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The Use of Sand Tray Therapy When Working with Families Impacted by Pediatric Illness

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Abstract

This paper will describe how therapists can utilize sandtray therapy to support families affected by pediatric illness. An outline of how pediatric illnesses impact the ill individual, their parents, and their siblings will be provided. Next, a description of the biopsychosocial model will be provided, which therapists can use to assess and conceptualize pediatric family cases. Lastly, there will be an introduction and discussion of sand tray therapy, exploring how it can be integrated with the biopsychosocial model to treat families affected by pediatric illness.

Certain illnesses are common in children and typically present with minimal to mild symptoms. However, more severe childhood illnesses can have prolonged adverse outcomes. It is these illnesses that can affect the child's ability to function on multiple levels. These levels extend beyond physical ramifications and include emotional, social, and other facets. Likewise, the outcomes of pediatric illness do not only affect the ill child but it also impacts their entire family. Therefore, therapists must have a biopsychosocial lens to assess and treat the totality of how the pediatric illness impacts the family as a unit. By providing treatment in this manner, therapists address each of the affected areas of the family.

Smith and Kaye (2012) state that pediatric conditions are quite common in children in the United States. According to the Centers for Disease Control (n.d.), approximately 7.3% of children between the ages of five and eleven missed multiple days of school due to illness, injury, or disability. These statistics offer a brief glimpse into the impact of pediatric illness. Pediatric illness, commonly called childhood illness, can be defined as a

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childhood disorder, disease, impairment, or injury that primarily impacts infants, children, and early adolescents and affects their quality of life (Hasanah et al., 2025). Pediatric illnesses can be categorized into infectious diseases, allergies, skin problems, and neurological issues. Examples of these illnesses include pink eye, strep throat, seizures, multiple sclerosis, measles, and the common cold. These conditions typically manifest anywhere between infancy and adolescence. Common symptoms include congestion, a runny nose, fever, sore throat, struggle to breathe, itchy skin, and other symptoms (Gilleland et al., 2019).

Because of children's underdeveloped immune systems and high exposure to germs, this increases the likelihood of them developing a pediatric illness. For example, attending school and participating in sports or other extracurricular activities. Additionally, regular doctor's visits and traveling to see family members can also increase the risk of exposure to germs. While these activities and interactions are not guaranteed to make a child sick, they are places where individuals come and go routinely, which increases the chances of getting sick.

In the article "Understanding Common Childhood Illnesses and Their Symptoms" (PediPec, 2025), the authors describe acute childhood illnesses as developing quickly and having a brief duration. These conditions include illnesses such as colds, ear infections, and the flu. Treatment for these illnesses focuses on symptom management and reduction through over-the-counter or prescribed medications, fluids, and rest. On the other hand, chronic illnesses have a longer duration, ranging from a few months to several years or longer. Examples of chronic childhood conditions include food allergies, diabetes, and asthma. Treatment for chronic conditions requires a more comprehensive approach—for example, interdisciplinary care, increased health education, lifestyle changes, and possible surgery. According to Rohan and Verma (2020), research has shown that children and adolescents are more likely to survive acute pediatric illness; chronic illnesses increase the likelihood of developing additional effects connected to the illness, treatment interventions, and maladaptive health behaviors. This includes reduced physical functioning, obesity, higher rates of mortality and morbidity, and other adverse effects.

Depending on multiple factors, including the child's age and illness type (acute or chronic), this will influence whether the child experiences short-term or long-term effects due to the illness. Another important factor to consider is the family structure. Often, in healthcare settings, the focus is on the child's physiological condition. However, because of the mental, emotional, and social outcomes of pediatric illness, a deeper examination of the entire family is warranted.

With the scope and severity of pediatric illness, this can significantly affect not only the child's physiological health but also their mental and emotional health (Compas et al., 2012). Therefore, in some circumstances, parents/caregivers of ill children seek the additional supportive services of therapists. Therapists can address the mental, emotional, social, and other related challenges that emerge during the presence of this illness. They can also help navigate any medical or biological hardships that are interconnected with different areas of need.

Research has shown that psychotherapy can help those impacted with chronic conditions. For example, according to Vranceanu et al. (2017), interventions such as cognitive behavioral therapy and other psychosocial interventions have been shown to be effective for individuals with medical illnesses.

Likewise, to provide effective treatment, these professionals must understand the structure of the family. Family structure is the relationship between people living in the same household and how they communicate, live, and interact with one another (Sharma, 2013). There are several types of family structures, which include nuclear families, step or blended families, same-sex families, and extended families (Colapinto, 2019). Without identifying and assessing the family structure, clinicians operate from a linear approach to treatment. By recognizing and understanding the family structure, clinicians can treat the biopsychosocial impact that pediatric illness has on families.

Impact of Pediatric Illness

Impact on The Child

There are many ways in which pediatric illness can impact a child. Some examples include challenges at home, school, and other social avenues. Depending on the type, severity, and duration of the illness, some children may have to adopt a different diet than their other family members (Van Cleave et al., 2010). Children may need to be isolated at home to prevent the spread of the illness to other family members. This type of separation can significantly alter the family structure and dynamics. This oftentimes has an impact on the overall family functioning. When children are sick, they may have to miss out on school. Children may need to be out of school for extended periods. They may have to leave a number of classes early. This causes social shifts as it interrupts children's interactions with their peers.

Missing school, leaving classes early, or arriving late disrupts the peer interactions that children have at school. When at school, children learn, develop, and implement multiple skills. For example, communication, conflict resolution, empathy, self-advocacy, listening, problem-solving, collaboration, patience, rule-following, and many other social skills. These skills are essential as children continue to develop and learn how to appropriately interact with their social worlds (friends, family, and other meaningful relationships). Navigating a pediatric illness can disrupt this development and manifest feelings of loneliness, confusion, and grief. Grief in children can result from feeling left out, feeling different than their peers, or feeling abnormal (Ferow, 2019).

