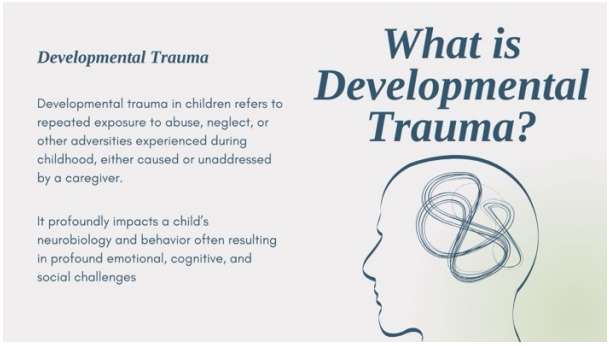
Professional Development Workshop Slides

Slide 1

This is the title slide.

Slide 2

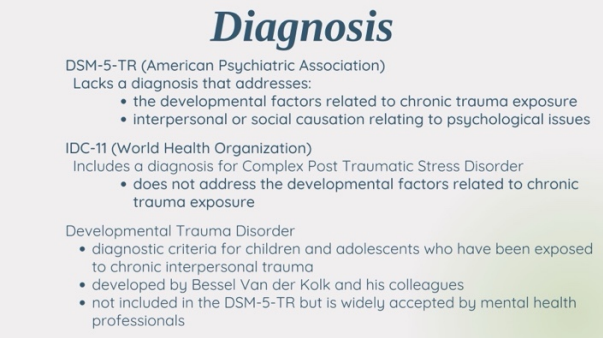
This slide defines developmental trauma according to The Centre for Addiction and Mental Health (CAMH) (*What Is Developmental Trauma ACEs*, 2025).



Slide 3

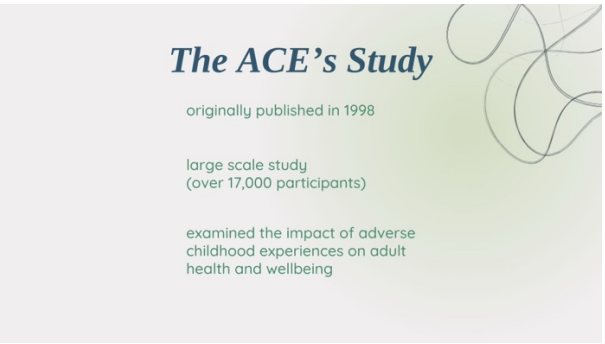
This slide discusses the diagnosing of developmental trauma. It covers how neither the DSM-5-TR (American Psychiatric Association, 2022a) nor the IDC-11 (World Health Organization, 2022) have a diagnostic criteria that covers the range of complex symptoms that the diagnosis of

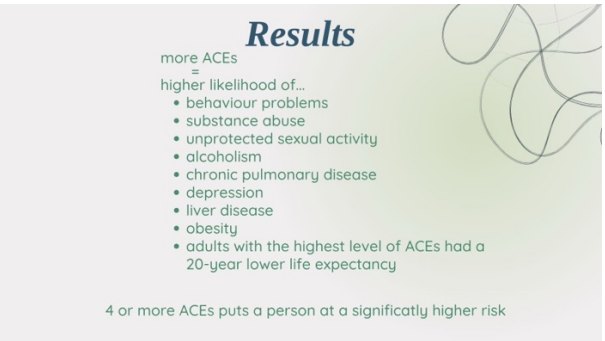
Developmental Trauma Disorder, developed by Bessel Vander Kolk (2015) and his colleagues have developed.



Slides 4 - 8

These slides cover the adverse childhood experiences study (Anda et al., 2006) (Lanius et al., 2010) and the long-term effects of developmental trauma. These slides also discuss the relationship between the onset and the duration of the trauma increase the intensity of symptoms and the likelihood that the symptoms with last into adulthood.





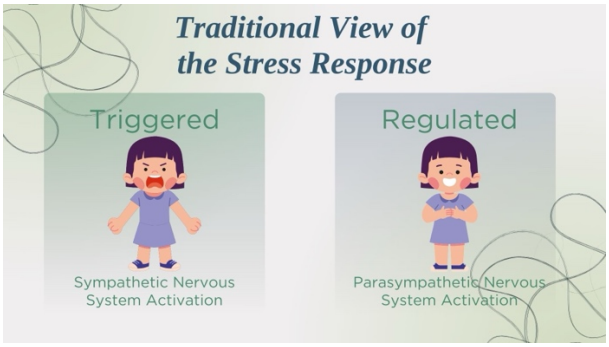
Notes

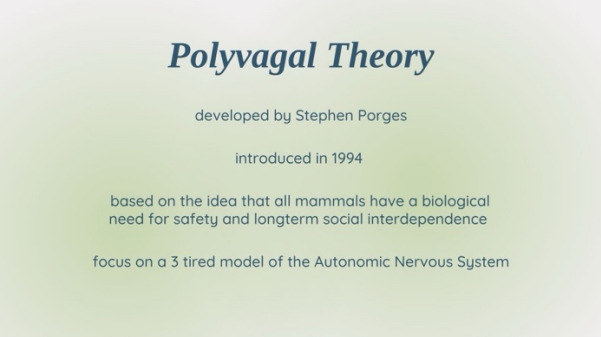
- The ACEs study looked at 10 different adverse childhood experiences
- There are many other adverse childhood experiences the researchers found that these 10 had a profound impact on future outcomes for people
- The more ACEs a person had the more likely they were to experience a variety of different mental and physical issues when they got older.
- For me the most shocking one was the 20 year decrease in life expectancy, I also found it interesting that a high number of aces is considered to be 4 or more.
- Some other facts about the long term effects of DTE are that the longer lasting the trauma, the greater the intensity of the symptoms and the greater the impact these symptoms have into adulthood
- Also, the earlier the onset of the trauma exposure, the greater the intensity of the symptoms and the greater the impact these symptoms have into adulthood
- Finally, the trauma impact is greater if it comes from a significant attachment relationship or sexual or emotional abuse, which are considered to be "violations of the self"

