Family interventions and resources of *Sandplay* therapy withadolescents victims of trauma

Intervenções familiares e recursos da terapia *Sandplay* com adolescentes vítimas de trauma

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ABSTRACT

Introduction: Trauma can be understood as a stressful experience or continuous exposure to an event that can cause harm to the healthy development of adolescents. Situations of physical, psychological, and sexual violence interrupt the natural flow of biopsychosocial development, presenting psychopathologies that often prevent adolescents from adapting to society. Objective: To investigate how psychological interventions, through an individual psychotherapeutic process, using resources such as Sandplay therapy along with meetings with parents, may allow improvement of traumatic symptoms in adolescents and therefore be better

conducted by psychology specialists. Methods: Descriptive research witha qualitative and exploratory approach, based on the pre-experimental method, including 10 adolescents who were victims of trauma. The Posttraumatic Stress Symptom Screening Instrument (PSSSI), the Perception Inventory of Family Support (PIFS), weekly psychotherapeutic follow-up with Sandplay Therapy, and meetings with parents of the adolescents were used. Results: In the comparison of PIFS before and after treatment, the results showed significant improvement ($p < 0.05$). In the comparison of the trauma scale (PSSSI) before and after treatment, although all variables showed improvement, only avoidance was statistically significant. After the meetings, parents and caregivers subjected to a sensitization approach could become more receptive and welcoming. Conclusions: The combination of individual and family interventions could trigger significant changes in the re-signification of the trauma, providing not only the adolescent but also his/her family with magnification and fortification of a healthier development, causing those involved to reposition themselves to the experienced contexts.

Keywords: adolescence, trauma, psychotherapy, family.

RESUMO

Introdução: O trauma pode ser entendido como uma experiência stressante ou exposição contínua a um evento que pode causar danos ao desenvolvimento saudável dos adolescentes. Situações de violência física, psicológica e sexual interrompem o fluxo natural do desenvolvimento biopsicossocial, apresentando psicopatologias que muitas vezes impedem os adolescentes de se adaptarem à sociedade. Objectivo: Investigar como as intervenções psicológicas, através de um processo psicoterapêutico individual, utilizando recursos como a terapia Sandplay juntamente com reuniões com os pais, podem permitir a melhoria dos sintomas traumáticos nos adolescentes e, portanto, ser melhor conduzidas por especialistas em psicologia. Métodos: Investigação descritiva com uma abordagem qualitativa e exploratória, baseada no método pré-experimental, incluindo 10 adolescentes que foram vítimas de trauma. Foram utilizados o Instrumento de Rastreio dos Sintomas de Stress Pós-Traumático (PSSSI), o Inventário de Percepção de Apoio Familiar (PIFS), o acompanhamento psicoterapêutico semanal com a Terapia de Sandplay, e reuniões com os pais dos adolescentes. Resultados: Na comparação do PIFS antes e depois do tratamento, os resultados mostraram uma melhoria significativa ($p < 0,05$). Na comparação da escala de trauma (PSSSI) antes e depois do tratamento, embora todas as variáveis mostrassem melhorias, apenas a prevenção foi estatisticamente significativa. Após as reuniões, pais e prestadores de cuidados sujeitos a uma abordagem de sensibilização poderiam tornar-se mais receptivos e acolhedores. Conclusões: A combinação de intervenções individuais e familiares poderia desencadear mudanças significativas na re-significação do trauma, proporcionando não só ao adolescente mas também à sua família uma ampliação e fortificação de um desenvolvimento mais saudável, fazendo com que os envolvidos se reposicionassem nos contextos experimentados.

Palavras-chave: adolescência, trauma, psicoterapia, família.

1 INTRODUCTION

Epidemiological research has shown that a significant number of children and adolescents have suffered some type of trauma (Morina, Koerssen, & Pollet, 2016).

Trauma can be understood as a stressful experience or continuous exposure to an event that can cause harm to the healthy development of adolescents. Situations such as sexual abuse, physical violence, mistreatment, theft/kidnapping, and natural disasters are on the list of traumatic events (Van Der Kolk, 2005).

Such situations generate what literature calls “trauma”, interrupting the natural flow of the biopsychosocial development, presenting psychopathologies that often prevent adolescents from adapting to society.