Furthermore, depending on their age, development, pediatric illness, family structure, and other factors, children may experience different forms of social disruption. For example, following recovery from a pediatric illness, a child may experience "reentering" their social

worlds. They may have missed out on important events such as birthday parties and similar celebrations. They may still be on dietary restrictions or are still required to take medications, which compounds their sense of feeling different than their peers.

Additionally, when being treated for a pediatric illness, children often interact with multiple healthcare professionals. For some children, this may be overwhelming as they have to meet with various medical professionals, including physicians, pediatricians, nurses, and other allied health professionals. They may try several medications, which can have side effects. Depending on their family's access to specific resources, this also affects the severity of the child's experience.

Impact on Parents

As described above, pediatric illness has multiple effects on the child. As children are dependent on their parents/guardians/caregivers for their basic needs, pediatric illness also affects those in care of nursing their child back to health. An example of the most immediate impact is the emotional toll this can have on individuals. Some common emotions that parents experience as a result of their child dealing with a pediatric illness include guilt, anger, frustration, and confusion. Having to help their child navigate these complicated feelings impacts their overall functioning. According to Cohn et al. (2020), parents who have children with chronic illnesses have a higher chance of developing anxiety and depressive symptoms than parents who do not.

These emotions can spill over and disrupt other areas of the parent's life. Parents must work to provide for their families. Having a child with a pediatric illness can lead them to miss work, affect work performance, or have to quit or be terminated from their employment. This can lead to a significant shift in the family's financial status. Paying for medical bills, travel to and from appointments, and other expenses can quickly become costly. Especially for single-parent households where they are the sole providers. Also, having more than one child can exacerbate costs during this time.

Similarly, as some families have more than one child, having one child with a pediatric illness can cause shifts in the family. Often, siblings assume a caretaker role when parents are managing other responsibilities. This can cause further stress on the entire family as the caretaker child may experience negative feelings towards their sick sibling or parents. The parents may also experience increased stress during this period (Zdun-Ryżewska et al., 2021).

With this in mind, some parents may undergo a form of questioning or immersion in their religion or spirituality. Sometimes, the overwhelming experience of having a child with pediatric illness can be so overwhelming that parents who have faith-based beliefs may begin to question their faith. For example: "Why are we being punished?". "Why does my child have to suffer like this?". "We are good people; we do not deserve this." On the other hand, some parents may experience an increased need for safety, security, and reassurance in their faith-based beliefs.

They may begin to lean more heavily on religion and spirituality to help ground them. They may seek the assistance of faith-based leaders, especially during the assessment, diagnosis, and treatment phases.

As their child begins to show symptoms of being ill, parents are tasked with the responsibility of getting their child treatment. Unfortunately, this is often not an overnight process. Again, depending on multiple factors such as socioeconomic status, ability, and access, parents have to navigate many levels of the healthcare system until they can get their child the proper treatment. It can take time to obtain an accurate diagnosis of a pediatric illness. Then, after an effective assessment of symptoms and diagnosis, an appropriate treatment must be developed. Through this process, parents face multiple potential hurdles and challenges. This further exacerbates the overall pediatric illness experience in the family.

Impact on Siblings

Keeping in mind all that is described above about the impact of pediatric illness on the sick child and the parents, it is clear that there is also an impact on the siblings as well. According to Hilário (2022), sometimes the well-siblings may find themselves in a parentified role. Parentification occurs when a child is forced to assume an adult role within their family. Some older siblings may have to do additional tasks to support not only their ill sibling but also the household, such as cooking or cleaning. Other responsibilities may include monitoring and administering medications, as well as assisting with studying and homework assignments. Should there be multiple children, this can expand the parentification experience. Siblings can also serve as an emotional support system for their other siblings, parents, and other family members. Similar to the challenges faced by their ill sibling, the well sibling may also experience academic and social difficulties. They may not be able to concentrate in school and may become increasingly distracted in the classroom. This wave of new responsibilities can take them away from social interactions with their peers.

Additionally, they may experience a multitude of emotions towards themselves, their ill sibling, and others. For example, having a sibling with a pediatric illness can interfere with the child's ability to self-regulate. They may be over-dependent on others for reassurance. Or alternatively, they may internalize their emotions, becoming isolated or engaging in negative self-soothing. On the other hand, they can develop both positive and negative feelings towards their sibling with the pediatric illness. According to Read et al. (2011), supporting their sick sibling may heighten their sense of empathy. Depending on age, culture, and other factors, they may naturally want to support them in any way they can. However, they may also develop a sense of jealousy or envy towards their sibling. Again, depending on the family structure, they may interpret their ill sibling as getting more attention from their parents (Chin et al., 2018). They may see doctor visits and other shifts as their ill sibling getting special attention.

Other emotions that can emerge in this process include grief. Grief can be defined as the cognitive, physical, emotional, social, and cultural process of reacting to loss and change (Worden, 2018). Some common physical reactions to grief include crying, fatigue, and poor appetite. Emotional reactions include anxiety, fear, confusion, and sorrow. Cognitive reactions include struggles focusing and cognitive distortions. Social reactions include role confusion, withdrawal, and isolation. Likewise, grief can encompass secondary loss. Secondary loss refers to more minor changes that result from the presence of a pediatric illness. Examples of this include financial insecurity, a sense of self, and connectedness to others, including the ill sibling. Other secondary losses are adjustments in their health, loss of identity, and shifts or losses of support systems such as friends. All of these reactions have a great impact on the child's ability to develop and function at a healthy level.

In summary, the above discussion described the impact that pediatric illness has on the ill individual, the parent or parents of that individual, and any siblings present. These impacts include physical, emotional, structural, relational, and social changes that can emerge as a result of a child experiencing pediatric illness (Golics et al., 2013). With this in mind, the above literature supports the notion that pediatric illness extends beyond a singular event to become a biopsychosocial and systemic process and experience. Therapists must recognize, assess, interpret, and treat families impacted by pediatric illness using the biopsychosocial model. Using this model promotes both the well-being and outcomes of each individual family member and also the family as a unit.