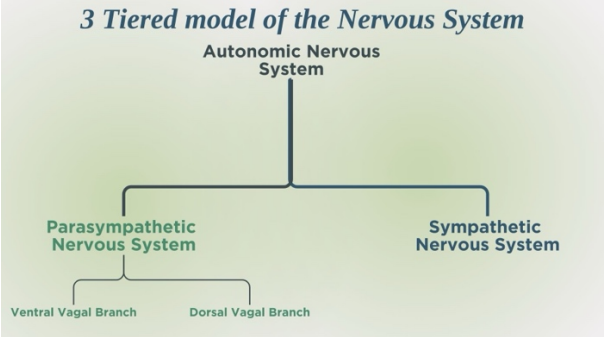
Slides 9 – 14

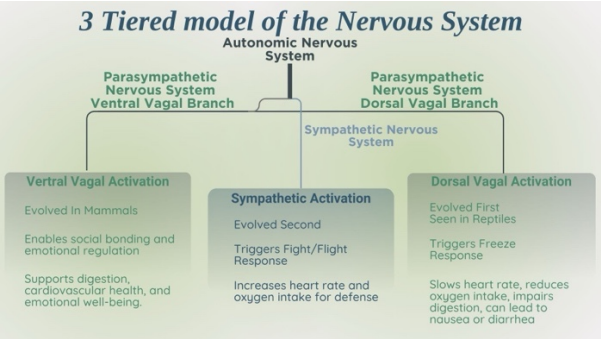
These slides cover the neurobiology of Trauma. They cover the traditional view of the stress response and then go into how the polyvagal theory focuses on the stress response as a three tired

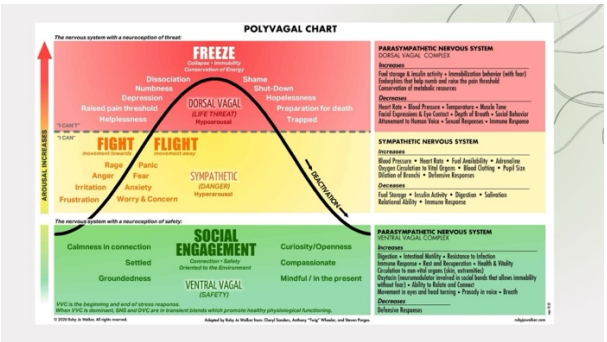
model of the autonomic nervous system and how mammals fluctuate between the ventral vagal state, the sympathetic state and the dorsal vagal state (Porges, 2017).











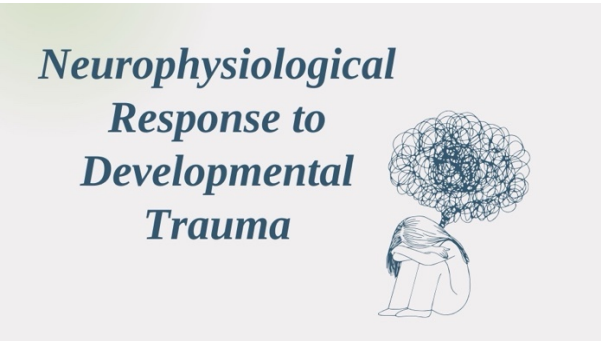
Notes

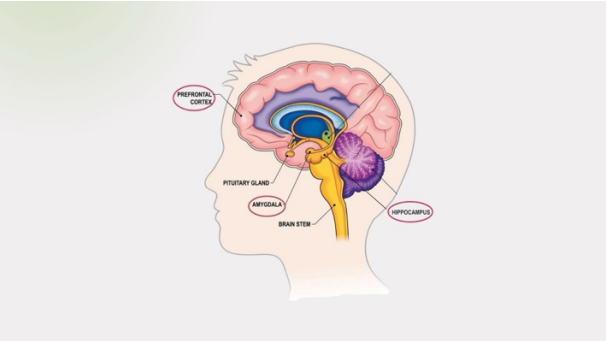
- Traditionally, the stress response was viewed binary terms (the stress response was triggered then a person entered a state of fight, flight, freeze and the SNS was activated, if they were regulated than the PNS was activated)
- Polyvagal theory states that the vagas nerve has 2 branches: the ventral vagal branch and the dorsal vagal branch

- The 3 tired model of the Polyvagal theory
    - Ventral Vagal Branch of the PSN restricts sympathetic activation, enables social bonding, supports healthy bodily systems and emotional well-being
    - Sympathetic Activation of the SNS triggers fight or flight response and increases heart rate and oxygen intake for defense.
    - Dorsal Vagal Branch of the PSN triggers a freeze response, slows heartrate, reduces oxygen intake, impairs digestion. Being in a dorsal vagal state for prolonged periods of time can be detrimental to a person's health in both the sort-term and long-term

Slides 15 – 25

These slides cover the neurophysiological response to developmental trauma looking at the relationship between the hippocampus, the amygdala, and the prefrontal cortex (Silberg, 2022). They also cover how the left and right hemispheres of the brain struggle to communicate for children coping with developmental trauma (De Little, 2019; Grayson, 2022; Sweeney, 2017). The slides also cover the symptoms of being stuck in a dorsal vagal or a sympathetic state concluding that the symptoms are a result of an unconscious reaction to trauma triggers and how children have to control over these symptoms (Porges, 2017).