Trauma is not a recent subject; however, it has recently gained the attention of health professionals. In the 1970s, there was an attempt by psychiatrist Sarah Haley, taking into account the literature available at that time,to build scientific knowledge from a comprehensive analysis of particular sets of symptoms. After that, Stockholm syndrome, battered woman syndrome, Vietnam syndrome, and child abuse syndrome were described from a traumatic event perspective/concept (Van Der Kolk, McFarlane, & Van Der Hart, 1996). The work of Haley was the seed that triggered the inclusion of the category “Posttraumatic Stress Disorder” (Schestastky, Shansis, Ceitlin, Abreu, & Hauck, 2003), in 1980, in the Diagnostic and Statistical Manual of Mental Disorders – 3rd edition (DSM-III).

Currently, the Diagnostic and Statistical Manual of Mental Disorders – 5th edition (DSM-V) (American Psychiatry Association [APA], 2014), the most current version of the manual, presents a broader category, namely “Trauma-related Disorders and Stressors”, encompassing any psychological suffering or condition caused by an exposure to a traumatic event, whether as a victim or a bystander.

A study (APA, 2014) points out that trauma in childhood may be a significant etiologic factor in the development of a number of disorders, also in adult life. Thus, in the long term, the individual who has experienced a traumatic event may present some problems, such as: psychotic thinking, violence/aggression, dissociation, passivity, self-mutilation, and anxiety-related disorders.

In this sense, the concept of “complex trauma” can point to multiple and prolonged exposures to stressful events. Van der Kolk (2005) states that there are important links between childhood experiences of trauma and depression, suicidal idealization, alcohol and drug abuse, highly sexual behavior, and obesity. Other changes may occur, such as: depersonalization, nightmares/sleeping difficulties, school and learning problems, and behavioral regression (Terr, 1991).

In a more recent meta-analysis (Morina et al., 2016), cognitive-behavioral approach and cognitive techniques are pointed out as the most used interventions whenworking with children

and adolescents with trauma. However, it should beemphasized that Cognitive-Behavioral Therapy (CBT) should not be used at the beginning of a treatment because the traumatic event has little to do with cognition, since it appears in the emotional part of the brain, responsible for sending messages of danger and anguish (Howe, 2005). Thus, CBT may provide trauma desensitization rather than its integration. Therefore, techniques such as sensory integration and Sandplay Therapy (ST) help children in their emotional regulation. According to Van der Kolk (2005), the use of non-verbal techniques and methods is quite effective for the treatment of traumatized children and adolescents.

ST is a method of psychotherapy, originated in the Jungian approach, initiated by Dora Kalff in the 1950s. Encouraged by Jung himself, the researcherinitially developed a method of analyzing children, which was later proven by the creator herself to be useful for both teenagers and adults. ST is influenced by the World Technique, proposed by English psychiatrist Margaret Lowenfeld, and by oriental traditions (Mitchell & Friedman, 1994).

ST is a recreational type of therapy that consists of the use of two boxes of sand – one dry and the other wet, and allows patients to manipulate the sand and use the miniatures available to create a scenario. This can be understood as a three-dimensional expression of some aspects of the psychic life of the subject. In producing a scenario, a conflict is transferred from the inner to the outside world, gaining life (Kalff, 1980). Some therapists use ST as the main method, while others integrate it into verbal analysis and other methods of psychotherapy (Von Gontard, 2010).

It is known that words often do not reach the most just and complete expression of meaning; they constitute the language of consciousness, while the image is the way whereby the unconscious communicates. Because it is a non-verbalmethod, ST can offer a universal communication of the psyche. Just as in dreams, the images that appear in the sandbox are images of the unconscious that can be understood and interpreted (Friedman, 1997).

ST has shown to be an excellent and versatile method, mainly in the treatment of internalizing disorders such as depression, phobias, and anxiousness disorders, among others (Von Gontard, 2010).

Research (Calvete, Fernández-González, Orue, & Little, 2018) also demonstrates that conflicts and issues involving trauma or that impair their identification arise from the combination between the difficulties of adolescents and their parents in dealing with the traumatic situation itself, which include the settings of the adolescence phase and sociocultural contingencies.