Biopsychosocial Model

Developed by George Engel (1977), the biopsychosocial model recognizes and addresses the interconnectedness of the biological, social-environmental, and psychological effects on health and human development. While historically, medical models have been centered on pathological problems; this approach considers various areas beyond the biological. In essence, this model acknowledges that while health conditions are biological in nature, the effects are felt physically, socially, and psychologically (Bolton & Gillett, 2019). This presents a systemic approach to understanding illness and health. Integrating physical, social, and mental factors into an individual's care provides a biopsychosocial approach to treatment rather than focusing solely on medical symptomatology (Erb & Schmid, 2021).

Biological factors refer to the genetic characteristics that influence health. This includes the immune system, age, sex, fitness, disability, and family health (including predispositions to certain diseases). Psychological factors refer to an individual's mental and emotional state. This can include stress, depression, anxiety, mood, beliefs, coping styles, and more. Social factors are the environmental, cultural, and relational components of an individual's family life that affect health. This includes socioeconomic status, occupation, education, community support and

resources, family relationships, marital and relational status, access to healthcare, traditions, norms, and stigmas, among others. Access to health care can also be factored into the social factors.

Additionally, according to Saad et al. (2017), many scholars argue that the spiritual dimension should also be incorporated into the biopsychosocial model. While the definition and integration of spiritual beliefs are fluid, research demonstrates the impact that spirituality has on health outcomes. Spirituality can encompass family, friends, community, others, nature, beliefs and values, traditions, practices, expectations, hopes, and fears, among other aspects. Individuals often engage in their spirituality through formal religious practices or other faith-based rituals. This research highlighted how spirituality can strengthen the coping abilities of those affected by illness. For example, someone and their family that utilizes prayer for a family member affected by illness can reduce stress and increase resilience.

Therefore, mental health clinicians must understand the physical, social, and psychological symptoms of illness and how they impact the family to maximize the restoration of wellness on various levels. Pate (2016) described that dealing with illness affects not only the ill child but the entire family. According to Law et al. (2019), family-based interventions can help strengthen parenting skills, mental health, and overall family functioning. The biopsychosocial model provides a framework for clinicians to assess and conceptualize these illness cases from a systemic lens. This encourages clinicians to understand the root causes of distress of these ailments and enables them to develop specific treatment plans tailored to the family's needs.

Sandtray Therapy

Sandtray therapy is an approach that encompasses a sandtray, miniature figurines, and a verbal processing element (Holliman & Foster, 2023). According to Margaret Lowenfeld (1993), she established sandtray therapy to work with children. Lowenfeld recognized that children benefited from having a free and protected space to express themselves. Over the past few decades, sandtray therapy has grown and been used with various populations. For example, Smith (2012) described how sandtray therapy is effective with children receiving special education services.

Sandtray therapy allows for the creation and re-creation of an individual, couple, or family's internal and external experiences. The therapist will ask the client to select different miniature figurines of their choosing, which can represent people, places, things, feelings, events, and trauma experiences in the client's life. Homeyer and Sweeney (2023) described how the sandtray can encompass both sand and water, which are natural elements of the earth, and that the assembly of miniature figurines represents universal symbols of the client's inner world. Therapists should have an abundance of different and diverse miniature figurines to represent various levels of intersectional identities and experiences (culture, race, gender, age, ability,

building, worship/religion/spirituality, grief/loss, etc.). The purpose of the client creating these sand scenes is to help the client to bring the unconscious mind to the forefront and minimize avoidance of painful memories. The client is then assisted by the therapist in going through their sand scene to identify and process emotions. The client can also develop and practice solutions to problems.

A benefit of sandtray therapy is that it creates a sense of safety and distance for clients that are hesitant or anxious to address certain challenges directly. According to Swank and Lenes (2013), clients can recreate outcomes of events, process unwanted moments of events, and create meaningful alternatives through self-guided practice. Similarly, Flahive and Ray (2007) conducted research that supports that sandtray therapy is trauma-informed, which is effective when working with refugee communities. The sandtray creates a sense of safety and distance that refugees may have been denied in various capacities. In effect, this allows refugees to recreate narratives of their lives that systemic, social, and societal norms have shaped. While this approach is often non-directional in the beginning, depending on certain factors and treatment goals, the therapist will select specific scenes for the client to create. However, this does not mean that the therapist chooses the miniature figurines, only the event, memory, experience, etc., that the client will create.

Sandtray Therapy and Children

Lacroix et al. (2007) conducted a qualitative study on the use of sandtray therapy with refugee preschoolers who experienced trauma from a tsunami. The findings indicated that sandtray therapy provided an opportunity for preschoolers to express, examine, and heal from experiences of past trauma and present thoughts and reactions. Alike, Kronick et al. (2018) conducted a qualitative study with refugee children and adolescents between the ages of 3 and 13 in Canada who routinely experience incarceration in immigration detention centers for "aggressive behaviors or disorderly conduct." Results revealed that as these children created sandtray scenes, it captured the traumatic experiences these children faced while incarcerated and the anxiety of separation and isolation from their families. They also created sandtray scenes that expressed their internalization of the meanings of their migration to Canada.

Yang (2014) researched the impact of sandtray therapy on the behavioral challenges, emotional intelligence, and self-esteem of children being raised by grandparents in South Chungcheong Province, South Korea. These children experienced emotional shifts due to separation from their parents due to poverty, cultural norms, or death. Participants were fifteen children from non-grandparent families and another fifteen from grandparent families. Each week for twelve weeks, these children would participate in 45-minute sandtray therapy sessions. Pre- and post-assessments were administered in the form of the Teacher's Report Form, Self-Esteem Scale, and the Emotional Intelligence Scale. Findings revealed increasingly higher rates of

improvement on all three assessments in the children following the conclusion on sandtray therapy.