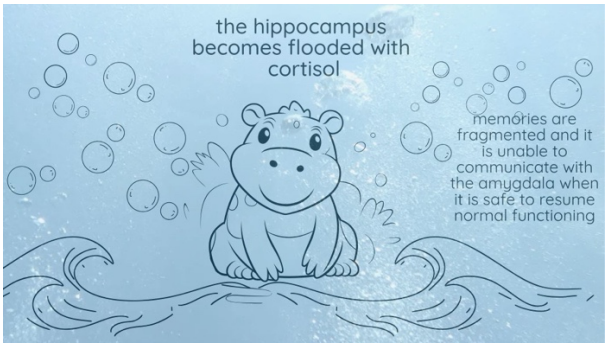


the amygdala senses danger and activates a response

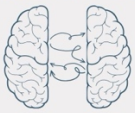
The Prefrontal Cortex

limited access to the prefrontal cortex when experiencing trauma

this affects the ability to observe oneself, talk about experiences objectively, and put experiences into context

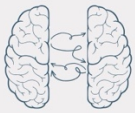


In children, the structure that allows the right and left hemispheres to communicate effectively is under developed.



In children who are coping with developmental trauma, this structure is even more under developed

This results in challenges integrating visual information and verbal encoding



In other words, the right brain recieves the information but the left brain can not process it or communicate it.

brains affected by trauma can become stuck in a sympathetic state or dorsal vagal shutdown

stuck in a sympathetic state:

- **hyper-activity**
- **anxiety**
- **impulsivity**
- **sleep difficulties**
- **tachycardia**

stuck in a dorsal vagal state:

- **decreased blood pressure**
- **lower heartrate**
- **sensations of pain**

Notes

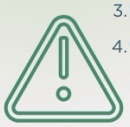
- The neurophysiological effects of trauma means how the brain structures are actually being affected
- There are 3 parts of the brain that are important when discussing trauma, the prefrontal cortex, the amygdala, and the hippocampus.
- PFC - controls many functions including cognitive functions like decision making, working memory, and attention. It also supports emotional regulation.
- Hippocampus - usually in charge of encoding, storing, and retrieving memories, however during a traumatic experience the hippocampus is flooded with cortisol and is unable to function properly resulting in fragmented memories. This cortisol flooding produces a hindered ability to communicate with the amygdala when it is safe to resume normal functioning.
- Amygdala - senses danger and triggers a fear response in the brain through the ANS.

Slides 26 – 32

These slides cover the definition of neuroception and how prolonged trauma exposure can create a hypersensitive neuroception. These slides then cover the four threats of danger that the amygdala is continually scanning for: physical danger, the unknown, incongruence in the environment and “should” or unrealistic expectations.

The brain is continuously scanning for 4 threats

1. **physical danger**
2. **the unknown**
3. **incongruence in the environment**
4. **"shoulds" or unrealistic expectations**

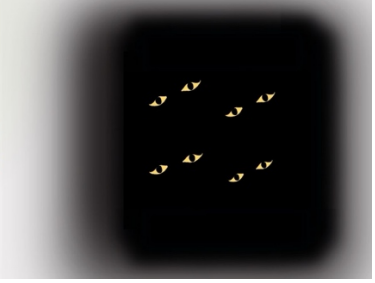


Physical Danger

People avoid pain. Our brains know that physical pain could mean a threat to our life and in an attempt at self-preservation we avoid it.

The Unknown

People like predictability. It is really the associations and memories about he possibilities of what could occur that is actually scary.



Incongruence in the environment

People crave authentic reactions from those around us

"Shoulds" or unmet expectations

danger to our sense of self by denying or being denyed who we are in the moment
autonomic nervous system is activated as we try to handle the discrepancy

"The number one thing that will block your ability to facilitate children through their aggression are the messages in your head about what you think you 'should' or 'shouldn't' do in the moment."
– Lisa Dion

Danger = Sympathetic Activation

prolonged trauma exposure = hypersensitive neuroception

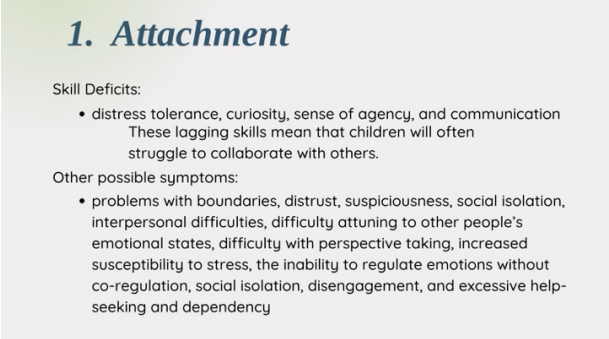
Notes

- The word neuroception refers to the process the brain uses to evaluate risk in the environment without awareness.

- The brain is continually scanning for danger.
- These dangers can be divided into 4 types: physical danger, the unknown, incongruence in the environment and "should" or unrealistic expectations
- Physical danger is the one we most commonly think of
- Incongruence in the environment can sometimes be harder to recognize but it is most recognizable when someone who is in a state of hyperarousal is being told to calm down. This can make them more agitated because their neuroception is detecting danger that the other person's is not.
- When a person's neuroception perceives danger, the nervous system goes into sympathetic activation.
- Children who have experienced prolonged trauma exposure often have hypersensitive neuroception and will unconsciously interpret seemingly benign events as dangerous. These children are often existing in a state of hyper arousal.