The family in general is involved in the origin, in the maintenance, and in the management of the difficulties of its members, especially when discussing the development of psychopathological symptoms such as those of trauma. However, care must be taken, since other factors – social, biological, cultural – may explain the behavior of the adolescents (Baptista, 2008).

Including the family in the therapeutic process of adolescents brings parents closer to their children's complaints. Adolescents can be understood from a broader perspective and no longer as the ones held responsible for all the problems. The family can recognize adolescents' peculiar characteristics and symptoms, thus contributing to resignification and symbolic reorganization of their subjectivities and history.

This study aims to investigate the effectiveness of the combination of twopsychological interventions in the treatment of trauma in adolescents, through an individual psychotherapeutic process, using ST and parents meetings to improve the traumatic symptoms and the management of the symptoms by the health professional.

2 METHODOLOGY

This is a descriptive research study, with a qualitative and exploratory approach, which used the pre-experimental method (Creswell, 2010), since it allows each one to reveal aspects of reality, allowing a wider observation of a given context and, consequently, obtaining safer results.

The sample consisted of 10 adolescents chosen through convenience sampling, who met the following criteria: a) traumatic experiences due to physical, physiological or sexual violence, neglect or abandonment; b) either male or female; c) ages between 10 and 16 years; d)referral to the Psychology Department of the Institute of Hebiatrics of theFaculty of Medicine of ABC and inclusion on a waiting list, awaiting for medical care. The referrals were made by an adolescent medicine specialist after the first clinical consultation.

Adolescents in psychiatric care and/or using psychiatric medications were excluded from the sample.

The 10 selected adolescents were treated in an individual psychotherapeutic process, in 12 weekly sessions.

In addition, five group meetings were held with the parents and/or guardians of the adolescents. In this group, 11 people attended:nine mothers, one father, and one stepfather.

The study was conducted at the Centro de Referência Adolescente Cidadão Esperança, headquarters of the Institute of Hebiatrics of the Faculty of Medicine of ABC, in Santo André,

São Paulo. The research project was approved by the Research Ethics Committee of the Centro Universitário Saúde ABC, process nº 3.361.498.

Prior to the research, a search was conducted in the medical records of the Institute of Hebiatrics for selection of adolescents.The referrals made to the Division of Psychology with indicators of violence, neglect or abandonment were assessed. The medical records were consulted at the Institution itself and were not removed from its facilities, not even reprogramed or photographed, thus ensuring content confidentiality.

The participants were then contacted and signed an assent form andtheir parents or guardians signed an informed consent form.

Subsequently, the participants were assessed through the following instruments:

2.1 POSTTRAUMATIC STRESS SYMPTOM SCREENING INSTRUMENT (PSSSI)

The instrument was designed with the objective of being a brief and self- reporting screening, in which the individual responds to 17 items (presented as statements) related to PTSD symptoms. It is not a diagnostic tool, but it is useful for identifying traumatic symptoms. Three factors are considered: avoidance, revival, and excitability (Kristensen, 2005).

Thus, the adolescent scores from 0 to 10 for the 17 statements, accordingto symptom frequency, where 0 means never and 10 means always. A score equal toor greater than 50 is indicative of the presence of symptoms. The instrument takes approximately 10 minutes to be applied.

2.2 PERCEPTION INVENTORY OF FAMILY SUPPORT (PIFS)

PIFS assists in the identification of the individual's perception of their family support and also helps in the detection of family patterns. The PIFS evaluates three functions: affective, adaptation, and autonomy through 42 questions, whose answer options include: always/almost always, more or less, and never/almost never. The instrument is intended for people aged 11 to 57 years (Baptista, 2008).

2.3 MEETINGS FOR PARENTS OF ADOLESCENTS

Five meetings with parents and guardians were held in order to provide guidance on the adolescence phase, on raising awareness of the symptoms, onrepositioning of family relations, and on the understanding of the trauma presented by the adolescents.

Follow-up and the inclusion of the family in the care of the adolescent is highly recommended, since adolescents will have the opportunity to involve their families in monitoring their conflicts. However, the professional and the adolescent must draw the line regarding the involvement of the family in certain questions, such as privacy, confidentiality, and autonomy (Crespin, 2007).