Furthermore, Lee et al. (2018) explored how sandtray therapy could assist children whose parents were divorcing. The participants were children aged between 3 and 11 years old. The focus was to assess the behavioral and emotional outcomes of children of divorced parents when receiving sandtray therapy services. These sessions were audio recorded and coded to identify themes that emerged during the sandtray therapy process. Results showed that by participating in sandtray therapy sessions, the children were able to identify and express difficult feelings, resolve issues surrounding the divorce, and use better communication skills.

Sandtray Therapy and Families

For some children, traditional therapy modalities may not be fully applicable for treatment, whereas play-based modalities are more effective (Schottelkorb et al., 2015). Children are still in the early stages of development and are still learning effective communication and other social skills. Therefore, many therapists adopt more expressive and play-based approaches. As children naturally express themselves through creative play, sandtray therapy encourages this natural expression (Petrović-Sočo, 2013). It also allows the child to explore and communicate thoughts, feelings, and reactions.

According to Ison et al. (2015), some creative and expressive therapy interventions are driven by the individual features of a client. The authors support that sandtray therapy provides greater adaptability for more than one client at a time. The authors provide and describe a case study that showcases how sandtray therapy can be implemented for familial clients. This supports the additional literature on how sandtray therapy is applicable for families and can be effectively implemented by therapists.

According to Mackova et al. (2022), parents are an essential element in the psychosocial development of their children. Therefore, the sand tray provides a therapeutic tool that allows families to collectively process and heal. Additionally, therapists using sandtray therapy can help families identify and process negative experiences therapeutically and experientially. Using sandtray therapy also promotes family unity as members work to create scenes together. This helps families individually and collectively increase self-awareness and insight.

While every family is unique, there are specific considerations when therapists are working with certain family types. For example, adoptive families encompass special elements that influence how these families function and how they interact during the therapy process. Some considerations include race, culture, ethnicity, attachment styles, communication styles, and many more. Research has shown that adopted children demonstrate higher rates of behavioral, emotional, and other related challenges than non-adopted children. This is often attributed to trauma and neglect experienced early in life before the adoption and can lead to

further issues later in life (Herce et al., 2024). Therefore, Lyles & Homeyer (2015) report research that supports the use of sandtray therapy as a valuable intervention for therapists working with adoptive families. The authors outlined how sandtray therapy is attachment-driven and trauma-informed for adoptive families.

Sandtray Therapy and Pediatric Illness

With the multiple implications that pediatric illness has on the ill individual and the family, this calls for the therapist to take the biopsychosocial approach to treatment. The biopsychosocial model provides a tool for assessment and conceptualization that therapists can use when implementing sandtray therapy. In doing so, the therapist incorporates the physical, emotional, mental, financial, and additional areas where the family has been impacted by the pediatric illness. Additionally, the biopsychosocial model can help the family recognize the impact of the illness beyond its physical aspects and acknowledge how it has affected the family as a unit. According to Kelada et al. (2022), psychosocial interventions that are family-based can help to strengthen sibling-parent relationships and the sibling-sibling relationship. Examples of the benefits of using a biopsychosocial approach in sandtray therapy include the following:

- Allowing the family to explore areas of stressors (emotional, relational, financial, academic, etc.).
- Allows families to explore and process feelings surrounding the various impacts of the illness.
- Provides a method for families to communicate thoughts, emotions, reactions, and experiences, promoting togetherness.
- Offers a safe and supportive space to explore anxiety-producing future scenarios related to the illness and other outcomes.
- Encourages creative expression and problem-solving between family members.
- Explore alternatives and possible hopes and goals for the future post-recovery.

The sandtray scene that the family creates is a place where they collaborate and present moments, thoughts, feelings, and reactions related to the illness. Sandtray therapy has a unique way of helping children and families express themselves through symbolic play. While individual scenes can be developed by family members, many of the scenes should be done as a unit. In doing so, each member can identify, express, and heal on a relational level. As treatment progresses, the therapist can name certain scenes to be created. Family-focused scenes allow for the manifestation of events representing important family dynamics, challenges, and opportunities for growth. Examples of these types of scenes include:

- "Create a scene of how you all learned about the illness".
- "Create a visit to the doctor's".
- "Create a scene of how it felt when you interacted with friends at school after being sick".

- "Create a scene of how you all felt when eating family dinner".
- "Create a scene of what, as a family, would you all like to do once treatment is done?"
- "Create a scene of how things at home were different before the illness".

Case Example: The Johnson Family

Michael is a 6-year-old bi-racial male. His mother, Ms. Johnson, is African American, and his father, Mr. Williams, is Caucasian. His parents are divorced; Ms. Johnson has primary custody, and Mr. Williams has visitation. He was born prematurely at six months old and spent approximately 3 months in the neonatal intensive care unit (NICU). When Ms. Johnson was pregnant with Michael, Mr. Williams was using alcohol and other drugs. She reported that she sometimes did not know if or when he would come home. Sometimes, he would disappear for days. During this time, Ms. Johnson became extremely sick and had to deliver Michael immediately. After giving birth, she had to remain in the hospital for three weeks, and Mr. Williams did not visit her once.

Michael is about to enter the first grade. He has recurring medical appointments regarding ongoing developmental challenges from his premature birth. He is the youngest of his parents' two children. His oldest sister, Ashlee, is 10 years old and attends 4th grade at the same elementary school that Michael attends. Michael has recently recovered from a urinary tract infection (UTI). Michael was experiencing symptoms of belly pain, frequent urination, and pain while urinating. At the beginning of therapy, Michael had just finished the last dosage of medications for the UTI. Ms. Johnson is concerned that this is an outcome of him being born prematurely. She is also concerned about his diet following a doctor's appointment where she was informed that Michael is "a bit underweight for his age". Mr. Williams was invited to participate in treatment, but never participated.