Slides 33 – 40

These slides cover possible impairments children and adults can face due to developmental trauma exposure. These include issues with attachment, biological development, affect regulation, dissociation, behavioural control, cognition, and self-concept development.



2. Biology

ability for the brain to communicate between left and right hemispheres
- feeling disorganized cognitively, emotionally, and behaviorally and is prone to react with extreme helplessness, confusion, withdrawal, or rage

brain's ability to develop certain areas of executive function
- lacking in self-awareness, the ability to engage with others, the ability to evaluate the significance and tone of experiences, the ability to make decision based on past lessons, their own perspective, and others' viewpoints

3. Affect regulation

(the ability to identify stress level, interpret and label their current feeling, and express their emotions safely, then change or regulate the experience)

struggles with affect regulation are associated with and impaired ability to self-sooth

Symptoms:
- dissociation, chronic numbing of emotional experience, dysphoria, avoidance of strong emotions or feelings, substance use, extreme and rapidly escalating behaviours, major depression, and also to earlier onset, longer duration, and poorer response to standard treatments.

4. Dissociation

3 forms of dissociation
- automatization of behavior
- the disconnection of thoughts and feelings
- a lack of awareness of physical sensations

Symptoms can include:

accident prone, learning difficulties, problems with behaviour management, affect regulation, and self-concept.

Chronic trauma can increase a child's reliance on dissociation as a coping mechanism.

5. Behavioural Control

struggles with behavioural control:
- aggressive behaviour, intense defiant behaviour, rigid in their behaviour patterns, compulsively complying with adult requests, resisting changes in routines, inflexibility with bathroom routines, controlling of food intake.

re-enactments of aspects of the trauma:
- aggression, self-harm, sexualized behaviours, controlling relationship dynamics.

reacting to triggers of trauma:
- compulsive avoidance, attempting to gain a sense of control, avoiding emotional arousal, attempting to gain closeness or intimacy.

6. Cognition

- delays in expressive language development
- less cognitive flexibility and creativity when using problem solving skills
- deficits in attention, abstract reasoning, executive function skills
- low academic achievement
- high dropout rate

7. Self-Concept

(Self-identity)

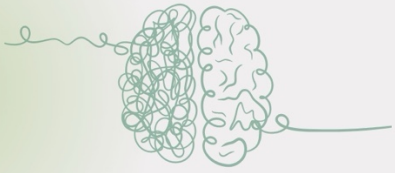
- feelings of helplessness, powerlessness, being unloved, deficient, incompetent expect rejection from others and will blame themselves for their negative experiences. Often this can lead to struggles seeking and responding to support.

There is an expectation of rejection from others and they will often blame themselves for their negative experiences. This can lead to struggles seeking and responding to support.

Slides 41 – 45

These slides cover how trauma effects memory encoding in the brain including both explicit and implicit memories.

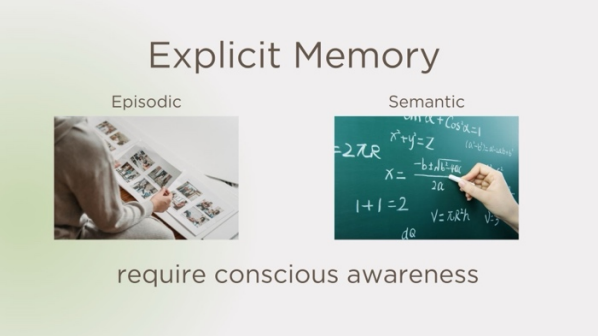
Memory Encoding in a Traumatized Brain

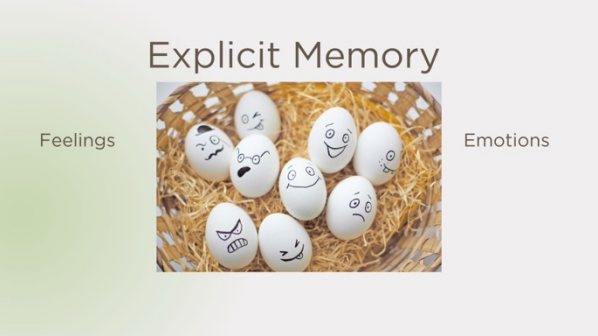


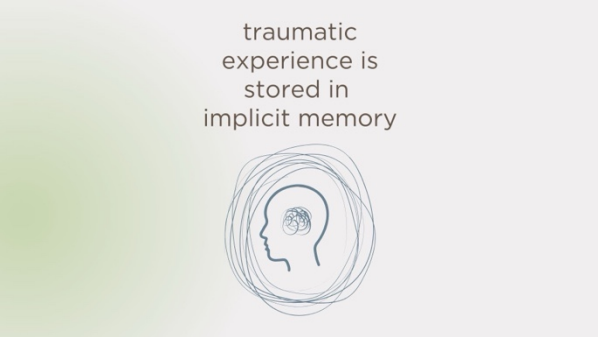
Memory Encoding in a Traumatized Brain

Implicit Memory

Explicit Memory







Notes

- There are two different forms of memory encoding called explicit and implicit memory.
- Explicit memory
    - can be divided into episodic memory – autobiographical memories, and semantic memory – the ability to recall general facts
    - needs conscious awareness to be encoded
    - the brain structures required to do so are not developed after birth.
    - This is why people are unable to remember anything from their early infancy
    - we usually associate memory with explicit memory recall. Remembering significant dates, mathematical procedures, how to drive to the store, and also what happened at work earlier today or the order of events in your favourite movie, all of these are examples of explicit memory.