The meetings emphasized some aspects of adolescents' psychosocial development and outlined expected behaviors, symptoms, and abnormalities.

The meetings were held every two weeks and lasted two hours.

2.4 SANDPLAY THERAPY (ST)

The technical materials for the ST were: two sandboxes with special size of 60 cm X 40 cm X 8 cm. Box size was adapted to the institutional reality, that is, outpatient care.

Miniatures were grouped by categories: people, housing, transport, stones, nature (trees, flowers, plants), unstructured objects (sticks, woodenblocks, ribbons).

All participants had the same number of miniatures (Kalff, 1980).The data were collected in three phases:

- 1st phase (pretest): rapport and the application of the PSSSI and the PIFS. Duration: 20 minutes.
- 2nd phase: the treatment consisted of 12 individual weekly sessions, with each session having an average duration of 40 to 50 minutes. In the first session, the professional started the ST by telling the adolescent: *"Here you find several miniatures and two sandboxes, one with dry sand and one wet. You can use these miniatures to make a scene in the box of your choice"*. Verbal and non-verbal expression of the participant was recorded in writing. While the adolescents were individually assisted, the parents were invited to participate in a psychoeducational group, in which topics emerged from the participants themselves and were managed by the professional.
- 3rd phase (posttest): after the 12 sessions, the PSSSI and the PIFS were reapplied.

Qualitative variables were presented as absolute and relative frequencies. And the quantitative variables were represented by mean, standard deviation, and 95% confidence interval, according to the Shapiro-Wilk normality test ($p > 0.05$).

The t-test for paired samples was used to compare the factors of the PIFS questionnaire before and after the treatment, whereas the McNemar test was used to compare the trauma scale (PSSSI) before and after the treatment.

The confidence interval was set at 95%. Statistical analysis was performed using Stata version 11.0.

3 RESULTS

The study included 10 adolescents (seven boys and three girls), with a mean age of 13.6 years (±2.0).

Of the total number of participants, six had incomplete elementary education and four had incomplete secondary education; five were children of divorced parents and five of married parents. These data are related to the information gathered from the PIFS (Table 1).

Table 1. Description of the sample.

Variables	n	%
Sex		
Male	7	70.0
Female	3	30.0
Education		
Incomplete elementary education	6	60.0
Incomplete secondary education	4	40.0
Evaluation		
Family nucleus	10	100
Marital status of the parents		
Married	5	50.0
Divorced	5	50.0
	Average (SD)	**Minimum – Maximum**
Age (years)	13.6 (2.0)	11 – 16

Table 2 presents a comparison of the PIFS before and after the treatment, showing that all the factors analyzed showed significant improvement($p<0.05$).

Note that for Factor 1 (consistent affective response), there was a statistically significant difference before (mean of 25.8) and after (mean of 32.3) the treatment.

For Factor 2 (adaptation), there was also a statistically significant difference before (mean of 15.6) and after (mean of 21.7) the treatment.

And, lastly, for Factor 3 (autonomy), a statistically significant difference was observed before (mean of 6.3) and after (mean of 10.4) the treatment.

Table 2. Comparison of the PIFS before and after the treatment.

Variables	Before	After
	n (%)	
Classification 1		
Low	2 (20.0)	0 (0)
Medium low	4 (40.0)	2 (20.0)
Medium high	2 (20.0)	3 (30.0)
High	2 (20.0)	5 (50.0)
Classification 2		
Low	7 (70.0)	3 (30.0)
Medium low	1 (10.0)	2 (20.0)
Medium high	1 (10.0)	0 (0)
High	1 (10.0)	5 (50.0)
Classification 3		
Low	9 (90.0)	5 (50.0)
Medium low	1 (10.0)	1 (10.0)
Medium high	0 (0)	3 (30.0)
High	0 (0)	1 (10.0)
Total Classification		
Low	7 (70.0)	0 (0)
Medium low	3 (30.0)	5 (50.0)
Medium high	0 (0)	4 (40.0)
High	0 (0)	1 (10.0)
	Mean (95% CI)	
Factor 1 *(p=0.025)**	25.8 (19.98; 31.61)	32.3 (29.26; 35.35)
Factor 2 *(p= 0.006)**	15.6 (11.59; 19.60)	21.7 (19.38; 24.01)
Factor 3 *(p<0.001)**	6.3 (4.03; 8.56)	10.4 (8.20; 12.59)
Total *(p=0.005)**	47.7 (38.28; 57.11)	64.2 (60.55; 67.84)

SD: standard deviation. *T-test for paired samples.