Presenting Problems

- Ms. Johnson came to family therapy (herself, Michael, and Ashlee) because Michael's teacher was reporting multiple problems which include: disruptive in class, couldn't follow directions, and had difficulties concentrating, hiding under desks, etc.
- Ms. Johnson also reported that Michael would sometimes feel anxious when going to school.
- Michael reported "not liking school that much". Ashelee mentioned "worried for Michael".
- Ms. Johnson also reported her personal challenging history. When she was engaged to Mr. Williams, both he and her lost a parent within several weeks of one another.
- Ms. Johnson also reported feeling like the school personnel treated her "aggressively" when she would have to go to the school for issues related to Michael. She also mentioned that

Ashlee will sometimes "protect" or "defend" Michael when other children would pick on him.

Biopsychosocial Model

Utilizing the biopsychosocial model as a framework in my assessment and conceptualization of this case, I was able to identify biological, social, psychological, and relational factors impacting this family. According to Ms. Johnson, the medical providers treating Michael's UTI stated that complications of his underdeveloped immune system resulted in his body being less proactive in fighting off harmful bacteria, which resulted in him developing a UTI. Michael also reported "hating taking medicines". Ms. Johnson worried about health and wellness and ensuring the physical needs of her children were being met. This concern would manifest as thoughts of "I try to do everything so they do not get sick, especially Michael". Socially Michael felt awkward among his peers because he would often be called "small" and hear phrases such as "what is wrong with you". Ashlee also felt pressure to "protect my brother from bullies". Ms. Johnson also did not have a close relationship with her extended family. There was communication but there was a lack of deep emotional connections. Also, she was essentially taking care of the children with her sole income and she was having hardships with her occupation. Psychologically Michael did have moderate worry about being separated from his mom. He would sometimes cry when being dropped off at school. Ms. Johnson was struggling with anxiety, guilt, and grief. She was anxious about how her son was being treated at school and of his medical challenges currently and in the future. She was struggling with the guilt of Michael being born prematurely, her marriage ending, and that Ashlee was "stepping up" for Michael at school. Both children presented signs of grief of "not having both parents in the same home". These factors combined to contribute to my clinical decision to introduce the family to sandtray therapy.

Johnson Family Sandtray Therapy

Utilizing the biopsychosocial model helped me to see the various areas where the family was struggling and how the pediatric illness exacerbated these areas and manifested new challenges. Given the family's history, characteristics, and developmental challenges, I introduced them to sandtray therapy. I discussed how everyone appeared to have been impacted by Michael's illness and health. I normalized their feelings of being nervous and scared about Michael's health and wellbeing. I talked to the children about play and activities that they enjoyed. I explained to Ms. Johnson how children express themselves through play-based activities and how sandtray therapy aligns with this. The family was shown the sandtray, the various miniature figurines, and they were encouraged to touch and manipulate the sand.

I discussed how sandtray therapy would be used to explore, identify, discuss, process, and heal from the outcomes of the illness and other issues that the family was experiencing. We discussed how they would choose sand scenes that they wanted to create, and I would also ask them to create specific scenes. I also highlighted that they would be able to explore possibilities for the future, both the immediate future and long term. Finally, I informed the family that there would be moments when they would create sand scenes separately and together. Examples of the individual sand scenes that were created include:

- Create your own world. (Michael scene)
- Michael chose to create a scene that represented how he felt when his teacher gets upset with him.
- Ms. Johnson chose to create a scene that represented how the school staff interacted with her and Michael.
- Create the type of lifestyle you desire for your children. (Ms. Johnson scene).
- Ms. Johnson chose to create a scene of when she took Michael to the emergency room and he received the diagnosis of the UTI. (Ms. Johnson scene).
- Create the type of wedding/relationship that you were hopeful for. (Ms. Johnson scene).
- Recreate what you did when you protected your brother and how that made you feel. (Ashlee scene).
- Recreate a time when you visited the doctor. (Michael scene).

Family Scenes

- Create a world together. (all family scene).
- Create a time that you all remember going to the doctor for a visit for Michaels health. Think about this, think about how you were feeling on the way there, when you arrived, and once you left. (all family scene).
- The family created a sand scene of a time when all four members (mother, children, and father) spent time together.
- Create how it felt when you both were at school and Michael was not feeling well and you met with the teacher and principal (Ms. Johnson and Michael scene).
- Michael and Ashlee chose to create a scene of them facing bullies in the hallway at school.
- Create how it feels for you both when Michal has to take his medications (Ms. Johnson, Michael scene).
- Create something that you all can do together once Michael feels much better (all family scene).
- Create a family dinner where everyone gets to eat at least one thing that they want (all family scene).

I conducted these sandtray therapy sessions over 20 weeks, each lasting approximately 20-25 minutes. These sessions also included verbal processing of what was developed and emerged from the sandtray. As these sessions progressed, the family would identify events that they wished to create in the sand tray. And I would also select some scenes to create based on their biopsychosocial needs. For example, I asked Michael to "create a time you remember being sick at school." Michael selected both human and animal miniature figurines, as well as some other miscellaneous items. I then asked, "Is there any part of your scene that you would like to share with me." Michael agreed and described experiencing abdominal pain in class and asking to see the nurse. Once in the nurse's office, he explained how she asked many questions and how he did not want to talk at that moment. As he continued to share, I asked, "If you could place anything else in your sand scene to make you feel better if you have to go to the nurse again, what might it be?" Michael then chose a few additional miniature figurines and shared, "I put in a bed in here because laying down makes me feel better, and I put these animal toys in because I have some at home, and having them makes me happy."