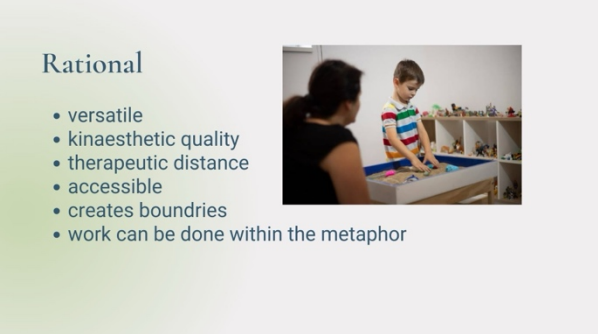
- Implicit memory
    - is the recollection of the feelings as though they are happening right now.
    - When a person remembers their wedding day, they may remember the feeling of joy and excitement. They may smile, remember the smell of the flowers, and have the urge to hug their spouse.
    - includes emotional reactions, behavioural urges, bodily sensations, or sensory fragments that we experienced in reaction to what was going on at that time
    - when they are not encoded alongside an explicit memory they will not carry a marker of time and therefore an implicit memory is recalled as if the original event is occurring.
    - These memories are recalled when something happening presently is felt similarly to a past experience
    - so much of a traumatic experience is stored in implicit memory
    - If, for example, a child is physically and verbally abused by his father as a young child and learns to avoid the abuse by hiding the moment he hears his father shouting, when the child gets older, they may not explicitly remember the abuse but finds that when he hears a teacher in the next room yelling at school, he has a sudden urge to elope from the building. This is an example of how implicit memories can intrude in the present lives of people without them being aware of why this behaviour is happening.

- The child who eloped from the class may justify his actions saying the school sucks and he just had to leave.

- The left hemisphere brain is where people make sense of what is happening and because trauma is stored in the right hemisphere this child's brain is only able to draw on what it is currently sensing to make sense of the situation.
- He will not be able to understand that his desire to run comes from past experiences and may not even know that it was the teacher in the next room that triggered the desire to run, so the left brain will build a justification.

Slides 46– 50

Theses slides define sandtray therapy and the therapeutic rationale behind using it.



Notes

- Versatile
    - uses non-verbal expression
    - less intimidating than art therapy as no creative or artistic ability is needed
    - accessable to a variety of cognitive abilities
    - figurines, objects, and the sand itself can express concrete or abstract thoughts or images
    - allows client to fully express themselves
- Kinaesthetic Quality
    - meets the client's need for kinaesthetic encounters
    - the client can encounter a tactile, calming, and anxiety reducing, therapeutic experience
- therapeutic distance
    - the distance created between the client and their experience by working within the tray
    - this is helpful for the client to be able to express their pain through the figurines and what has been built in the tray.
    - The client is able to separate themselves from their painful story allowing for space to process emotions implicitly and make meaning for what they are expressing rather than get caught in the struggle to find words.
- Accessible
    - Many clients can struggle with verbal skills in therapy.

    - The verbal abilities of adults and children vary greatly and depending on their developmental stage, verbal abilities can even vary among children too.
    - People with developmental language delays, social or relational struggles, neurodivergence, physical differences, and many other barriers will all benefit from having alternative ways to communicate and express themselves.
    - When a person is unable to express their needs, they can become frustrated, and this can cause challenges with a variety of relationships in a client's life
    - Bilingual and non-English speaking clients can also benefit from nonverbal strategies in therapy.
    - often prefer to express themselves in their first language and sandtray therapy allows the language of symbolism to facilitate the therapeutic process
    - For clients with high verbal skills, verbalism can often be used as a defense in a therapeutic setting.
    - These clients will often communicate on an intellectual level and use rationalization or storytelling defensively.
    - When working in the sandtray and using metaphor to express themselves these clients are better able to put down their defenses and access the feelings needed for the therapeutic process to happen
    - sandtray therapy evens the therapeutic process by removing the potential barrier of verbalization
- Boundaries
    - are crucial for clients, and especially children, to feel safe.

  - Sandtray therapy provides natural boundaries and limits through the therapy environment, the use of carefully selected figurines, the size of the sand tray, and any prompts provided by the therapist
  - boundaries contribute to the felt sense of safety for the client. Without this feeling of safety, children are unable to experience learning or growth.
- Working in the metaphor
  - Novel metaphors are those generated by the clients.
  - allows clients to access information stored in the right hemisphere of the brain
  - caution against trying to interpret the client's metaphor
  - A therapist can only make an interpretation based on their own thoughts, feelings, and experiences and in a sandtray session it is the client's meaning that is the most important.
  - It is not necessary for interpretation to happen in order for the client to experience healing.
  - trust the process.

Slides 51 – 53

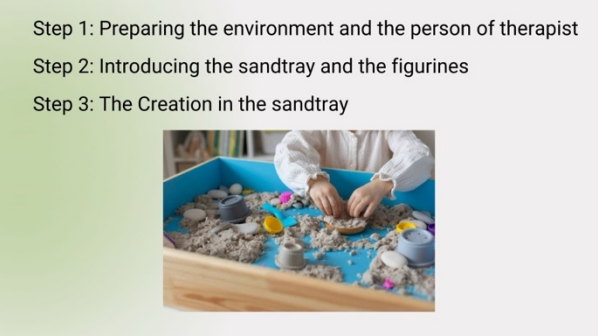
These slides cover the historical pioneers of sandtray methods Margaret Lowenfeld and Dora Kalff and the various institutes that offer sandtray training.