Table 3 shows the comparison of the trauma scale (PSSSI) before and after the treatment, showing that, although all variables improved, only avoidance presented significant results.

Table 3. Comparison of trauma scale (PSSSI) before and after the treatment.

Variables	Before	After	p*
	n (%)		
Avoidance			
Yes	8 (80.0)	2 (20.0)	0.031
No	2 (20.0)	8 (80.0)	
Revival			
Yes	5 (50.0)	1 (10.0)	0.125
No	5 (50.0)	9 (90.0)	
Excitability			
Yes	7 (70.0)	2 (20.0)	0.063
No	3 (30.0)	8 (80.0)	

*McNemar test.

In addition, five meetings were held with parents and/or guardians, allowing them to reposition themselves, by giving them information about the adolescence phase, awareness of the trauma, and necessary changes within the family nucleus.

The meetings, through interventions and selected themes, provided a space for the exchange of experience, externalization of feelings, and the possibility of behavioral change.

In order to establish an understanding of adolescence, associated psychosocial aspects were discussed in the first meeting. At thatmoment, parents presented difficulty or lack of information regarding the characteristics of adolescence. In order to properly address the questions, a presentation was conducted, providing important information on how adolescents function.

In general, in order to broaden the information, the starting point waswhat was expected from the adolescence phase. It was specified that by the end of the adolescence phase each individual will have acquired an adult body, reproductive capacity, social responsibility, independence, emotional maturity, professional choice and, above all, adult identity.

Identity is the awareness an individual has of himself/herself and about himself/herself in relation to the world. For the structuring of the sense of identity to take place, individuals should lose their child's referential in order to inhabit a new body and experience a "new mind". A true "awakening of self".

In this regard, the adolescent is faced with a great need for adaptation. Inthis passage from childhood to adulthood, a rupture with the subjectivity of childhood and progressive separation from the parents are necessary and, during this loss of the referential, meetings become one of the most significant aspects of this phase, since they represent a form of identification, support, and refuge (World Health Organization [WHO], 1986).

Adolescents are expected to have the desire for autonomy and thesearch for the discovery of other ideals, so they can have a better perception of reality (Calvete et al., 2018). From that point, doubts and hesitations arise. It is a time of searching and knowledge, and dialogues with parents and/or guardians become paramount.

How to establish a welcoming dialogue within the limitation of the affective scope and, at the same time, to punctuate rules and limits? How to welcome and delineate the appropriate and the inadequate?

Doubts about education and assertive punishments were questioned. How to intervene?

How to apply punishments that are meaningful and that can trigger changes?

I cannot “spank”, what to do? Do I take the cell phone or not?
After a suicide attempt, do I allow my son/daughter to go out with friends or not?Can I have the password to his/her social media?

No ready formula exists. Each individual has unique and complex characteristics. The etiology is multifactorial. There are hereditary andenvironmental aspects. Thus, we understand that the uniqueness of each individual has to be respected.

These punitive interventions need to be felt and applied immediately. They will trigger a healthy movement of change if it involves coherent psychic aspects. What to expect? What not to expect? Punitive measures will be more accurate if they are compatible with the unique characteristics of the adolescent in question.

Within this context, aspects related to the singularity of adolescents and their family and social environment were addressed. Along with this, behaviors towards the trauma situation and towards the sociocultural context and ways to understand the individual and complex aspects of adolescence were emphasized.

Understanding the behavior and the symptoms that are part of this psychosocial development, such as the search for adult identity, group tendency, the desire to fantasize and intellectualize, religious crises, claims, progressive separation from parents, and sexual evolution, may enable the understanding of the abnormalities and attitudes that are not assertive (Calvete et al., 2018).