In another session, I asked the family to create how they each felt about Michael and Ashlee's school. During this session, Ashlee placed an animal miniature figurine in the sandtray and she reported that this represented her desire to protect her brother from bullies and how she also felt like another mom to him (Ashlee's miniature figurine was near in size to Ms. Johnson). Ashlee was able to express that she also needed her mother's protection, which she felt she did not have, unlike her brother. Ms. Johnson chose a large fantasy character for this session and placed it in the middle of Ashlee and Michael's identified miniature figurines. Ms. Johnson stated that this character represented how she felt the school perceived her as "a larger than life, angry, and aggressive person." She also said this represented her desire to be as strong as possible for the family. I asked if Ms. Johnson's figurine could walk into the school (an identified building structure in the sand tray) and what she might see. Ms. Johnson began to cry and said, "Happy children, my happy children. I have not really thought about the fun of their experiences because I have been so concerned about the bad." At this moment, Michael said, "I do have fun at school sometimes." Ashlee then shared, "I am not mad about helping my brother, not mad at you, just the bullies."

A final example: I asked the family to create something fun that they could all do together once Michael had finished taking his medication for being ill. The family began to dialogue about the various miniature figurines and then placed items in the sand tray. Michael shared that he chose several elemental and natural items that represented a beach. This included water, the sun, seashells, etc. Ashlee selected a vehicle and some miscellaneous items that she said the family could use along the ride to the beach, and once they arrived. Ms. Johnson manipulated the sand to create a path for them to walk down to the beach area. She also placed some food items for the family to eat. Specifically, she chose foods that were both the children's favorites.

I asked the family, "If you were inside this scene looking around, what would you see and how might you feel?" Michael said, "Me playing in the sand and water, and having fun with my mom and sister. And maybe seeing fish,". Ashlee stated, "I get to spend time with my brother and not fight bullies." Ms. Johnson shared, "I see myself sitting in a lawn chair, smelling fresh air and sea water, and watching my children, and not stressing about Michael being sick or them getting hurt in some way."

This illness case illustrates how integrating a biopsychosocial framework with sandtray therapy can help families impacted by pediatric illness. The case example provided an overview of how to use the biopsychosocial model to assess and identify distress in family illness cases. And then identifying how to implement sandtray therapy based on the family's biopsychosocial needs. Through the creation of the sand scenes and the verbal processing, the Johnson family, individually and collectively, was able to recognize and heal their biopsychosocial wounds. At the conclusion of these sessions, the children reported experiencing more positive emotions in various settings, including at school and home. Michael shared that he enjoyed making things in the sand about himself and his family. He also mentioned that he liked talking about how being sick made him feel. Ms. Johnson reported more emotional reassurance, reduced negative thinking, and a more hopeful outlook for the family's future.

Other outcomes of integrating the biopsychosocial model with sandtray therapy with this family included helping the family to understand the impact Michael's illness had on the family. Helped to explore the issues Michael experienced at school when he was ill, processing his feelings, and exploring positive alternative interactions. Also, this aided Ms. Johnson in identifying and clarifying various negative interactions with medical providers and school personnel. Each family member was able to recognize and appreciate the positive elements and experiences at the school. And the family was able to explore and develop exciting plans for the future.

Limitations

While integrating the biopsychosocial model with sandtray therapy does promote holistic treatment, it does not come without limitations. According to Foster (2023), humanistic sandtray therapy is used to work with clients in a holistic manner, treating distress of the mind, body, and spirit. While this model has evidence-based research, there is minimal research on the effectiveness of integrating the biopsychosocial model and sandtray therapy in treating pediatric illnesses. Some literature has argued that in itself, the biopsychosocial model may misrepresent or under-represent one of its three areas of focus: biological, psychological, and social (Benning, 2015). Benning (2015) also highlighted the potential minimization of the person's unique illness experience as it relates to the biopsychosocial model. Similarly, depending on the child's chronological age and the type and severity of the pediatric illness, sandtray therapy may not be

appropriate while symptomatology is at its height.

However, despite these limitations, there is literature that demonstrates the success of sandtray therapy in treating various illness-related challenges. According to Tan et al. (2021), sandtray therapy is effective for families with children who have chronic illnesses. Specifically, this study revealed that sandtray therapy helped to decrease isolation, anxiety, and behavioral challenges for children with chronic diseases. Also, sandtray therapy reduced symptoms of depression and anxiety for the children's parents. This supports the integration of the biopsychosocial model with sandtray therapy as it promotes individual and family-based healing.

Conclusion

In conclusion, pediatric illness is common among young children and adolescents. Due to their newly developing immune systems, this age group is more susceptible to pediatric illnesses. Depending on multiple factors, such as the type of illness, the severity of symptoms, age, and development, these factors influence the severity of the illness. In conjunction, as the illness impacts the ill child, it also affects the family as a whole. As the literature outlines, the parents or caregivers, and siblings can experience adverse outcomes as a result of a pediatric illness—for example, financial challenges, mental and emotional issues, and anxiety and depressive symptoms. With the presentation of these challenges, mental health clinicians can offer assistance to help navigate these stressors.

Pediatric illness can impact families along the spectrum of the biopsychosocial model, and therapists must utilize a holistic and systemic approach. The biopsychosocial model recognizes that physical illnesses are also linked with social-environmental and psychological implications. While the biopsychosocial model does acknowledge that illnesses can have a biological drive, this model also recognizes the impact of illnesses psychologically and socially. In this manner, mental health clinicians can incorporate this model into their conceptualization of family cases with pediatric illness. As children routinely express themselves through their natural tendency of play, sandtray therapy is an intervention that draws upon this natural tendency. Using sandtray therapy with a family can help to address each of the areas of concern identified through the biopsychosocial model. This method of treatment maximizes addressing both the individual and familial challenges. This also promotes the family moving at their own pace while being guided by the therapist.

Moreover, using this approach also encourages collaboration across disciplines. As families explore, identify, and express various elements related to the illness, discussions about interactions with other healthcare providers are likely to arise. Utilizing the biopsychosocial model helps therapists recognize and understand the other professionals the family is working with, as well as how and where collaboration between providers may be necessary. Also, sandtray therapy can be combined with different forms of psychotherapy, such as solution-

focused therapy, to promote a strength-based approach to growth and health (Taylor, 2009). While using this integration does not come without limitations, this collaborative approach of the biopsychosocial model and sandtray therapy promotes individual and collective healing of all family members. Furthermore, this integration fosters stronger family relations, promotes self-discovery, and instills hopefulness for the future.