Notes

- Margaret Lowenfeld was the first clinician known to use sand in her therapeutic practice.
- was a medical doctor and pediatrician from London.
- In the 1920 she worked in Poland during the Russo-Polish War providing medical care to those in prisoner of war camps in Poland.
- She was also a relief worker in Poland for students suffering from the effects of war.
- Upon returning to London, she observed many children suffered from the same symptoms as the children she had helped in war-torn Poland.
- develop a method to support children's mental health issues and help them to share their "inner worlds."
- opened the "Clinic for Nervous and Difficult Children" in 1928.
- Here she developed the World Technique.
- provided clients with trays of sand and small toys or figurines and encouraged them to express feelings and events in the sandtray
- 1985, Dora Kalff developed the International Society for Sandplay Therapy at her home in Switzerland.
- Kalff and her colleagues saw a need for more structure to the study and practice of Sandplay

Slides 54 – 57

These slides cover the 6 steps to of the basic sandtray process.



Notes

Step 1 Preparing the environment and the person of the therapist

- Ensure the environment is ready to receive the client
- no traces of previous clients
- all of the figurines are in place and that the sand is free of figurines
- smooth out the sand so that it is level and generally smooth but not too smooth.
- Ideally, the client should be able to walk around all sides of the tray so that they can view their creation from a variety of perspectives.
- The therapist also needs to ensure that they are prepared to facilitate a session with a client.

- Individual self-care to ensure that they can be fully prepared to welcome and focus the client to the sandtray therapy process

Step 2: Introducing the sandtray and the figurines

- process is unique to the therapist and to the client
- two types of prompts that a therapist may choose to use in a sandtray therapy session: directive or nondirective

Step 3: The Creation in the sandtray

- This is the client's time to build their scene in the sandtray
- attunment during this time is key
- observe what the client is touching and not touching in their creative process and building rapport with the client while using minimal verbal interactions, within the client's level of comfort
- observe the therapist's and the client's somatic reactions
- "trust the process."

To talk or not to talk

- With young children, it may be more appropriate to verbally track the child's play as a play therapist would do as they are more likely to create active and dynamic scenes
- If a client seems more withdrawn and is struggling to relax in therapy the counsellor may want to support the client by participating in that dialogue with the client.
- for some clients who are working on developing self-regulation and their tendency towards over-verbalization a therapist may choose to encourage discussion only after the sandtray is finished

- know what the intention is behind using sandtray and tailor responses and interactions appropriately

Step 4 sandtray processing

- take a moment to view the completed tray and points out simply what is there without judgement.
- be curious and ask skillful questions that help the client to explore their own insights within the sandtray
- use the creation as a springboard for discussion or to work with the metaphor
- focus on the emotional content of the sandtray

Step 5: Sandtray Clean up

- some therapists may want to work with the client to clean up from a sandtray session
- most sandtray therapists believe that cleaning up from a sandtray session should be done after the client has left
    - it provides further time for the therapist to process the sandtray
    - it leaves the image of the completed sandtray in the client's mind, allowing them to further process their experience even after leaving the therapy room (this is especially important if a therapeutic transformation has happened in the sandtray)
- communicates to the client that their work is respected and honoured
- not a time to teach manners and the self-regulation associated with cleaning up after oneself

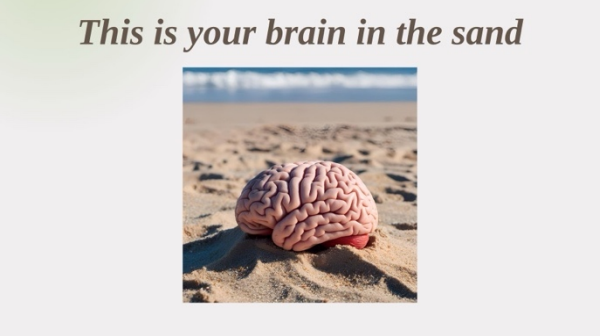
Step 6: Documenting

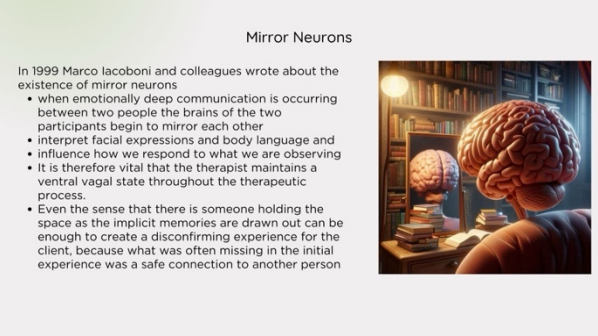
- an ethical and legal part of the therapist's job
- therapist can reflect on the time they spent with that client

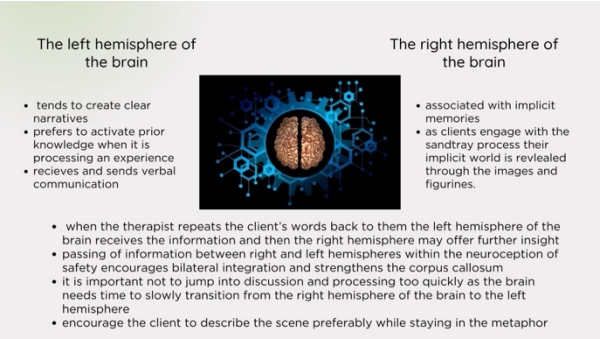
- may want to include any prompts used, the client's approach to building their tray, the organization of the tray, any verbal or non-verbal communicationsa title or theme a summary of the discussion
- may also want to include photographic documentation of the session

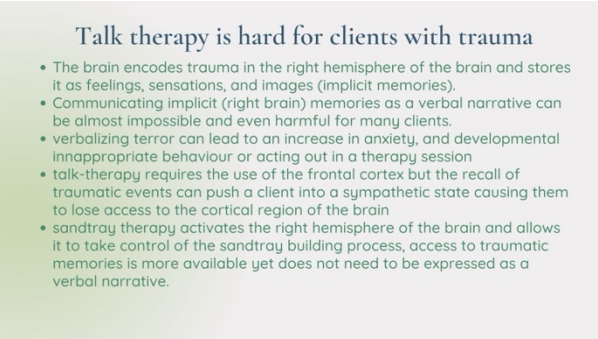
Slides 58 – 61

These slides cover the neurological effects of sandtray therapy. They include information about mirror neurons (Badenoch & O'Mahony, 2021; Grayson, 2022), left and right brain roles and communication in sandtray therapy(De Little, 2019; Grayson, 2022; Sweeney, 2017), and a discussion about why talk-therapy can be challenging with children and with people coping with developmental trauma (Badenoch & O'Mahony, 2021; Grayson, 2022).