In the work developed with parents and/or guardians, it was possible to establish the variables between the expected and unexpected within that age group. Based on that, the understanding between what is part of the adolescence phase and what delimits the possible psychic suffering was delineated.

Establishing a space of comfort, triggered by the therapeutic link, the traumas presented by the adolescents were approached, such as mistreatments, sexual abuses, bullying, and lack of family support. Some conceptions were collected about such themes, such as:

Bullying – many parents and guardians do not really understand what bullying is and what it can mean in the lives of adolescents. The interventionneeds to be made immediately and jointly, by parents and school. In the family context, dialogue is essential, since it is a form of support and welcome for adolescents who lack group reference.

Mistreatments – refer to an intentional injury or threat, whether for a shortor long period of exposure, and which may trigger damage to the individual’s development (Schwartz et al., 2017). In this way, the importance of support and the process of compensation against trauma were discussed. Some questions were asked by some members of the group, as follows:

> Now that this has happened, will my son be traumatized forever?
> The father is already away and "paying for what he did", but all thathe has been through I cannot change.
> Will my son have problems for the rest of his life?

At the first meeting, through a dynamic of integration, the psychology specialist asked each parent or guardian to answer a question. This question was also used as a pretest and posttest measure to verify the change in the conceptions of these parents/guardians regarding their children. The question asked was: what does it mean to be a parent of an adolescent?

> Difficult to deal with bad habits of education and challengingbehavior.
> Owners of truth.
> They will better value when they suffer.They think they are adults.
> Friends have more value.
> They do not accept no as an answer.They spend a lot of time in their rooms.
> Clutterers.

In the last meeting, the same question was asked, and the answers changed in relation to all parents and guardians who followed up the treatment process of their children:

> Because of the meetings I could understand my son better. I remembered my adolescence.
> Giving up at times is important. Family love makes all the difference.I understood what family is.
> They grew up.
> They are suffering. Me too, but I need to be a mother.I need to say more often that I love him/her.
> I think I overreacted.
> I need to compliment more.

4 DISCUSSION

Avoidance was the PSSSI category in which 80% of the adolescents scored, since the escape from the traumatic situation, on the one hand, facilitates moments of greater introspection; on the other hand, it hinders access to the psyche of adolescents and necessary elaboration so that the balance can be resumed.

In category D, which concerns excitability, 70% of the adolescents exhibited recklessness, anxiety, hyperarousal, and sleep and/or eating disorders as a "consequence" of the trauma. The anxiety that prevents them from having a family or social relationship (with friends) and the feeling of being always alert, as if they were always waiting for danger, cause adolescents to cut off contact with reality, avoiding healthy relationships with the outside world.

After 12 ST sessions, adolescents answered the PSSSI once again. The results suggest improvement after treatment. Avoidance symptoms decreased from 80% at the beginning of

treatment to 20%, showing that the treatment allowed adolescents to address traumatic issues, breaking up isolation behaviors and affective detachment (Freedle, Altschul, & Freedle, 2015).

The traumatic event can be continually revived, through images, dreams,illusions, and flashbacks. Numerous situations can lead to the sensationof being reliving the event and, consequently, the suffering (Besset, 2006). These symptoms decreased from 50% at the beginning to 10%.

Excitability symptoms decreased from 70% at the beginning to only 20% after the treatment, and symptoms of anxiety, irritability, hyperarousal, sleeping difficulty, low concentration, and restlessness[20] were less intense after the treatment.

By looking at the data and thinking about the effectiveness of ST, with the purpose of endorsing ST as a possibility for treating traumas, we can verify the themes and content of the scenarios produced in the sandbox. Although a clinical analysis of the psychodynamics of the ST is not within the scope of this study, the themes changed from chaos and catastrophe to construction, interaction, and nutrition. Themes that have been removed from the configuration of each scenario itself.

The use of ST with people who have experienced trauma has alreadybeen discussed; however, the contribution of this study suggests that Sandplay can be used as an important intervention (Von Gontard, 2010). The duration of a therapeutic process in a public health environment has to be rethought and traumatic events in a vulnerable population require effective and global interventions.

Adding ST to the outpatient treatment of adolescents improves their participation, making them more motivated to endure a 12-week treatment course.