References

Benning T. B. (2015). Limitations of the biopsychosocial model in psychiatry. *Advances in Medical Education and Practice*, *6*, 347–352. https://doi.org/10.2147/AMEP.S82937

Bolton, D., & Gillett, P. G. (2019). The biopsychosocial model 40 years on. In *www.ncbi.nlm.nih.gov*. Palgrave Pivot. https://www.ncbi.nlm.nih.gov/books/NBK552030/

Centers for Disease Control. (n.d.). *Interactive summary health statistics for children.* Retrieved December 28, 2024, from https://wwwn.cdc.gov/NHISDataQueryTool/SHS_child/index.html

Chin, W. L., Jaaniste, T., & Trethewie, S. (2018). The Role of Resilience in the Sibling Experience of Pediatric Palliative Care: What Is the Theory and Evidence?. *Children (Basel, Switzerland)*, *5*(7), 97. https://doi.org/10.3390/children5070097

Cohn, L. N., Pechlivanoglou, P., Lee, Y., Mahant, S., Orkin, J., Marson, A., & Cohen, E. (2020). Health outcomes of parents of children with chronic illness: A systematic review and meta-analysis. *The Journal of Pediatrics*, *218*, 166–177.e2. https://doi.org/10.1016/j.jpeds.2019.10.068

Colapinto, J. (2019). Structural family therapy. In B. H. Fiese, M. Celano, K. Deater-Deckard, E. N. Jouriles, & M. A. Whisman (Eds.), *APA handbook of contemporary family psychology: Family therapy and training* (pp. 107–121). American Psychological Association. https://doi.org/10.1037/0000101-007

Compas, B. E., Jaser, S. S., Dunn, M. J., & Rodriguez, E. M. (2012). Coping with chronic illness in childhood and adolescence. *Annual Review of Clinical Psychology*, *8*, 455–480. https://doi.org/10.1146/annurev-clinpsy-032511-143108

Engel G. L. (1977). The need for a new medical model: a challenge for biomedicine. *Science*, *196*(4286), 129–136. https://doi.org/10.1126/science.847460

Erb, M., & Schmid, A. A. (2021). *Integrative rehabilitation practice: The foundations of whole-person care for health professionals*. Jessica Kingsley Publishers.

Ferow, A. (2019). Childhood grief and loss. *The European Journal of Educational Sciences*, 6(1), 1-13. https://doi.org/10.19044/ejes.s.v6a1

Flahive, M., & Ray, D. (2007). Effect of group sandtray therapy with preadolescents in a school setting. *Journal for Specialists in Group Work, 32*, 362-382.

Foster, R. (2023). Humanistic sandtray therapy: Theoretical underpinnings and practical applications. *World Journal for Sand Therapy Practice, 1*(7). https://doi.org/10.58997/wjstp.v1i7.38

Gilleland, J., Bayfield, D., Bayliss, A., Dryden-Palmer, K., Fawcett-Arsenault, J., Gordon, M., Hartfield, D., Iacolucci, A., Jones, M., Ladouceur, L., McNamara, M., Middaugh, K., Moore, G., Murray, S., Noble, J., Singh, S., Stuart-Minaret, J., Williams, C., & Parshuram, C. S. (2019). Severe illness getting noticed sooner - SIGNS-for-Kids: developing an illness recognition tool to connect home and hospital. *BMJ Open Quality*, *8*(4), e000763. https://doi.org/10.1136/bmjoq-2019-000763

Golics, C. J., Basra, M. K., Salek, M. S., & Finlay, A. Y. (2013). The impact of patients' chronic disease on family quality of life: an experience from 26 specialties. *International Journal of General Medicine, 6,* 787–798. https://doi.org/10.2147/IJGM.S45156

Hasanah, I., Nursalam, Lei, C. P., Sari, A. S., Simanjuntak, S. R., Supinganto, A., Zulkahfi, Halid, S., Hadi, I., & Mulianingsih, M. (2025). Factors related to quality of life in children with chronic illness from their own perspectives: A cross-sectional study. *Journal of Pediatric Nursing*, *80*, e218–e227. https://doi.org/10.1016/j.pedn.2024.12.016

Herce, N., Ochoa de Alda, I. & Marrodán, José. (2024). Sandtray and sandplay in the treatment of trauma with children and adolescents: A systemic review. *World Journal for Sand Therapy Practice. 2*(1). https://doi.org/10.58997/wjstp.v2i1.74

Hilário, A. P. (2022). Sibling caring roles and responsibilities when a child suffers from a chronic illness. *Sociology Compass, 16*(1), e12950. https://doi.org/10.1111/soc4.12950

Holliman, R., & Foster, R. D. (2023). The way we play in the sand: A meta-analytic investigation of sand therapy, its formats, and presenting problems. *Journal of Child and Adolescent Counseling*, *9*(2), 205–221. https://doi.org/10.1080/23727810.2023.2232142

Homeyer, L. E., & Sweeney, D. S. (2023). *Sandtray therapy: A practical manual* (4th ed.). Routledge. https://doi.org/10.4324/9781003221418

Isom, E. E., Groves-Radomski, J., & McConaha, M. M. (2015). Sandtray therapy: A familial approach to healing through imagination. *Journal of Creativity in Mental Health*, *10*(3), 339–350. https://doi.org/10.1080/15401383.2014.983254

Kelada, L., Wakefield, C. E., Drew, D., Ooi, C. Y., Palmer, E. E., Bye, A., De Marchi, S., Jaffe, A., & Kennedy, S. (2022). Siblings of young people with chronic illness: Caring responsibilities and psychosocial functioning. *Journal of Child Health Care: For Professionals Working With Children in the Hospital and Community*, *26*(4), 581–596. https://doi.org/10.1177/13674935211033466

Kronick, R., Rousseau, C., & Cleveland, J. (2018). Refugee children's sandplay narratives in immigration detention in Canada. *European Child & Adolescent Psychiatry*, *27*(4), 423–437. https://doi.org/10.1007/s00787-017-1012-0

Lacroix, L., Rousseau, C., Gauthier, M. F., Singh, A., Giguère, N., & Lemzoudi, Y. (2007). Immigrant and refugee preschoolers' sandplay representations of the tsunami. *Arts in Psychotherapy*, *34*(2), 99–113.