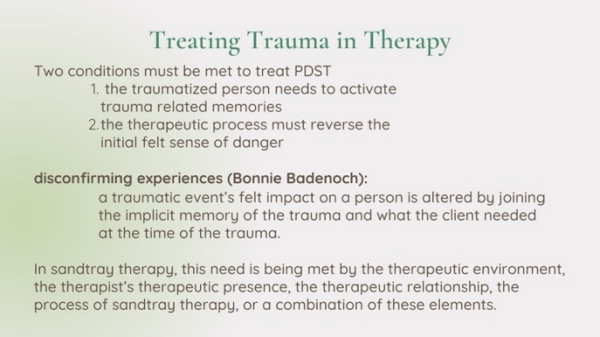
Notes

- Mirror Neurons
    - 1999 Marco Iacoboni et al. wrote about the existence of mirror neurons

- help to interpret facial expressions and body language and influence how we respond to what we are observing
- when emotionally deep communication is occurring between two people the brains of the two participants begin to mirror each other
- therefore, it is vital that the therapist maintains a ventral vagal state throughout the therapeutic process
- Even the sense that there is someone holding the space as the implicit memories are drawn out can be enough to create a disconfirming experience for the client,
- what was often missing in the initial experience was a safe connection to another person (Badenoch & O'Mahony, 2021; Grayson, 2022)

Slides 62 – 63

These slides cover the current research on how to treat PTSD and trauma in therapy and includes a definition of a disconfirming experience and the role of control in sandtray therapy (Badenoch & O'Mahony, 2021; Grayson, 2022).



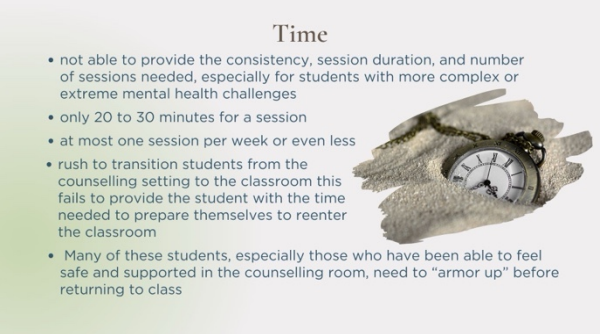
Notes

- 1996, Rothbaum and Foa stated that 2 conditions must be met in order to treat PDST
  - the traumatized person needs to activate trauma related memories
  - the therapeutic process must reverse the initial felt sense of danger

- confirmed by Badenoch's research
    - disconfirming experiences: a traumatic event's felt impact on a person is altered by joining the implicit memory of the trauma and what the client needed at the time of the trauma.
- Sandtray therapy meets this need through
    - the therapeutic environment
    - the therapist's therapeutic presence
    - the therapeutic relationship
    - the process of sandtray therapy
    - or a combination of these elements

Slides 64 – 71

These slides cover the limitations, challenges and barriers school counsellors face when using sandtray therapy in schools. These include having enough time, getting proper training, limited access to resources and tools, space limitations, and getting support from the school community for sandtray therapy (Harper, 2024; Ray et al., 2015).



Slides 72 – 79

These slides address the limitations, challenges and barriers of using sandtray therapy in schools. They include ways to make sandtray more mobile and compact, where to look for materials, how to access funds for materials and training, managing time, and onboardig stakeholders for support.

Addressing the Limitations, Challenges, and Barriers

Finding Space

- consider confidentiality
- avoiding being close to multipurpose rooms or principals office
- children can communicate a wide range of feelings with only a limited number of materials
- consider a mobile sandtray therapy unit

Accessing tools and resources

- ask for a budget
- approach the parent association
- solicit for donations from families and teachers (provide a list to avoid an abundance of un needed supplies)
- approach a local business to support the development of sandtray counselling space

Seek Training

- ask for professional development funds from administration or your union
- look for scholarships or burseries
- check out the continuing education options offered by local organizations

CANADIAN ASSOCIATION FOR PLAY THERAPY

NSST Institute
Where Words Cannot Reach

CANADIAN SANDTRAY INSTITUTE

CAST
Canadian Association for Sandplay Therapy
Association canadienne pour la thérapie par le jeu de sable

Finding and managing time

- aim for consistency - six to eight weeks at a time and then evaluate the need for further sessions
- focus on developing relationships with staff so that you can support each other's schedules
- counselling should never be done as a reward
- beware the message that "only good kids get counselling"
- be deliberate and mindful of transitioning a child back to their class
- finish with a wish (De Little, 2019)
- talk about school activities when walking back
- consider offering to take a picture of the sandtray (also good for your notes)

Onboarding the school district and board members

- presentation for the school board outlining the advantages of play therapy in the school setting, the cognitive development of children, and how play and toys are the language of children

- describing the function of play therapy through the lens of the school/district improvement plan and incorporating research data regarding play therapy