In this study, adolescents in contact with Sandplay ended up getting involved with themes and actively participating in their own treatment (Freedle et al., 2015). The imagination that is awakened to create their “world” leads themto resort to various ways of expressing themselves, easing their trauma. Thus, the theme ends up gaining life and energy and that can be expressed through Sandplay.

Sandplay is presented as a possibility to intervene in the trauma and is described as an instrument that provides any professional involved with the treatment with four relevant aspects: relational security, sensory processing,expression and narrative of the trauma, and facilitation of homeostasis. In this way, sandplay is an instrument that offers a favorable space where trauma is worked through in a respectful, creative, and spontaneous way (Von Gontard, 2010; Freedle et al., 2015).

This study shows, from a small sample, that sandplay appears to have significant efficacy similar to other interventions already establishedin the literature.

Another intervention during the treatment period was the meeting for parents/guardians of adolescents who were victims of trauma. Although the focus of this project is not to evaluate them, the PIFS is a self-reported assessment of family support given to the adolescents.

It is understood that individual intervention affects the adolescents, and the adolescents reverberate these changes obtained with their families. Autonomy was the category that had the highest score increase, which leads us to think that families demand more responsibility from adolescents and provide them with more power over their own lives (Besset, 2006; Baptista, 2008).

The merit of such changes must also be attributed, in part, to workingwith the family.

At the time of the pretest, the adolescents obtained a predominantly low score (70%) for the perception of family support. The overall low score is indicative that in the three categories evaluated – affection, adaptation, and autonomy – adolescents perceived that the dialogue between the parties, often deficient, unproductive, and of poor quality.

After individual intervention with the adolescents and meetings with parents and/or guardians, the instrument was reapplied as a posttest, and a different final score was obtained: 50% medium-low, 40% medium-high, and 10% high, which represents a change in the perception of these adolescents of their relationships with their parents, demonstrating more cohesion and family adaptability, contributing as a protective factor for these adolescents, facilitating symptom improvement and elaboration of the trauma (Baptista, 2008; Briggs-Gowan et al., 2019).

At first, parents' cultural and personal conceptions centered around negative aspects of adolescence and of adolescents themselves. After the meetings, the answersgiven by parents and/or guardians varied significantly and were more welcoming of adolescents' subjectivity.

We can assume that this change occurred because parents/guardians came into contact with their own adolescence, triggering a feeling of empathy for the adolescent's experience and his/her issues. In this way, through sensitization, parents and guardians could become more receptive and welcoming.

5 FINAL CONSIDERATIONS

In a context of primary outcomes (quantitative ones), pretest and posttest data demonstrated improvement of avoidance symptoms, while the other two symptomatic categories, revival and excitability, measured by PSSSI, did not show significant results.

It is understood that traumatic experiences are difficult to manage, and the improvement of avoidance symptoms indicates that when defense mechanisms are turned off, trauma can be worked through. It is suggested that additional studies are needed in order to further investigate the methodological approaches used in this research.

The data obtained from the PIFS suggest significant improvement in the three categories evaluated, indicating that the inclusion and participation of the family in adolescent care may help adolescents heal from trauma.

The secondary outcome of this study enabled a clinical analysis of the combination of two interventions that, albeit not statistically supported by the data, may suggest improvement.

Since ST involves creativity and play, working with trauma has become somewhat less expository. Sandplay itself invites adolescents to try it, facilitating adherence to the treatment and willingness to actively participate in the psychotherapeutic process.

Because it is a difficult work subject, since traumas involve psychicsuffering and difficulty in verbalizing it, Sandplay presented itself as a facilitator of how subjectivity, often of difficult reality, could be approached and elaboratedthrough a more creative and lighter approach.

Although individual care to adolescents had good responses, family involvement in the psychotherapeutic process also contributed to significant changes. The family, considered as the primary group of the adolescent, can influence directly or indirectly and can affect affective and cognitive development.

The study evidenced the difficulties in the treatment of traumatic symptoms in adolescence and showed that the combination of individual and family interventions could trigger significant changes in the re-signification of the trauma, providing not only the adolescent but also his/her family with magnification and fortification of a healthier development, causing those involved to reposition themselves to the experienced contexts.

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