Law, E., Fisher, E., Eccleston, C., & Palermo, T. M. (2019). Psychological interventions for parents of children and adolescents with chronic illness. *The Cochrane Database of Systematic Reviews*, *3*(3), CD009660. https://doi.org/10.1002/14651858.CD009660.pub4

Lee, G. M., Johari, K. S., Mahmud, Z., & Abdullah, M. N. (2018). Sandtray for children of divorced parents. *International Journal of Academic Research in Business and Social Sciences*. *8*(4), 1224-1234.

Lowenfeld, M. (1993). *Understanding children's sandplay: The world technique.* Rowe. (Originally published as The World Technique, George Allen & Unwin, 1979).

Lyles, M., & Homeyer, L. E. (2015). The use of sandtray therapy with adoptive families. *Adoption Quarterly, 18*(1), 67–80. https://doi.org/10.1080/10926755.2014.945704

Mackova, J., Veselska, Z. D., Geckova, A. M., Jansen, D. E. M. C., van Dijk, J. P., & Reijneveld, S. A. (2022). The role of parents in the care for adolescents suffering from emotional and behavioral problems. *Frontiers in Psychology*, *13*, 1049247. https://doi.org/10.3389/fpsyg.2022.1049247

Pate, T. (2016). Families of children with chronic illness and the Relational Family Model. *The Person and the Challenges. The Journal of Theology, Education, Canon Law and Social Studies Inspired by Pope John Paul II*, *6*(2), 57–65. https://doi.org/10.15633/pch.1892

PediPec. (2025). *Understanding common childhood illnesses and their symptoms*. https://www.pedistat.com/blog/understanding-common-childhood-illnesses-and-their-symptoms

Petrović-Sočo, B. (2013). Symbolic play of children at an early age. *Croatian Journal of Education, 16,* 235-251.

Read, J., Kinali, M., Muntoni, F., Weaver, T., & Garralda, M. E. (2011). Siblings of young people with Duchenne muscular dystrophy--a qualitative study of impact and coping. *European Journal Of Paediatric Neurology: EJPN: Official Journal Of The European Paediatric Neurology Society*, *15*(1), 21–28. https://doi.org/10.1016/j.ejpn.2010.07.006

Rohan, J. M., & Verma, T. (2020). Psychological considerations in pediatric chronic illness: Case examples. *International Journal of Environmental Research and Public Health*, *17*(5), 1644. https://doi.org/10.3390/ijerph17051644

Saad, M., de Medeiros, R., & Mosini, A. C. (2017). Are we ready for a true biopsychosocial-spiritual model? The many meanings of "spiritual". *Medicines (Basel, Switzerland)*, *4*(4), 79. https://doi.org/10.3390/medicines4040079

Schottelkorb, A. A., Swan, K. L., Jahn, L., Haas, S. A., & Hacker, J. G. (2015). Effectiveness of play therapy on problematic behaviors of preschool children with somatization. *Journal of Child and Adolescent Counseling, 1*, 16 - 3.

Sharma, R. (2013). The family and family structure classification redefined for the current times. *Journal of Family Medicine And Primary Care*, *2*(4), 306–310. https://doi.org/10.4103/2249-4863.123774

Smith, S. D. (2012). *Sandtray play and storymaking: A hands-on approach to build academic, social, and emotional skills in mainstream and special education.* Jessica Kingsley.

Smith, B. A., & Kaye, D. L. (2012). Treating parents of children with chronic health conditions: the role of the general psychiatrist. *Focus*, *10*(3), 255–265. https://doi.org/10.1176/appi.focus.10.3.255

Swank, J. M., & Lenes, E. A. (2013). An Exploratory Inquiry of Sandtray Group Experiences With Adolescent Females in an Alternative School. *The Journal for Specialists in Group Work*, *38*(4), 330–348. https://doi.org/10.1080/01933922.2013.835013

Tan, J., Yin, H., Meng, T., & Guo, X. (2021). Effects of sandplay therapy in reducing emotional and behavioural problems in school-age children with chronic diseases: A randomized controlled trial. *Nursing Open*, *8*(6), 3099–3110. https://doi.org/10.1002/nop2.1022.

Taylor, E. R. (2009). Sandtray and solution-focused therapy. *International Journal of Play Therapy, 18*(1), 56–68

Van Cleave, J., Gortmaker, S. L., & Perrin, J. M. (2010). Dynamics of obesity and chronic health conditions among children and youth. *JAMA*, *303*(7), 623–630. https://doi.org/10.1001/jama.2010.104

Vranceanu, A-M., Greer, J., & Safren, S. (2017). T*he Massachusetts General Hospital handbook of behavioral medicine: A clinician's guide to evidence-based psychosocial interventions for individuals with medical illness*. Humana Press. https://doi.org/10.1007/978-3-319-29294-6

Worden, J. W. (2018). *Grief counseling and grief therapy* (5th ed.). Springer Publishing.

Yang, Y. (2014). The effects of sandplay therapy on the behavioral problems, self-esteem, and emotional intelligence of children in grandparents-grandchildren families in rural Korean areas. *Journal of Symbols & Sandplay Therapy, 5*(1), 7–13. https://doi.org/10.12964/jsst.130012

Zdun-Ryżewska, A., Nadrowska, N., Błażek, M., Białek, K., Zach, E., & Krywda-Rybska, D. (2021). Parent's stress predictors during a child's hospitalization. *International Journal of Environmental Research and Public Health*, *18*(22), 12019. https://doi.org/10.3390/ijerph182212019

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