Onboarding the staff and administration

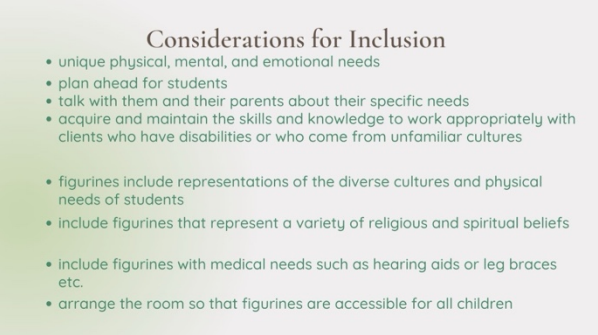
- develop a relationship of respect and collaboration with staff
- presentation for the teachers and school administrators
- information about play therapy methods and their impact
- present a case study allowing participants to get an idea of how play therapy works and the impact that it can have on students in the context of the school setting
- an experiential activity that allows the adults to experience the play for themselves
- *remind them that the purpose of the experience is this is not for therapy but an opportunity to increase the awareness of sandtray therapy

Onboarding parents

- regular communication with parents that includes information about
  - the sandtray therapy process
  - suggestions for how to support their children at home
  - resources that parents can use with their children
  - resources to access more information
  - advertisements for upcoming parenting classes or groups
  - items needed for the counselling room
- be available and visible during the school open house events so that parents can see the counselling room and ask questions.

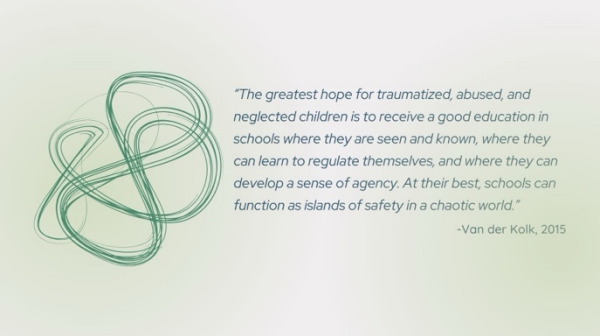
Slides 80 – 81

These slides cover some things that counsellors may need to considerations for inclusion to ensure that students of all abilities and backgrounds can access and feel represented in sandtray therapy.



Slide 82

This final slide is a quote from Bessel Van der Kolk's book *The Body Keeps the Score*.



Notes

- I have included this quote because it speaks to a fundamental belief that I hold close to my heart and is the reason that I do the work I do.

Conclusion

Developmental trauma among children in schools is a profound challenge for school counsellors today. School counsellors are balancing a multitude of responsibilities and are expected to deliver effective and developmentally appropriate therapeutic interventions. There are many children in Canada who are being investigated for suspected maltreatment or living

outside of their families due to abuse or neglect. The presence of these trauma-affected students in classrooms today is a reality and one that often falls to the counsellors to address. The trauma these children carry with them are invisible wounds that influence their ability to learn, make connections, and regulate their emotions. A common recommendation is for counsellors to refer these children to outside mental health agencies, however, systemic barriers such as long waitlists, financial limitations, and accessibility issues prevent these students and their families from accessing the services they need. As a result, school counselors often serve as the first and sometimes only line of support. Because of the number of responsibilities school counsellors are required to take on, from guidance counsellor to crisis intervention on top of their usual duties, school counsellors struggle to provide the therapeutic support that the students coping with developmental trauma require.

There is an increasing need for creative and developmentally appropriate interventions that can work within the school counselling environment. Sandtray therapy is a powerful and expressive technique that allows students to externalize their experiences and emotions in an unintimidating and non-verbal manner. For many students, talk therapy is not appropriate for their developmental stage and non-verbal techniques are required for them to feel safe and supported. Students can effectively and creatively communicate their inner worlds using figurines and sand within the boundaries of the sand tray. Allowing children to process difficult experiences and emotions at their own pace makes sandtray conducive to the school counselling setting as children are not required to communicate traumatic memories explicitly (De Little, 2019; Homeyer & Sweeney, 2023).

For a child navigating developmental trauma, words can be difficult or sometimes impossible to access. Sandtray therapy provides a therapeutic alternative to talk therapy built

from stories, symbols, and sensory engagement through the sand. In the process of a student arranging figures in the sand, there is a narrative unfolding, a hidden pain being released, and a healing process taking shape. By creating a world within the sand tray, the student can explore themes of safety, resilience, and self-identity, all within a contained therapeutic space.

Despite the significant benefits of sandtray therapy, using play-based interventions in the school counselling setting is not without its challenges. Counsellors face many institutional barriers such as limited funding, a lack of training, and push back about non-traditional therapeutic approaches. Not all educational professionals are on board with counsellors using school time to do their work. As well, school environments often make academic achievement a priority over emotional well-being, making it difficult to advocate for the inclusion of counselling, however, using play-based approaches like sandtray therapy is undeniably worthwhile. Not only do these techniques align with children's natural ways of processing emotions, but they also provide an accessible, engaging, and developmentally appropriate method for addressing trauma. When children are able process trauma, they are more likely to be able to participate learning activities and accomplish the academic achievements that drive the education system today.

When creativity in school counselling is embraced, school counsellors can offer students more than just guidance, they can provide students with the tools they need to be able to heal and to reclaim their sense of agency. Sandtray therapy is an opportunity for children to rewrite their stories to find the shields and bridges they need to move into a healthier and more hopeful future. The path to integrating creative therapies may require some advocacy, education, and additional training. The ability to offer students a space where their voices, spoken or unspoken, can be heard makes the effort profoundly worthwhile.

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